healthpolicyconsortium
Advancing sound health policy at a state, regional and national level.

THE CASE FOR CONTINUING MEDICAID EXPANSION IN NORTH DAKOTA

NOVEMBER 2016

PRODUCED BY
THE HEALTH POLICY
CONSORTIUM (HPC)

The Health Policy Consortium is comprised of North Dakota health care leaders committed to sound public policy at the state, regional, and national level. HPC's members provide more than 80 percent of North Dakota's health care through a combined network of 13 hospitals and 137 clinics. HPC facilities serve as community cornerstones, each year generating more than $5 billion in revenue and providing quality jobs to more than 20,000 North Dakotans. These skilled professionals annually oversee more than 1.3 million outpatient visits, 70,000 inpatient visits, and 200,000 emergency room visits. HPC's membership includes:

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01 EXECUTIVE SUMMARY

In 2013, North Dakota joined 30 other states and the District of Columbia in embracing Medicaid expansion for its potential to improve the lives of vulnerable North Dakotans within a funding structure that would allow the state to heavily leverage federal dollars. North Dakota's decision to expand Medicaid opened the doors for its citizens and providers to access the rich benefits of a program for which all states must pay — directly and indirectly — regardless of expansion status.

Early estimates placed North Dakota's eligible expansion population at 20,500 to 32,000 lives, and enrollment figures have generally plateaued at or below the low end of that estimate. But unexpected costs, coupled with a strained state budget, have compelled an assessment of the program's structure and stakeholder collaboration to find efficiencies that minimize the forfeiture of millions of federal dollars and the quality patient access those dollars help fund.

These discussions arrive as North Dakota and other expansion states prepare to assume a small, but noteworthy, percentage of Medicaid expansion costs. Medicaid expansion is 100% federally funded through the end of 2016. Beginning January 1, 2017, expansion states assume 5% of costs, a share that will gradually increase to and cap out at 10% by 2020. For the 2015-2017 budget period, North Dakota is expected to receive approximately $533.6 million in federal funds on a state investment of $8.2 million.

North Dakota's early experiences with Medicaid expansion highlight that many of its previously uninsured citizens suffer from long-neglected and complex health care issues. This is reflected in costs of claims nearly 3½ times those incurred by commercially insured populations. The dignity and quality of life Medicaid expansion offers North Dakotans can hardly be quantified, but certain metrics are beginning to capture the positive effects of North Dakota's nascent health care investment.

One study suggests the lives of 20 North Dakotans are saved each year as a direct result of Medicaid expansion.

The expansion population is increasingly taking advantage of colorectal and mammography screenings, which should curb long-term costs for citizens at risk for those diseases. Source: Sanford Health Plan

For the 2015-2017 budget period, North Dakota is expected to receive approximately $533.6 million in federal funds on a state investment of $8.2 million.

Source: Gallup-Healthways Well-Being Index GALLUP®

Consequently, providers have witnessed reductions in uncompensated care that allow for workforce and infrastructural investments that improve access and quality of care for all North Dakotans.

North Dakota's share of the roughly $37 billion in federal funds expansion states receive this year will ripple throughout the state's economy. It begins with health care providers, who feel an estimated economic impact of $68 million annually. These dollars have an especially strong bearing on rural providers and their recruitment and retention efforts. Rural hospitals in Medicaid expansion states are half as likely to be at risk of closure as their counterparts in non-expansion states. And that economic security extends well beyond the rural health care sector.

North Dakota enjoyed the nation's fifth-largest drop in personal bankruptcies between 2013 and 2015. Some estimates suggest every federal dollar North Dakota receives has a return factor between 1.5 and 2.0, meaning each federal dollar generates economic activity of $1.50 to $2. While Medicaid expansion has created budgetary challenges for some states, a number of others are finding expansion to be budget-neutral or budget-positive, as high-need populations pivot to the more heavily federally funded expansion coverage. Economic studies have further shown a net economic benefit for states with relatively limited state-funded safety net programs.

As always, North Dakota policymakers and health care stakeholders are tasked with determining ways to improve care delivery in a manner consistent with sound tax-dollar stewardship. Medicaid expansion has exposed North Dakota to the evolving landscape of risk-based managed care, which might inform ways to generate efficiencies within the state's comprehensive Medicaid program. National momentum toward more aggressive, value-based payment arrangements will continue to press stakeholders to consider changes in program design.

Other savings opportunities particularly relevant to North Dakota might also be considered. Emerging federal payment reforms will allow states to effectively reduce their share of Medicaid expenditures on American Indians — all the while increasing that population's access to quality care. This change is potentially so significant that demographically similar states like South Dakota are eying the new policy as a mechanism to cover the full cost of Medicaid expansion.

North Dakota's next steps are not all obvious, but reauthorizing Medicaid expansion is unequivocally sensible. Thoughtful collaboration, already taking place, will yield advancements that better maximize available resources and bring North Dakota even closer to full realization of the benefits Medicaid expansion offers.

North Dakota enjoyed the nation's fifth-largest drop in personal bankruptcies between 2013 and 2015.

Source: March 2016 Omaha World Herald

02 EXPANSION HISTORY & IMPLEMENTATION

THE AFFORDABLE CARE ACT

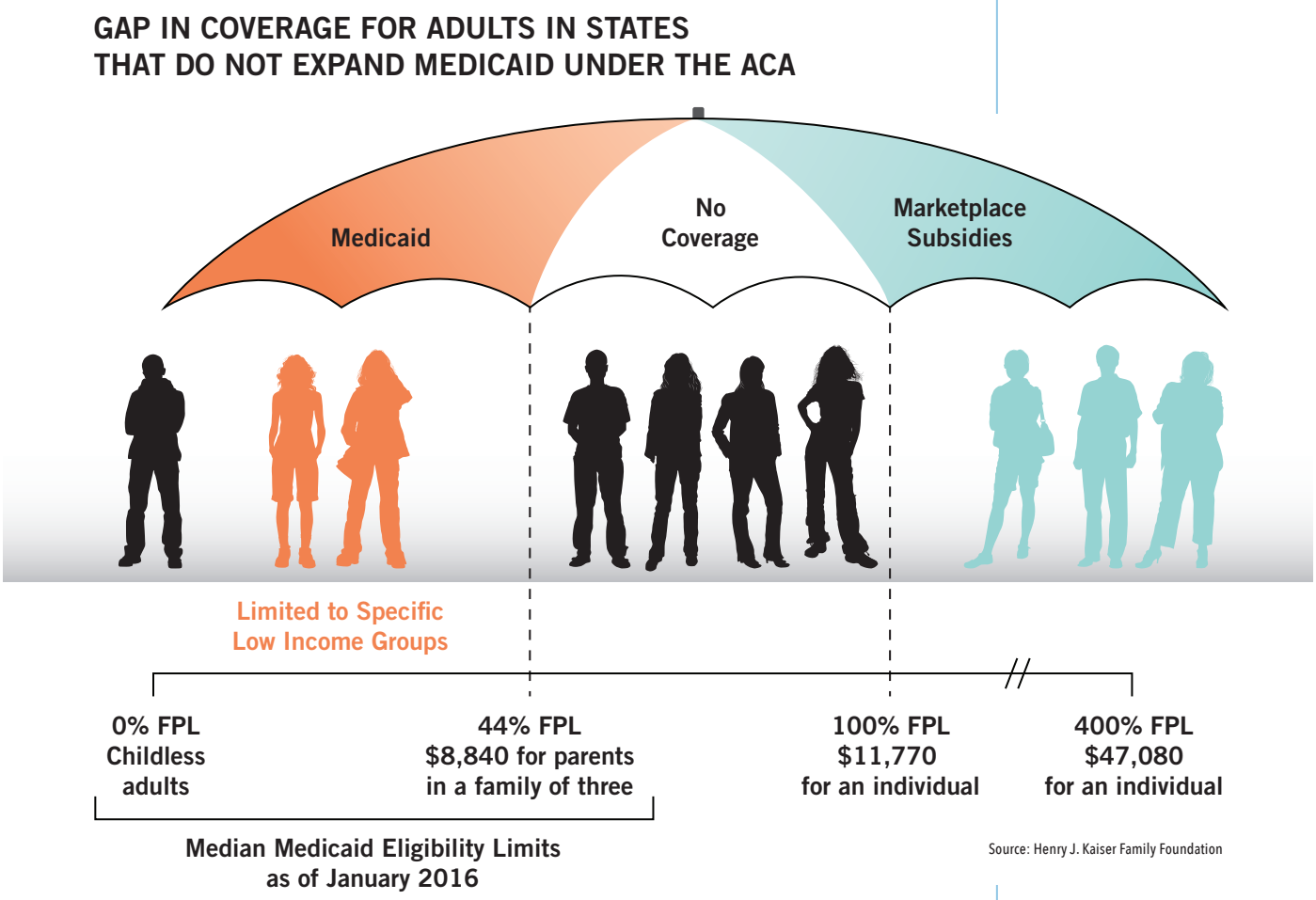
The 2010 Patient Protection and Affordable Care Act (ACA) required every state to expand Medicaid, effective January 1, 2014, to all individuals under the age of 65 with incomes below 138% of the federal poverty level ($16,243 individual; $33,465 family of four). In June 2012, the United States Supreme Court struck down this requirement, leaving expansion optional to each state.

