
HMA

HEALTH MANAGEMENT ASSOCIATES

*Medicaid Expansion in Missouri - Economic
Implications for Missouri and Interviews
Reflecting Arkansas, Indiana, and Ohio
Experiences*

RELEASED BY MISSOURI NURSES ASSOCIATION, MISSOURI ASSOCIATION OF
RURAL HEALTH CLINICS, MISSOURI EMERGENCY MEDICAL SERVICES
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PEDIATRICS

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Executive Summary

Health Management Associates (HMA) conducted a targeted analysis of the economic impact of an ACA Medicaid Expansion in Missouri, with an emphasis on the effects on the state budget. As Missouri considers the costs and benefits of adopting the ACA Medicaid Expansion, state officials and private sector leaders should consider the experience of other similarly situated states that have implemented Expansion in the past few years. HMA examined the literature on states' experience with Medicaid Expansions, and took a deeper look at three largely Republican states that had robust discussions about the potential impact of an Expansion prior to its implementation — Ohio, Indiana, and Arkansas. We interviewed leaders with first-hand experience in those states and asked them to reflect upon what did and did not work in their state.

Both our review of carefully conducted research studies and our interviews with state leaders from nearby states lead to a conclusion that the full cost of a well-designed and well-synchronized program in Missouri can be covered by the offsets from replacing state-only funding with a 90 percent federal match, current Medicaid programs that would be matched at higher rate, and other policy and operational adjustments. When considering the multiple policy and budgetary implications of Medicaid Expansion, states are wise to proceed both strategically and cautiously. Synchronizing an Expansion with the appropriate policy and operational adjustments is imperative to designing a cost-effective program that ultimately reflects the goals, vision and priorities of the state. An Expansion program in Missouri can be designed to budget for savings and revenue opportunities that significantly exceed the state's cost of implementation. An Expansion can be designed to free general revenue funds for other priorities, such as K-12 education, transportation, and law enforcement. Our report's key findings are:

General Findings

No State has Reversed its Expansion Decision. Despite significant initial concerns in the states interviewed for this report, as well as other Expansion states, no state has reversed its decision to adopt the Medicaid Expansion in the more than six years since this program was first authorized on a national scale. In fact, additional states continue to choose the Expansion option. More importantly, no state has reversed its decision because of "out of control" costs. It is far more likely that states regard the Expansion as having a positive impact on the state's general revenue budget.

Arkansas, Indiana, and Ohio Expansion Costs Have Been Controlled. Each state meticulously worked to customize its program to keep costs under control and to capture state dollars that were then used to fund the state's share of the Expansion.

Costs and Offsets

Costs

Confirming Reasonable Cost and Enrollment Estimates. Although there are costs to the state for the required ten percent match, these costs can be offset through a variety of mechanisms, as demonstrated by the experience of other states that synchronized program changes and revenue matching initiatives as part of the Expansion design. After a thorough review of data, our research and estimates are in line with

the enrollment and cost assumptions from the May 2019 Missouri State Auditor’s Office Fiscal Note. The estimated costs of Expansion would include the State’s 10 percent share of the new program costs, new administrative costs, and the “woodwork effect,” which results when the Expansion enrollment process draws in people previously eligible for Medicaid but not participating.

Offsets

Expansion Benefits the Mental Health, Substance Use Disorders, and Incarcerated Populations. Large state-only outlays could be used to draw down a 90% federal match. Not only are matching funds available for populations currently served with state-only outlays, funding opportunities expand for opioid and addiction prevention programs. Federal money also becomes available to help combat recidivism for incarcerated populations.

Subsets of the Medicaid Population Will be Positively Affected. Pregnant women, women eligible for the Breast and Cervical Cancer program, the Medically Needy, and individuals with disabilities will potentially move from a lower matching Medicaid eligibility category to the higher matching rate available through Expansion. This creates direct financial benefits for the state.

Revenue opportunities

Provider Taxes Offer Additional Offset Opportunities. A potential Managed Care Organization (MCO) tax and the option to re-visit other provider taxes present opportunities to offset the costs of Expansion.