The consequences of this ruling disrupted critical assumptions made within the ACA framework. Providers nationwide were asked to absorb hundreds of billions of dollars in cuts, primarily to Medicare reimbursements. But the Supreme Court's ruling opened the door for states to reject expansion, leaving providers in non-expansion states to sustain the steep cost of a program from which they receive no benefit.

A second major consequence is coverage gaps in non-expansion states. The ACA provides federal tax credits and subsidies for low-income individuals to purchase insurance on health insurance exchanges. It was assumed all states would expand Medicaid and, therefore, credits or subsidies were not extended to most citizens eligible for Medicaid expansion.

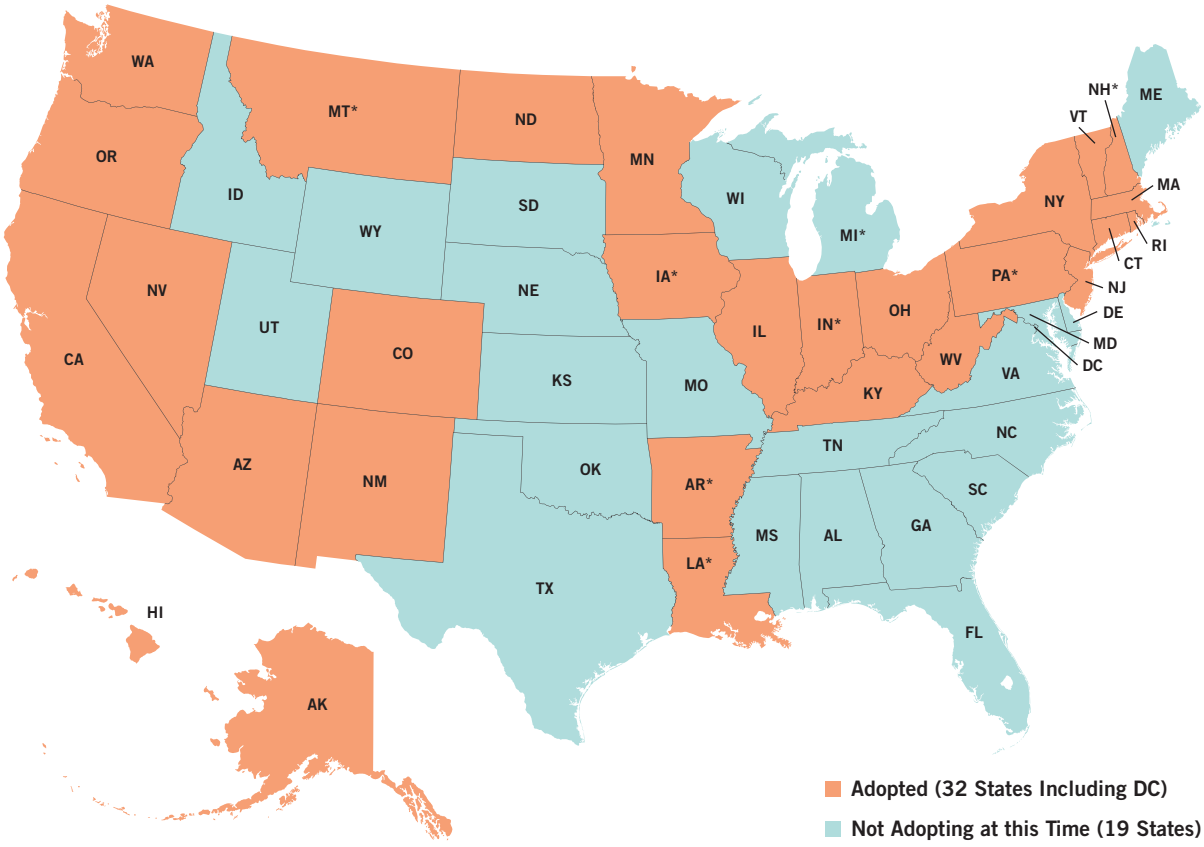
Consequently, millions of individuals in non-expansion states are currently too poor to receive federally subsidized health care coverage. This is especially true among childless adults, who are generally ineligible for any kind of traditional Medicaid coverage, regardless of income. But even low-income parents have a difficult time qualifying for Medicaid coverage in non-expansion states.

Millions of individuals in non-expansion states are currently too poor to receive federally subsidized health care coverage.



Thirty-one states and the District of Columbia have fully implemented Medicaid expansion, with others actively studying the issue. The principal "carrot" of expansion remains the federal government's commitment to cover all costs in the short term and no less than 90% in perpetuity. This arrangement is dramatically more generous than the federal match applicable to states' traditional Medicaid programs — the Federal Medical Assistance Percentage (FMAP) — which is determined by the strength of a state's economy. For North Dakota's traditional Medicaid population, the FMAP covers the federal statutory minimum of 50% of costs based on the state's generally strong income. In poorer states, like Mississippi, the FMAP covers nearly 75%.

CURRENT STATUS OF STATE MEDICAID EXPANSION DECISIONS



Notes: Current status for each state is based on KCMU tracking an analysis of state executive activity. *AR, IA, IN, MI, MT, NH and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it has transitioned coverage to a state plan amendment. Coverage under the MT waiver went into effect 1/1/16. LA's Governor Edwards signed an Executive Order to adopt the Medicaid expansion on 1/12/16, but coverage under the expansion is not yet in effect. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion. See source for more information on the states listed as "adoption under discussion."

Source: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated March 14, 2016. http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

NORTH DAKOTA EXPANSION

North Dakota approved Medicaid expansion during its 2013 legislative session. Backed by Republican Governor Jack Dalrymple and a broad coalition of North Dakota health care advocates, Medicaid expansion (H.B. 1362) passed the House 57–36 and the Senate 33–14, with a sunset clause effective July 31, 2017.

Sanford Health Plan was awarded a state contract to serve as the Managed Care Organization charged with administering benefits to the Medicaid expansion population, beginning January 1, 2014. The plan chosen was consistent with the package chosen for North Dakotans purchasing health insurance on the health insurance exchange.

As of December 2015, approximately 19,499 North Dakotans had enrolled in the Medicaid expansion program. Calendar year 2016 marks the final year in which the federal government pays 100% of the costs associated with serving that population. The state is responsible for 5% of the costs starting January 1, 2017, a share that will gradually increase to and cap out at 10% by 2020.

When the North Dakota Legislature debated expansion in 2013, DHS projected a general fund liability of approximately $2.9 million for the final six months of the biennium ending June 30, 2017. That figure was later revised upward to $8.2 million during a challenging interim period for the state budget. While enrollment is in line with projections, the Medicaid expansion population has proven to be in desperate need of services — generating higher-than-expected claim costs. At the time of this writing, DHS and other stakeholders were assessing strategies to reduce expansion costs while minimizing forfeiture of generous federal matching funds. These efforts coincide with broader budgetary cuts across state government.

Impacting lives

The content below reflects the experiences of real North Dakota Medicaid expansion patients.