State Sales Tax Will Grow. Missouri could expect an increase in sales taxes as a result of the Medicaid Expansion, as other states have experienced.

Other State Economic Benefits

Gains in Employment Are Expected. Experience from other Expansion states demonstrates that Expansion has had a positive impact on people’s ability to seek work, obtain jobs, and engage in volunteer work.

The Health Care Infrastructure Will be Enhanced. Improvements in the health care delivery system and quality of care are likely to occur. A reduction in uncompensated care can be expected as well.

Lessons from HMA Interviews with Arkansas, Indiana and Ohio

HMA conducted in-depth interviews with leaders directly involved in the Medicaid Expansions in Ohio, Arkansas, and Indiana. Lessons learned included:

- Leverage the flow of new federal money to implement reforms to Missouri’s health care delivery and payment systems, potentially as part of a more systemic transformation initiative
- Keep financing straightforward, building on existing mechanisms when possible
- Recognize that some costs will be incurred up front while the full effect of the offsets and other benefits may take some time to emerge
- A number of policy accomplishments were achieved as these states rolled out their Medicaid Expansions. For example, Arkansas simultaneously enacted a state income tax cut during the Medicaid Expansion implementation.

- Compelling messages from the interviews include: newly eligible people include veterans and “people we know”; Expansion reduces cost-shifting and loss of federal tax dollars to other states; Expansion data shows better outcomes for enrollees with substance use disorders and mental illness; consumer education is important; and if you run a responsible program that helps people, the majority of state residents will support it.

Introduction

This paper examines the most common concerns expressed about the potential negative effects of Medicaid Expansion in Missouri, and in other states, with a focus on the financial and budgetary impact. Section 1 estimates the cost of Expansion in Missouri and identifies cost offsets and other sources of state savings. These calculations are based on a large body of research evidence as well as the experiences of states that have adopted the Medicaid Expansion.

A key focus of the paper is to explain state budget savings and financial opportunities created by the Expansion and identify the proven strategies used by other states to offset the state's required 10-percent share as well as other Expansion-related administrative costs. These offsets include reductions in non-Medicaid state spending on mental health and substance use disorder services and on health services provided to people who are incarcerated because they gain access to coverage through the Expansion. In addition, there will likely be savings resulting from access to additional treatment options covered under Expansion to address the opioid crisis, reduced uncompensated care outlays, and reductions in spending for existing state programs. Ninety percent of state-only dollars used to fund these critical services would be replaced by federal dollars, freeing up general revenue funds for other priorities, such as K-12 education, transportation, and law enforcement.

Section 2 of this paper examines the experience of three states - Ohio, Indiana, and Arkansas - with government leadership largely in Republican hands, that have implemented Medicaid Expansion and that have multiple years of experience with the program expansion. We conducted in-depth interviews with key leaders and experts with direct knowledge of the impact of the Medicaid Expansion in these comparison states and examined:

- Key stakeholders' perceptions of some of the most prominent concerns expressed by opponents of the Expansion
- Strategies used to address these concerns
- The consequences of Expansion

Our report identifies multiple policy options that were concurrently enacted with Expansions in other states to support the states' share of the cost of Expansion. State policymakers frequently find themselves in difficult situations, presented with options that "save" money on the back end with significant investment on the front end. We attempt to provide a balanced, fact-based set of assumptions designed to inform decision-makers and the general public and foster constructive dialogue as they consider this important policy step. If our assumptions can be improved as new or more refined data emerges, this new information can further inform the decision-making process.

Section 1: Financial Analysis

The Economic Impact of Medicaid Expansion in Missouri.

Background

The Affordable Care Act (ACA), passed in 2010, and later modified through a June 2012 U.S. Supreme Court ruling, made Medicaid Expansion optional for states. At this point in time, 37 states have adopted the Expansion. Non-Expansion states include southern states such as Florida, Georgia, Mississippi and Texas, and several states in the central United States, including Missouri. Multiple Non-Expansion states are actively considering expansion proposals at the time of this writing.