***Harry** is 46 years old with a history of congestive heart failure. In less than a year, without health coverage, Harry was hospitalized three times because of his condition, once immediately following a work shift. Harry's income was too high to qualify for traditional Medicaid, and too low to qualify for a federal subsidy. All of Harry's hospitalizations might have been avoided had he been able to afford prescription medications. In late 2014, Harry was enrolled in Medicaid expansion and adhered to a regimen that allowed him to receive a desperately needed defibrillator. Since that time, he has avoided hospitalization and continues to work to support his children.*

03 HELPING NORTH DAKOTANS

PENT-UP DEMAND

North Dakota's early experiences reveal profound demand for complex health care services from a sick, previously uninsured population. The resulting cost overruns have created unfavorable fiscal pressures, but they also signal that North Dakota's sickest and most vulnerable citizens are taking critical steps toward beneficial and, in some cases, life-saving care. One estimate suggests the lives of at least 20 North Dakotans are saved each year as a result of Medicaid expansion, with countless more gaining access to care that offers dignity and the capacity to lead more productive lives.

As more North Dakotans pivot from no insurance to Medicaid coverage, positive movement is occurring within uninsured metrics. Gallup reports North Dakota's uninsured rate in 2015 fell to 6.9%, a drop from 15% in 2013.

STATES WITH THE LARGEST REDUCTIONS IN PERCENTAGE OF UNINSURED, 2013 VS. 2015

"DO YOU HAVE INSURANCE?" (% NO)

State	% of residents without health insurance, 2013	% of residents without health insurance, 2015	Percentage-point change in uninsured, 2013 to 2015	Medicaid expansion and/or state/partnership exchange by Sept. 1, 2015?
Arkansas	22.5	9.6	-12.9	Both
Kentucky	20.4	7.5	-12.9	Both
Oregon	19.4	7.3	-12.1	Both
West Virginia	17.6	7.7	-9.9	Both
California	21.6	11.8	-9.8	Both
Washington	16.8	7.4	-9.4	Both
Alaska	18.9	10.3	-8.6	One
North Dakota	15.0	6.9	-8.1	One
Rhode Island	13.3	5.6	-7.7	Both
Mississippi	22.4	14.7	-7.7	One

Source: Gallup-Healthways Well-Being Index GALLUP®

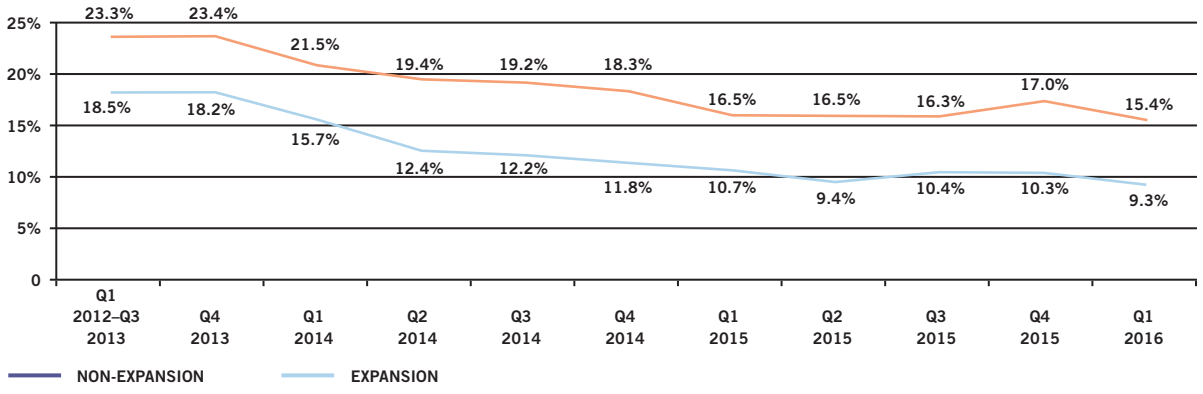
But North Dakota's drop in uninsured ushered in a new set of challenges. Generally, the Medicaid expansion group ends up in an emergency department or hospital — and stays longer — than North Dakota's commercially insured. Sanford Health Plan reported the average cost of claims among the Medicaid expansion group was 3½ times that of the company's commercial group — $1,215 per member versus $352 per member. The Medicaid expansion group logged 1,021 inpatient days per 1,000 people, quadruple the 251 inpatient days in the commercial group.

North Dakota's drop in uninsured ushered in a new set of challenges.

The gap in emergency room visits was even greater: 1,201 visits per 1,000 people in the Medicaid expansion group compared with 175 in the commercial group. The latter statistic, consistent with nationwide trends, suggests that the expansion population 1) is struggling to control complex, long-neglected health issues; and 2) requires a sustained education effort regarding appropriate avenues to receive non-emergent services. Another factor may simply be a lag in the impact of newly formed primary care relationships. Expansion-state beneficiaries are 6.6 percentage points more likely to visit a general physician than their counterparts in non-expansion states.

QUARTERLY UNINSURED RATE ESTIMATES FOR NONELDERLY ADULTS

(AGES 19–64) BY MEDICAID EXPANSION STATUS



SOURCE: The Office of the Assistant Secretary for Planning and Evaluation's (ASPE) analysis of the Gallup-Healthways Well-Being Index survey data through February 22, 2016.

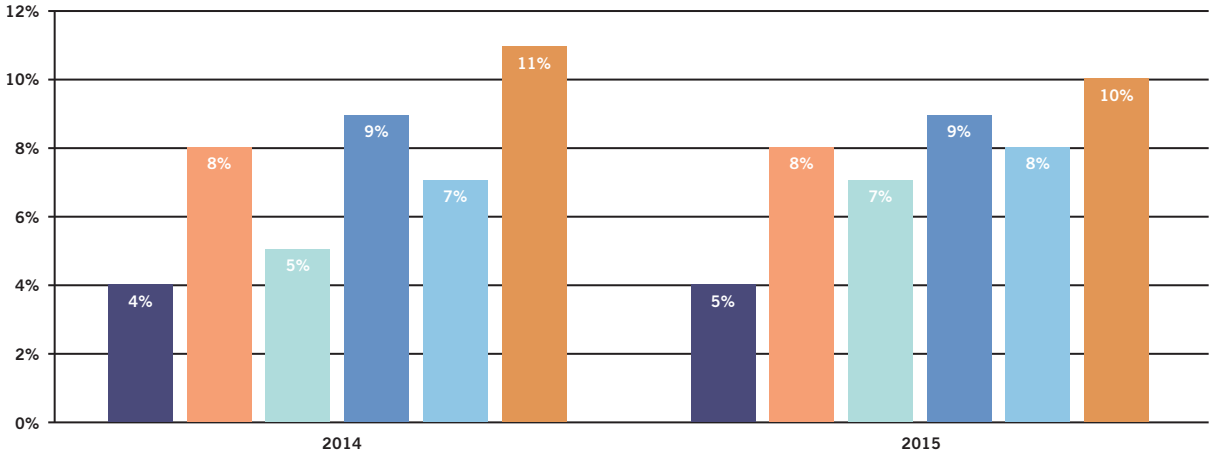
Other expansion states share North Dakota's experience with sustained high levels of emergency department usage. But these states have also enjoyed the corresponding drop in the number of uninsured patients accessing those services. In North Dakota, the Sanford Fargo Medical Center's emergency department has witnessed a steady downward trend from a spike of 774 uninsured patients in August 2013 — prior to Medicaid expansion — to a low of 385 in November 2015.

PREVENTIVE CARE

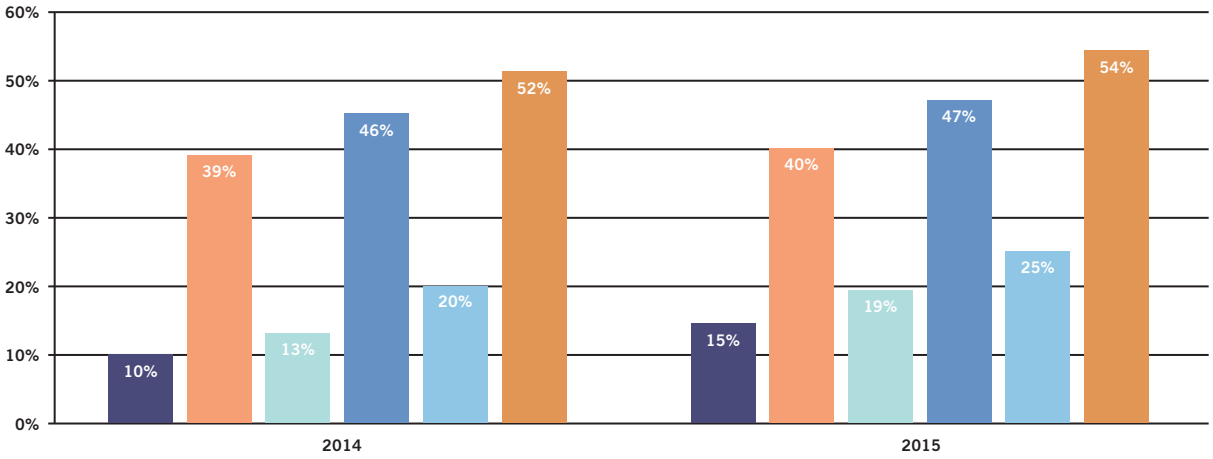
One positive, long-term step toward reducing emergency department utilization is the North Dakota Medicaid expansion population's increasing use of certain key preventive care services. Colorectal cancer and mammography screening rates, for example, have increased across the board from 2014 to 2015.

ND MEDICAID EXPANSION
SHP COMMERCIAL SCREENING RATES

COLORECTAL SCREENING RATES



MAMMOGRAPHY SCREENING RATES



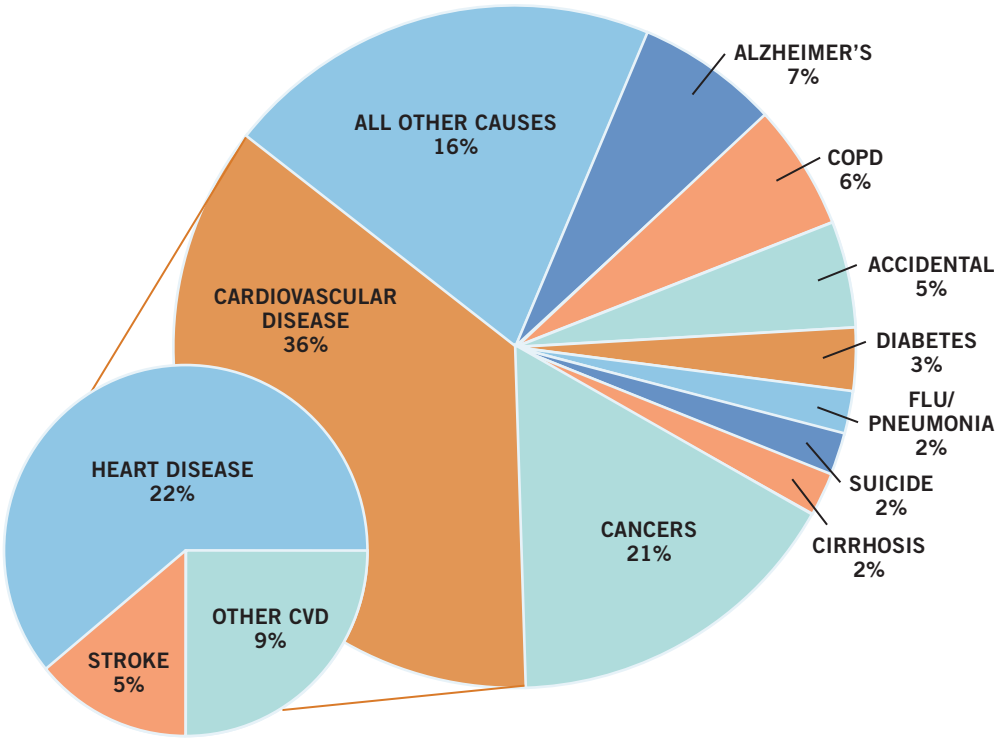
Source: Sanford Health Plan

MEDICAID > = 1 MONTH | COMMERCIAL > = 1 MONTH | MEDICAID > = 6 MONTHS | COMMERCIAL > = 6 MONTHS | MEDICAID > = 12 MONTHS | COMMERCIAL > = 12 MONTHS

The longer individuals benefit from Medicaid expansion coverage — and the more they properly access primary care — the more likely they are to utilize health-screening tools, though rates still lag behind the commercially insured population. Nationwide, Americans use preventive care services at about half the recommended rate, but removal of cost-sharing barriers such as deductibles and co-pays has been proven to facilitate better usage. Diabetes offers a profound example of Medicaid expansion's impact. Early diagnosis of diabetes increased 23 percent in expansion states compared to less than 1 percent in non-expansion states. This is significant, as chronic diseases like heart disease, cancer, and diabetes are annually responsible for seven of every 10 deaths and account for 86% of health care costs.

Predictably, having no insurance coverage at all hampers preventive care access even more dramatically. Uninsured women are half as likely to seek mammograms as insured women. This disparity is magnified in non-expansion states. It's estimated that by 2017, 23% of low-income women in non-expansion states will remain uninsured, compared to only 8% in expansion states. Net health care savings from preventive care are sometimes debated among economists — and preventive care is, almost by definition, a long-term investment — but certain screenings made available through Medicaid expansion have been held up as cost-effective tools to improve health outcomes and quality of life for vulnerable populations.

NORTH DAKOTA LEADING CAUSES OF DEATH, 2013



Source: https://www.ndhealth.gov/chronic disease/Publications/2014_CD_StatusReport.pdf

Medicaid expansion has allowed thousands of North Dakotans to seek preventive care and direct treatment for deadly chronic conditions that annually generate hundreds of millions of dollars in private and publicly subsidized health care expenditures. In 2010, nearly a quarter-billion dollars were spent in North Dakota to treat various types of cancer, and the American Heart Association estimates that direct and indirect costs to treat cardiovascular disease in North Dakota totaled $1.1 billion.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE

In a 2016 report, Mental Health America ranked North Dakota 7th (favorably) regarding the overall prevalence of mental illness, substance abuse, and suicidal thoughts. But other evidence reveals serious challenges that Medicaid expansion may help mitigate. Mental Health America ranked North Dakota only 19th in terms of access to behavioral health care, even though the state ranks in the top-10 in terms of overall health care access.

There are only 31 facilities or programs statewide that provide mental health services. Nationally, there is one mental health provider for every 566 individuals. In North Dakota, that ratio is 638:1, ranking the state 15th worst nationwide. Those statistics are consistent with the central finding of a 2014 Behavioral Health Planning report prepared for the State of North Dakota, which characterized the state's mental health and substance abuse system as in a state of "crisis" driven largely by a shortage of services.

The report outlined six primary ways to better address behavioral health needs of youth and adults in North Dakota. The six areas included addressing service shortages, expanding workforce, changing insurance coverage, changing the structure and responsibilities of DHS, improving communication, and expanding data collection and research.

While Medicaid expansion is not the panacea for North Dakota's behavioral health and substance abuse woes, it has and should continue to positively influence the pursuit of sustainable solutions. Leveraging enhanced federal funding is key. States spent more than $44.2 billion in 2012 providing mental health and substance use disorder services. State general funds constituted the largest source of funding to address substance use disorders and, after Medicaid, represented the second-largest funder of mental health services nationwide. Mandated coverage and screening for behavioral health issues are widely viewed as critical pieces of Medicaid expansion. Individuals with a mental or substance use disorder constitute 28% of the nation's population eligible for Medicaid expansion. That figure mirrors the number of North Dakotans who report one or more days of poor mental health over the course of a month.