Medicaid currently enrolls about 75 million people nationwide. The program features comprehensive health benefits, and a wide range of social support services. Traditional populations served include low-income parents and their children, pregnant women, the elderly, and individuals with disabilities. States not adopting the Medicaid Expansion have widely varying income limits for parents' eligibility, ranging from 17 percent to 100 percent of the FPL. Most states did not cover adults without dependent children prior to the ACA, and this population remains ineligible for Medicaid in states that have not adopted the Medicaid Expansion. Parents with incomes below 100 percent of the FPL (which is \$25,750 for a family of four) and above the eligibility limit, which in Missouri is 19 percent of the FPL or \$4,893,¹ as well as adults without dependent children, are in what is called the "coverage gap". This means that their incomes are too low to obtain subsidized health coverage through the ACA Marketplaces, but too high to qualify for Medicaid under their states' eligibility limit. Individuals not otherwise eligible for Medicaid (e.g., those with disabilities, pregnant women) are currently ineligible for both Medicaid and the Marketplace. To put this in perspective, a worker with a family of four who earns the Missouri minimum wage of \$9.45 an hour and works half-time (20 hours a week) for a full year (50 weeks) earns \$9,450, well above the eligibility threshold for this adult to enroll in Medicaid. Even if that worker had a full-time job at 40 hours a week, he or she would still be ineligible for Marketplace premium and cost-sharing subsidies.

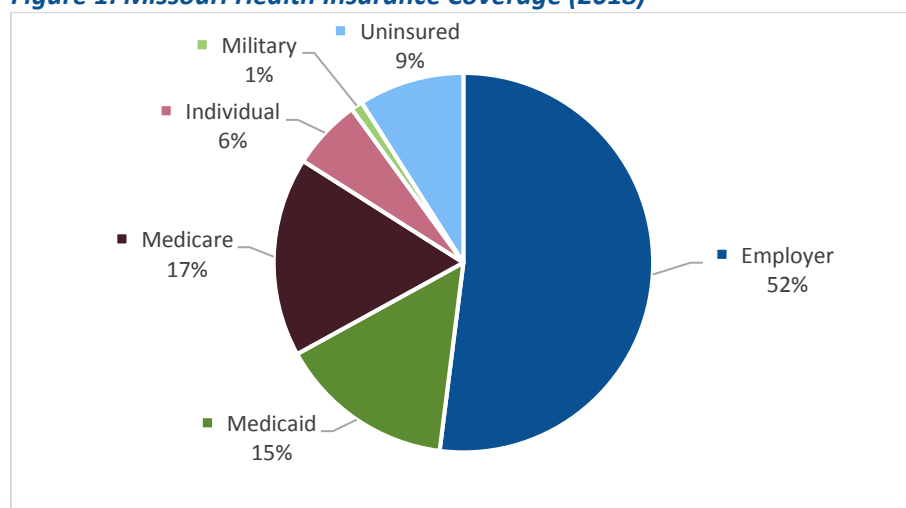
Nationally, approximately 69% of Medicaid beneficiaries are enrolled in in risk-based managed care organizations (MCOs) that provide care management and receive "capitation rates"; in turn the MCOs are held accountable for risk and the cost of health care. Medicaid payments to hospitals, physicians and other providers are typically substantially less than Medicare payment rates and even further below commercial insurance payment rates. This is particularly magnified after provider taxes are netted out of the equation.

Because of its significant budget and large scope of coverage, Medicaid impacts the state economy, the state budget, the job market, other insurance carriers, most health care providers, and the state's most vulnerable residents. Of Missouri's population of 6.2 million, Medicaid insures just over 800,000 individuals at a total annual cost of just over \$10 billion in 2019.² About two-thirds of this \$10 billion is paid by the federal government through Federal matching funds using the Federal Medical Assistance Percentage (FMAP) used to determine the amount of the match. The other one-third is, in terms of gross dollars, paid by the state. A substantial proportion of that gross state share, however, is offset by provider

taxes such as the hospital tax, bringing the net Missouri share of the total cost to a much lower level of state funding.