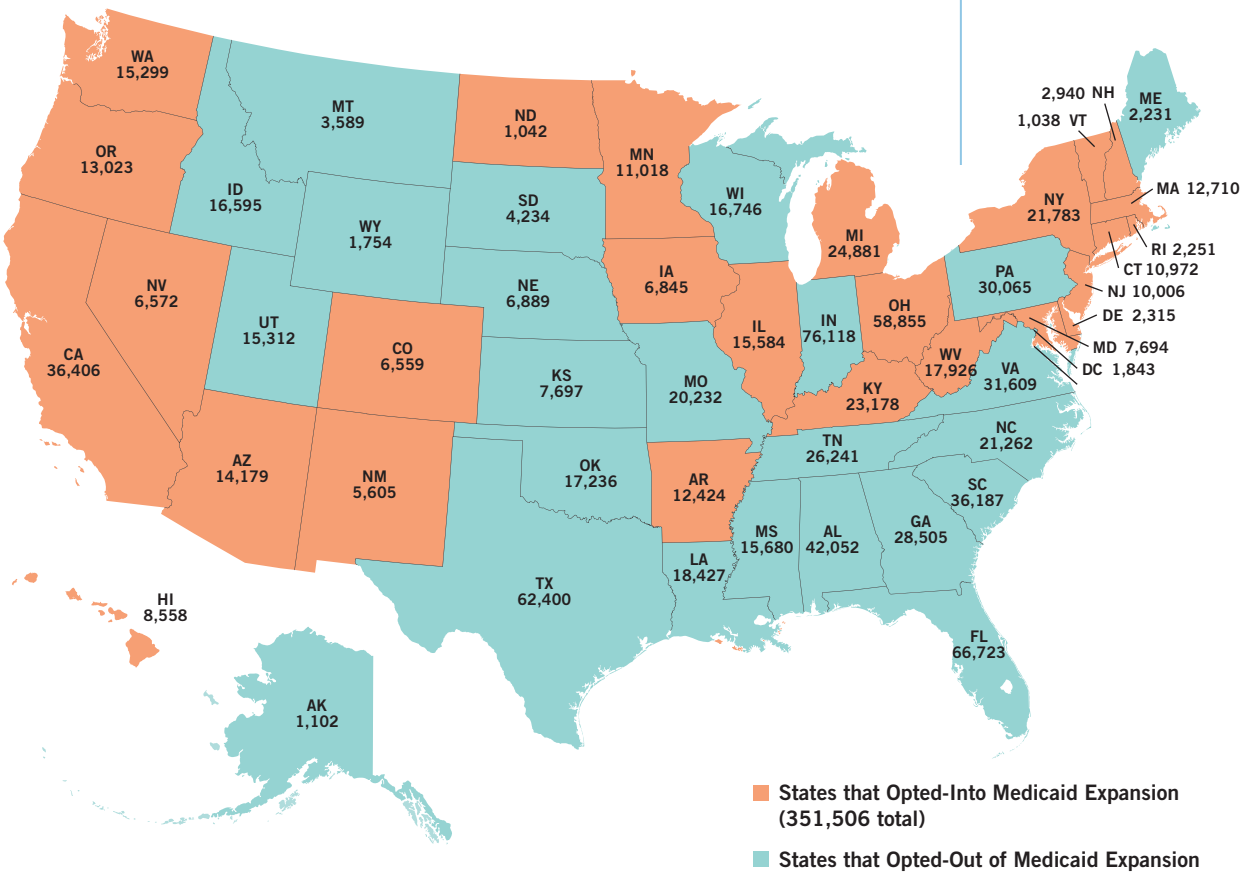
Prevention and early detection of behavioral health issues allows for early intervention, which can effectively reduce significant, far-reaching societal costs.

One in four U.S. citizens experiences a diagnosable mental health disorder each year, and it's estimated that 1.9 million uninsured individuals

with a mental illness or substance use disorder live in states that have not yet expanded Medicaid. Had every state expanded Medicaid in 2014, an estimated 925,000 uninsured individuals diagnosed with a serious behavioral health issue would have accessed affordable and needed treatments.

NUMBER OF UNISURED PEOPLE AGES 18–64 WITH A SERIOUS MENTAL HEALTH DISORDER

PROJECTED TO ACCESS AFFORDABLE SERVICES UNDER MEDICAID EXPANSION IN 2014



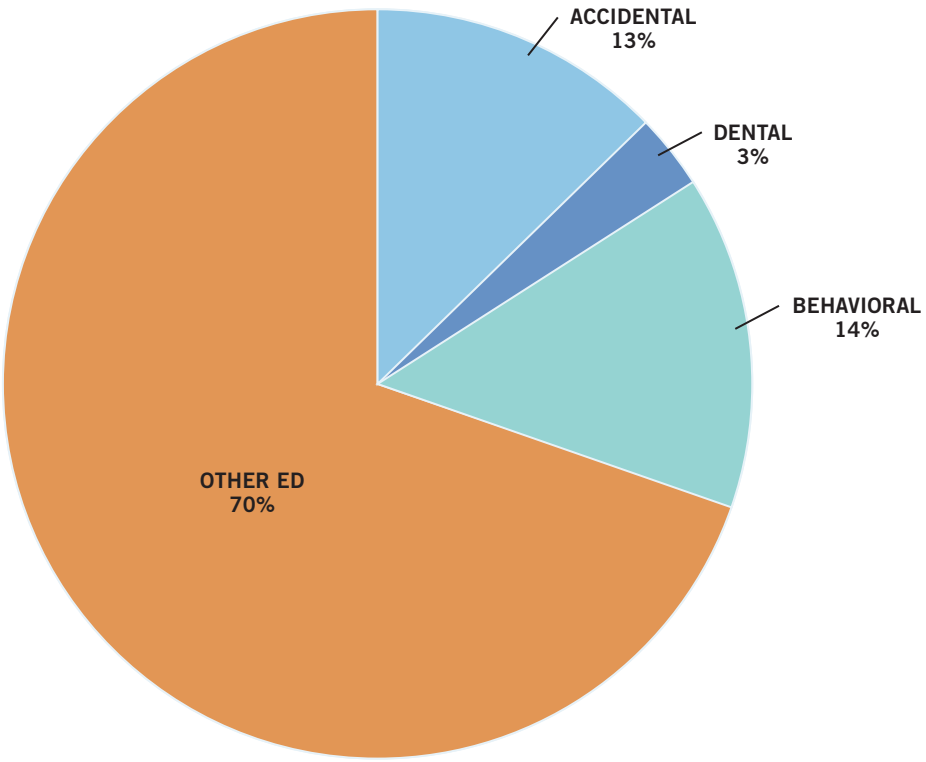
Source: https://c.ymcdn.com/sites/amhca.site-ym.com/resource/resmgr/Reports/AccessDenied_Fnl_3.pdf

Untreated — oftentimes preventable — behavioral health and substance abuse issues result in more emergency department visits, hospitalizations, school failures, incarcerations, and suicides.

More than one in five incarcerated individuals suffers from serious mental illness, and 70% of individuals held in juvenile detention centers have a diagnosable mental health condition. It's further estimated that individuals suffering from behavioral health and substance abuse issues visit emergency departments 7.6 million times each year. Among the North Dakota Medicaid expansion population, an estimated 14% of emergency department visits involve behavioral health as the primary patient complaint. Yet, behavioral health problems are thought to be present in a much greater percentage of emergency department cases.

Behavioral health problems are thought to be present in a much greater percentage of emergency department cases.

ED UTILIZATION BY ENCOUNTERS



Source: Sanford Health Plan

As Medicaid expansion further takes root, and its covered population stabilizes, North Dakota should increasingly realize the potential of liberated resources to address behavioral health care access. A 2016 study of Medicaid expansion by the U.S. Department of Health and Human Services generated a number of noteworthy findings:

1. Medicaid expansion reduces costs that are incurred by state and local governments and state economies as a consequence of behavioral health problems.

2. States that choose to expand Medicaid may achieve significant improvement in their behavioral health programs without incurring new costs.

3. Access to appropriate treatment results in better health outcomes. Research on the effects of Medicaid expansion suggests if the remaining states expanded Medicaid, there would be 371,000 fewer people experiencing symptoms of depression.

Impacting lives

The content below reflects the experiences of real North Dakota Medicaid expansion patients.

***Roger and Jill** were homeless and uninsured, unable to work. Jill was pregnant and Roger suffered from a number of health issues. After reaching out to local hospital staff, Jill was enrolled in traditional Medicaid and Roger in Medicaid expansion. Jill subsequently gave birth to a healthy baby and Roger became healthy enough to secure full-time employment. Medicaid expansion served as a true stepping stone for Roger, as his employer offered him health insurance. On their feet, Roger, Jill, and their child were able to move into an apartment and now live healthier lives.*

04 ECONOMIC IMPACT

Despite turbulance in the oil market and a weakened agriculture sector, North Dakota's unemployment rate of 2.8% is one of the lowest in the nation, and the state boasts 13,000 job openings. But there's no question the economic dynamics have changed. North Dakota has lost an estimated 20,000 to 22,000 jobs during the oil downturn, cutting into tax revenues. With energy-sector jobs scarce in other states, it's thought a sizeable portion of North Dakota's oil workforce has remained in state to fill lower-paying construction and low-skill manufacturing jobs, or otherwise wait for a rebound in the oil market.

North Dakota's energy-sector tumult might offer policymakers a clearer lens through which the value of Medicaid expansion can be reassessed. A popular argument against Medicaid expansion is that it incentivizes able-bodied adults to forego employment in order to receive a government health care benefit. However, expansion enrollment in North Dakota remains steadily in line with early projections — despite unforeseen instability in the oil market — signaling that the expansion program is not serving as a "freebie," but rather performing its core safety-net function.

Moreover, Medicaid expansion remains a positive economic force for North Dakota. Mining, quarrying, and oil and gas extraction account for more than 14% of North Dakota's gross domestic product, the largest share for any industry. But health care accounts for between 6 and 7%, with steady industry growth.

On average, states that expanded Medicaid in January 2014 saw health-sector jobs grow by 2.4% during 2014, while jobs in states that did not expand grew by only 1.8% in the same year. Medicaid expansion has empowered North Dakota's hospitals to better recruit and retain high-quality health care professionals.

The North Dakota Hospital Association estimates that Medicaid expansion positively impacts the state's hospitals at a rate of $68 million annually.

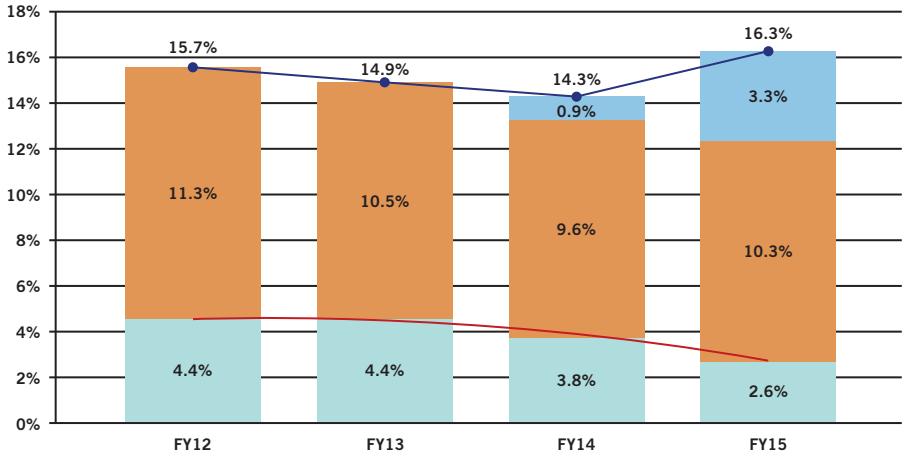
Source: http://www.med.und.edu/about-us/_files/docs/third-biennial-report.pdf

UNCOMPENSATED CARE

Medicaid expansion's primary economic impact on health care is readily apparent — greater volumes of patients and greater assurance of payment for services. The North Dakota Hospital Association estimates that Medicaid expansion positively impacts the state's hospitals at a rate of $68 million annually.

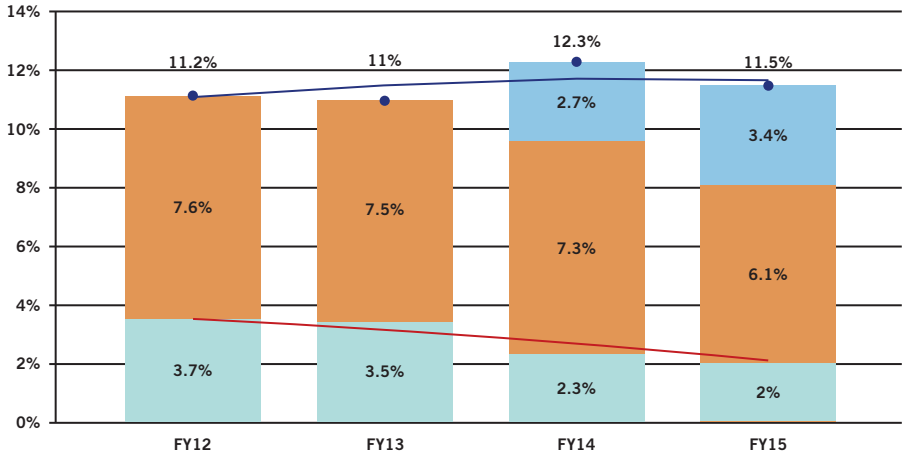
AT RISK COMPOSITE TRENDS

SANFORD FARGO AND SANFORD BISMARCK



Source: Sanford Health Plan

ALTRU HEALTH SYSTEM



Source: Altru Health Systems

MEDICAID EXPANSION | MEDICAID | SELF PAY | AT RISK COMPOSITE | AT RISK PATIENT TREND | UNINSURED TREND

This can largely be attributed to reductions in uncompensated care. Medicaid expansion states this year will enjoy a $4.4 billion reduction in uncompensated care, while non-expansion states absorb costs of $4.5 billion. North Dakota's providers have generally witnessed steady declines in uncompensated care aligned squarely with the implementation of Medicaid expansion.

But uncompensated care statistics remain just a small — too often isolated — piece of the economic picture. The federal government's comprehensive coverage of Medicaid expansion costs is truly a windfall to North Dakota, and even within the eventual framework of a 90–10% cost share, the return on investment is immense.

MULTIPLIER EFFECT

As 2017 approaches, North Dakota and other expansion states are preparing for the gradual assumption of part of the program's direct costs. The involved degree of difficulty varies by state, influenced by a number of factors. Some states — expansion and non-expansion — face cost overruns related to unexpected growth in their traditional Medicaid programs.

Observers sometimes refer to this as the "woodwork effect," i.e., individuals previously eligible but not enrolled in traditional Medicaid signing up as a result of publicity surrounding expanded health care coverage. Unlike Medicaid expansion enrollees, traditional Medicaid patients receive services paid for under a state's regular FMAP rate, creating more significant budget pressures.

Some expansion states are further bracing for the impact of elevated enrollment with their Medicaid expansion populations. Where general fund dollars meet a controversial federal program, political quarreling is bound to occur. But a unifying element in the debate over Medicaid expansion — apart from the provision of needed care — is the infusion of federal money into state economies. This year, expansion states will receive in excess of $37 billion in federal funds from Medicaid expansion, while non-expansion states leave at least $29 billion sitting on the table.

Moreover, Medicaid expansion dollars do not sit idle. They ripple through state economies, influencing behavior and revenue patterns.

The economic momentum created by these funds is a product of the "multiplier effect," which suggests that a dollar placed into the economy produces more than a dollar of economic activity. With federal

Medicaid dollars, this starts with enabling the provision of compensated care and associated labor to meet demand for services. Rural health care facilities are particularly sensitive to resources that address tenuous financial positions and further aid in the recruitment and retention of qualified professionals.

Rural hospitals in Medicaid expansion states are half as likely to be at risk of closure as their counterparts in non-expansion states. Those health care workers, in turn, consume goods and services that stimulate local economic cycles. Likewise, newly insured individuals enjoy greater economic security, boosting demand for medical and non-medical goods and services. Notably, North Dakota enjoyed the nation's fifth-largest drop in personal bankruptcies between 2013 and 2015.

A healthier workforce is also a more productive workforce, boosting long-term economic performance. In 2013, absenteeism cost U.S. businesses $84 billion, and research suggests that figure is comfortably overshadowed by "presenteeism," where workers are present but function below capacity due to health challenges. As is the case in other states, much of North Dakota's Medicaid expansion population works a full-time or part-time job, and many of those unemployed point to health challenges as an obstacle to employment.