While Medicaid has a very large presence in Missouri, and all states, Figure 1 illustrates the importance of other payers. Half of Missouri residents have employer-sponsored coverage, including Missouri state employees. One in five insured Missourians are enrolled in Medicare, including some individuals who are also enrolled in Medicaid (the dual eligible population). It is noteworthy that Missouri's unemployment rate in October 2019 was one of the lowest in the nation at 3.1 percent, and the workforce participation was 65.1 percent.³ This affects insurance coverage opportunities across the board. None the less, Missouri's rate of uninsured citizens of 9.4% is higher than the national average. Thirty-three states have uninsured rates lower than Missouri.⁴

Figure 1: Missouri Health Insurance Coverage (2018)⁵



Note: Percent covered by Medicare was rounded up to 17 percent for total coverage to equal 100 percent.

Costs Related to Medicaid Expansion

States face many pressures and challenges when attempting to balance their budgets. Unlike the federal government, states cannot use deficit financing to cover current obligations. Many states are appropriately wary of new financial commitments, particularly if they are long-term commitments. When states consider a substantial program expansion, especially one that includes entitlement provisions such as Medicaid, state policymakers have an obligation to consider the risks and benefits carefully.

States must also consider the timing of costs and savings. Among states that have adopted Medicaid Expansion, the costs related for the state's share of benefit payments starts immediately when enrollment begins, and the administrative costs are "front-loaded" to fund needed staff and IT systems. As a result, the costs in the first year, and perhaps to a lesser extent in the second year, may not be fully offset by the early savings. Over time, however, Expansion states have realized numerous offsets and savings that exceed the program costs, as described further below.

Estimating Changes in Medicaid Enrollment

Based on the May 2019 Missouri State Auditor’s Office Fiscal Note, approximately 250,000 Missourians could be potentially covered if the state expands Medicaid. Washington University projects a total eligible count of 271,500. Table 1 displays the number newly eligible through Expansion, whose costs would be matched at 90 percent by the federal government, and those newly identified as eligible for traditional Medicaid during Expansion enrollment, the “woodwork” eligible (whose costs would be matched at Missouri’s Medicaid matching rate of 65 percent). Table 1 estimates the size of the populations affected by the Expansion. These numbers would likely take several years to reach.

Table 1: Estimated Expansion Population (includes minor HMA interpretation)⁶

Population Category	Washington University Estimates
Uninsured Adults (19-64)	139,000
Adults (19-64) with Individually Purchased Private Insurance	72,000
Adults (19-64) with Employer Sponsored Insurance (ESI) Coverage	20,000
Total Estimated Adults (19-64)	231,000
Uninsured Children (0-18)	20,000
Children (0-18) with Individually Purchased Private Insurance through Parents	13,500
Children (0-18) with Employer Sponsored Insurance (ESI) through Parents	7,000
Total Estimated Children (0-18), “Woodwork Children”	40,500
ACA 90% Match Population (Total Adult Population Less “Woodwork Adults”)	190,500
ACA 65% Match Population (“Woodwork Children” Plus “Woodwork Adults”)	81,000
Total Expansion Population	271,500

The “Woodwork Effect”

In other states that implemented Expansion, some uninsured individuals who were already eligible for traditional Medicaid came “out of the woodwork” to enroll, likely as a result of the public awareness created by the Expansion. An estimated 81,000 uninsured children and adults in Missouri are already eligible for Medicaid under existing eligibility categories but not enrolled. Newly eligible Missourians would include primarily parents with income above the current limit and childless adults with income up to 138 percent of the FPL (or \$17,236 for an individual and \$35,535 for a family of four annually).

Estimating Changes in Medicaid Costs

According to national studies, Medicaid Expansions did not lead to significant increases in spending from state funds. Solid research has also shown that there were no significant reductions in state spending on education, transportation, or other state programs as a result of the Medicaid Expansion during a five-year period. Single-state studies, discussed below, in Louisiana, Kentucky, Arkansas, Michigan, and Montana have shown that the Medicaid Expansions resulted in significant state savings.⁷ Of course, each state is different and national studies need to be looked at carefully with respect to the application to individual states. Below we discuss how our interviewees responded to these legitimate concerns. It is also critical to explore state costs and to carefully consider an Expansion with all variables clearly identified – both costs and benefits. Some of the savings resulting from state-only programs discussed below (e.g. mental health, substance abuse) will phase-in over time, given the operational issues involving eligibility, state appropriations, and moving from state-only resources to Medicaid matched resources.