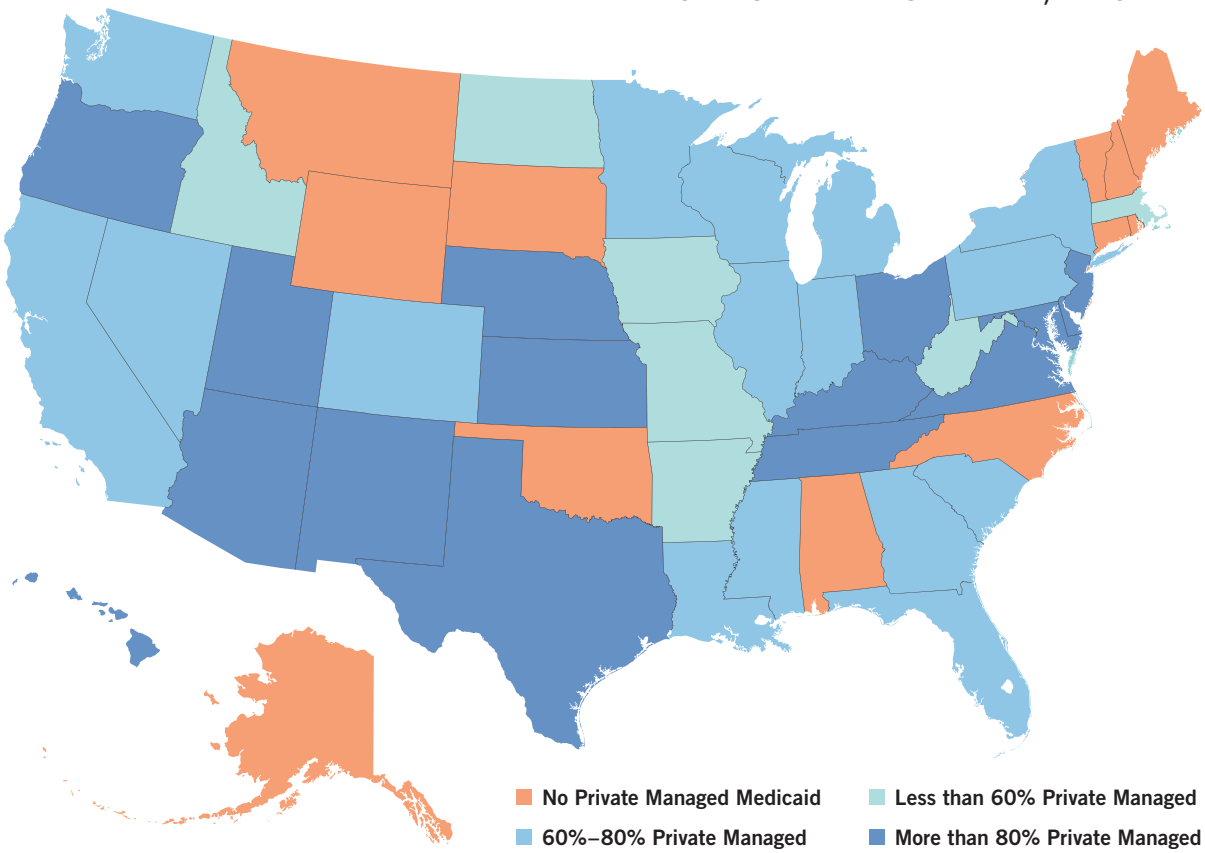
The bottom line is enhanced federal matching funds create an environment in which not every dollar in a state budget is created equal. Even in times of scaling back, a penny saved may be a dollar lost. Accordingly, policymakers are encouraged to consider all budgetary options that might preserve and reasonably maximize a funding arrangement uniquely beneficial to the health and economic well-being of North Dakota.

05 FURTHER MEDICAID OPPORTUNITIES

MEDICAID MANAGED CARE

The term "managed care" varies in meaning depending on the health care delivery context in which it is used. Fundamentally, managed care is simply an effort to coordinate, organize, and rationalize the delivery of health care services in a manner that might efficiently improve access and quality. The idea of managed care was born in the private sector more than 80 years ago in response to rising medical costs. These were the headwaters of modern-day, employer-based health insurance, which has evolved to recognize the advantages of managed care to controlling the costs and quality of health care services.

PRIVATE MANAGED CARE ENROLLMENT, BY STATE



Source: http://www.pwc.com/us/en/healthcare/publications/assets/pwc-the-still-expanding-state-of-medicaid-in-the-united-states.pdf

Today, 48 states deploy varying forms of Medicaid managed care. The most common form is the comprehensive risk-based MCO, which is Sanford Health Plan's function relative to North Dakota's Medicaid expansion population. Under these arrangements, qualified health plans receive fixed per member per month (PMPM) payments from states for furnishing enrollees a defined range of health care services through a network of participating providers. The MCO generally assumes the risk of losses from expenditures exceeding total income.

Thirty-nine states and the District of Columbia have contracted with risk-based MCOs to serve their Medicaid enrollees. In 21 of these states, at least 75% of all Medicaid beneficiaries were enrolled in MCOs. That share should continue to increase as states phase out other managed care models that remain strongly tied to fee-for-service payments.

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Source: http://files.kff.org/attachment/report-medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2015-and-2016

Prior to Medicaid expansion, the State of North Dakota had only dipped its toes into managed Medicaid waters, and had generally abstained from private managed care. North Dakota has historically and continues to require much of its traditional Medicaid population to enroll in Primary Care Case Management (PCCM), which launched in North Dakota in 1994. On July 1, 2014, North Dakota had 45,154 PCCM enrollees.

PCCM requires enrollees to choose or be assigned a primary care provider who has contracted with the state to provide a core set of case management services in exchange for a small PMPM administrative fee. Providers bear no risk, and all services they otherwise provide are reimbursed on a traditional fee-for-service basis. Only 19 states continue to administer PCCM programs, 10 of which also contract with MCOs. In most of those states, MCOs cover more Medicaid beneficiaries than PCCM programs, with North Dakota, Iowa, and Colorado being exceptions. In October 2015, the Kaiser Family Foundation reported that seven states have taken action to decrease PCCM enrollment, five of which intend to end their PCCM programs and transition enrollees to risk-based MCOs.

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Migration away from traditional PCCM models signals hunger by state policymakers to more aggressively pursue cost controls and realize budget certainty. In 2015, private Medicaid plans added 7.8 million beneficiaries, while the number of Medicaid beneficiaries enrolled in PCCMs or other publicly operated fee-for-service programs decreased by 1.4 million. While PCCMs have generated some positive health and fiscal results, momentum is building toward more ambitious, value-based payment arrangements.

In FY2015 and FY2016, a total of 37 states undertook efforts to adopt or expand initiatives that reward quality and promote integrated care. Prominent among such efforts are Patient-Centered Medical Homes (Medical Homes) and, increasingly, Accountable Care Organizations (ACOs). In FY2014, Medical Homes operated in half of Medicaid programs nationwide. Like PCCM models, Medical Homes pay providers a PMPM fee in addition to fee-for-service payments.

But the Medical Homes model's more holistic approach has proven attractive to state policymakers. Nine states adopted or expanded Medical Homes in FY2015, and six states planned to follow suit in FY2016. Advocates point to health care savings that stem from reductions in hospital and emergency department visits, mitigation of health disparities, and improvement in patient outcomes.

In its 2015 legislative report, the Minnesota Department of Health reflected on the six-year arc of the state's Medical Home program, Health Care Homes (HCH), finding:

- HCH clinics had better overall rates on quality measures than non-HCH clinics.
- From 2010-2014, HCH certified clinics were 9% less expensive than non-HCH clinics based on Per-Member-Per-Year (PMPY) reimbursement costs within the Medicaid and Medicare programs.
- HCH clinics had fewer hospitalizations compared to non-HCH clinics.
- Hospital costs were lower for HCH clinics compared to non-HCH clinics.
- Across a five-year evaluation period, spending for Medicaid, Medicare, and Dual-Eligible patients cared for in HCH clinics would have been approximately $1 billion more if those patients had not been in HCH clinics.

Like Medical Homes, Medicaid ACOs more directly engage providers to promote patient-centered health care. But ACOs generally go a step further by requiring providers themselves to assume financial risk — with the incentive of shared savings — for their enrolled patient populations. That said, there is no universal definition for Medicaid ACOs, and parameters vary state to state. One potential benefit of the ACO model is greater inclusiveness and integration of behavioral health and other social services.

The handful of states that have turned to ACO models have done so, in part, out of concern that traditional managed care models are no longer the most effective means to achieve fiscal savings or advances in population health. In theory, ACOs empower and incentivize providers to tackle traditionally avoided high-need populations, as they present opportunities to lower costs that result in shared savings. In practice, however, implementing ACOs is a heavy and time-consuming lift.

Whatever their future, there's no question delivery models that rely heavily on fee-for-service payments will increasingly give way to systems that require greater care coordination and shared risk. As North Dakota balances short-term health care cost containment against long-term investments — both within its traditional and expansion Medicaid populations — the evolving landscape of care delivery should inform pathways to greater state savings and better health outcomes.

Impacting lives

The content below reflects the experiences of real North Dakota Medicaid expansion patients.

***Jim** is 53 years old with a history of gastric ulcers, colon uncertainties, an enlarged prostate, hepatitis C, bipolar disorder, chronic headaches, severe dental decay, and other conditions. Upon referral from a local ambulance service, Jim agreed to visit with a high-risk care manager who confirmed Jim's eligibility for Medicaid expansion coverage and worked with him to assess the many health challenges he faced. In the weeks and months that have followed, Jim has enjoyed access to quality health care that continues to offer him dignity and dramatic improvement to his wellbeing. Upon Jim's completion of the appropriate medication regime for hepatitis C, the virus is undetectable, mitigating further liver damage and the potential need for a liver transplant. Jim enjoys a noticeable decline in headaches and received prostate medication that should eliminate the need for surgery. He received an upper and lower endoscopy to assess and treat his stomach and colon.*

AMERICAN INDIAN HEALTH CARE

American Indians are North Dakota's largest minority, representing 39,669 of the state's nearly 740,000 total residents. Unfortunately, North Dakota's largest minority is no exception to the severe health disparities from which American Indians suffer across the country. Disproportionate death rates from largely preventable causes include infant mortality, suicide, diabetes, alcohol-related deaths, heart disease, and unintentional injuries. American Indians in the northern plains, where smoking rates are high, are especially prone to cancer deaths. The plight of American Indian health care in North Dakota and elsewhere is well documented, yet traditional systems of care, predominantly Indian Health Services (IHS), have struggled to effectively address these deeply complex and expensive challenges.

While IHS and tribally operated health care facilities are often the entry point to care for American Indians, state Medicaid programs and non-IHS providers serve as a safety net to deliver oftentimes unavailable services.

The fiscal ramifications of this dynamic are significant.

Federal law provides that IHS is a payor of last resort, so when patients of IHS are dually eligible for Medicaid, it is Medicaid that is responsible for payment. The location at which patients receive care is hugely consequential.

When patients dually eligible for IHS and Medicaid receive care at an IHS facility, the resulting Medicaid payment obligation is covered by the federal government at an enhanced FMAP rate of 100%, costing states nothing. When care is not received through IHS, the resulting Medicaid payment obligation mirrors that of any other Medicaid beneficiary, i.e., the state is responsible for its normal share of the cost under regular FMAP rates, absent the presence of IHS Purchased/Referred Care or some other payment mechanism.

Because federal law and treaties obligate the federal government to provide American Indians adequate health care, states for years have complained about and litigated the costs of absorbing patients who opt or are forced to utilize services outside the IHS system. This certainly factored into payment policy reforms released earlier this year by the Centers for Medicare and Medicaid Services (CMS). The new policy expands the scope of Medicaid-covered services provided to American Indians and Alaska Natives for which the federal government will pay 100% of costs.

Under previous policy, services had to be provided directly by an IHS/Tribal facility for the 100% FMAP rate to apply. Under the new policy, when an IHS/Tribal facility asks a non-IHS/

Tribal facility to provide services to a Medicaid-eligible American Indian, those services are eligible for the 100% FMAP rate so long as the non-IHS/Tribal provider has entered into a "care coordination agreement" with the referring facility.

While the detailed content of care coordination agreements is a work in progress and, likely, unique to each state, CMS has advised that the following conditions will apply for states to capture the 100 percent FMAP rate:

- Both the IHS/Tribal facility and non-IHS/Tribal provider must be Medicaid providers.
- The service must be requested by a practitioner at an IHS/Tribal facility; it may not be self-requested by the beneficiary or requested by the non-IHS/Tribal provider.
- The patient must have an established relationship with a provider at the IHS/Tribal facility.
- The care must be provided pursuant to a written care coordination agreement between the IHS/Tribal facility and the non-IHS/Tribal provider, under which the IHS/Tribal facility remains responsible for overseeing the patient's care and retains control of the patient's medical record.

CMS has described its shift in payment policy as an effort to "help states, the IHS, and Tribes to improve delivery systems for American Indians and Alaska Natives by increasing access to care, strengthening continuity of care, and improving population health." Politically, however, the policy change serves as a fiscal incentive for states with high American Indian and Alaska Native populations to implement or maintain Medicaid expansion.

In South Dakota, where Medicaid expansion has not occurred, Republican Governor Dennis Daugaard has steadily endorsed a plan to implement and pay for Medicaid expansion based entirely on projected savings generated from the new CMS policy. Gov. Daugaard's administration has erred to the side of budgetary caution, planning for the state's estimated 50,000-plus residents eligible for Medicaid expansion to all sign up by year two. That would require the state to identify $12 million in ongoing savings to fund expansion through FY17, and $58 million to fund expansion through 2021.

To date, savings estimates appear promising. South Dakota has identified $85 million in annual Medicaid expenditures on American Indians that could be saved under the new CMS policy. Realizing those savings in South Dakota or elsewhere, of course, requires heightened coordination among state and federal officials, IHS/Tribal providers, and non-IHS providers. But if South Dakota's projections hold true, demographically similar states like North Dakota may be positioned to realize immense state savings for Medicaid services provided to their American Indian populations.

While IHS and tribally operated health care facilities are often the entry point to care for American Indians, state Medicaid programs and non-IHS providers serve as a safety net to deliver oftentimes unavailable services.

06 CONCLUSION

North Dakota's decision to expand Medicaid came as the result of thoughtful debate and analyses among a broad spectrum of stakeholders.

Ultimately, the immediate and long-term fiscal and human benefits of expansion were determined to outweigh its projected costs. That sound rationale remains true today.

While recent state budgetary challenges have resulted in an operational assessment of North Dakota's Medicaid expansion program, policymakers are urged not to place undue weight on short-term challenges or undervalue the developing health and economic benefits to the state. North Dakota Medicaid expansion is in its infancy, and emerging data and anecdotal evidence suggest the program, on balance, remains in the best interests of the state.

Accordingly, the public-private partnerships that lifted Medicaid expansion off the ground in North Dakota should endure to resolve immediate fiscal challenges and help move the program toward its full potential. This discourse should proceed thoughtfully to avoid programmatic overcorrections that could squander millions of dollars in federal funding and, consequently, compromise the health care access that Medicaid expansion delivers to thousands of vulnerable North Dakotans.

Impacting lives

The content below reflects the experiences of real North Dakota Medicaid expansion patients.

***Kate** is 39 years old with a history of type 2 diabetes, iron-deficiency anemia, hyperlipidemia, depression, anxiety, and post-gastric bypass. Kate had established a trend of visiting the hospital emergency department around three times per month, and because she lacked financial means, she would regularly go without medications to treat her behavioral health issues, diabetes, restless leg syndrome, and hyperlipidemia. Her conditions prevented her from maintaining steady employment, despite her efforts to do so. Medicaid expansion turned things around for Kate. With proper primary care, Kate's health issues were made manageable. Doctors determined she was suffering from iron deficiency anemia requiring B12 injections and an iron infusion, which enhanced her physical and emotional health. Kate hasn't entered the emergency department in more than five months, and she's held full-time employment even longer.*

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