With respect specifically to Missouri, the main costs of a Medicaid Expansion are explained below and summarized in Table 2.

Table 2: ACA State-Only Expansion Costs in Missouri (HMA analysis)

Category	Cost
State Share for Full Participation (10%)	\$97 million
State Share for Woodwork Effect (35%)	\$94 million
State Share Administrative Costs	\$10 million
TOTAL State-Only Expansion Costs	\$201 million

Ongoing State Share of Medicaid Expansion

Effective this year (2020), federal law requires that states fund 10 percent of the cost of the Medicaid Expansion population. In Missouri, the state share is estimated to cost \$97 million in 2020. The Missouri Auditor and Washington University report similar total enrollment and expenditure costs. We believe the estimates for both the newly eligible and the “woodwork effect” populations to be realistic and they certainly do not understate costs.

“Woodwork Effect” Costs

New enrollment in the traditional program resulting from the “woodwork effect” is estimated to cost Missouri \$94 million for the state share applying the state’s Medicaid FMAP of 65.65 percent.

New Administrative Costs

Significant resources will be required to implement a Medicaid Expansion. These would include additional resources for eligibility/adjudication, provider education (particularly education for behavioral health and substance abuse providers regarding billing issues and transition from state-only resources), Medicaid Management Information System (MMIS) programming, and other administrative expenditures.

The Missouri State Auditor’s Fiscal Note on the Medicaid Expansion projects that the Missouri Family Support Division will need fifty-six Eligibility Specialists, six Eligibility Supervisors, and one Social Services Manager to assist in enrolling new participants at an estimated cost of \$4.6 million. The Family Support Division also estimates an increased cost of \$9.1 million for additional staffing of the call center to answer eligibility questions. Another \$5 million cost is projected for MMIS changes, and MO HealthNet estimates a needed increase of \$4.1 million to fund additional staff for customer support, tracking, and claims data reporting.⁸ Using a conservative approach, we estimate a cost of \$10 million for the state share. The combination of state and federal matching funds would provide over \$20 million in funding. Some of these costs would be one time (non-recurring) costs. To put this in perspective, an additional 100 FTEs could be supported within this estimate.

Crowd-Out

Crowd-Out refers to a process in which an expansion of public coverage displaces, or “crowds out” private health insurance. Our analysis suggests that crowd out under a Medicaid Expansion would have a relatively small impact over time. The Washington University study concluded that: “According to Kaiser Family Foundation, studies exploring the potential for Medicaid Expansion to crowd out private insurance have found mixed results, with most showing no evidence of crowd out and some showing slight declines

in private coverage in Expansion states following Expansion.”⁹ Crowd-out is a more serious issue for coverage programs targeting population with substantially higher income levels, as can occur in the Children’s Health Insurance (CHIP) program, where some states increased their CHIP eligibility levels above the original 200 percent of the FPL threshold.

It is also important to note that Medicaid enrollment nationwide declined in 2018 and 2019. While certain states and certain studies may show different experiences, overall enrollments have not been surprises to states in recent years and states project less than one percent growth in 2020 nationally.

CMS Flexibility

Our state-based interviews identified considerable evidence that CMS and states have created customized Expansion programs that feature flexibility – particularly when CMS authorizes the use of waivers. We discuss state experience in Section 2 of this report.

Economic Benefits Related to Medicaid Expansion

The evidence shows that a large part, if not perhaps all, of the cost of the Expansion would be offset by multiple sources of state budget savings and revenue enhancement options unrelated to any traditional tax increase.

Louisiana reported extensively on a variety of economic benefits, including local government savings, benefits to the state’s economy related to the infusion of federal dollars, and the restructuring of programs resulting from fewer people being uninsured. Other states had a similar experience, deriving savings from Expansion, including Virginia (which saved \$421.6 million in the first year of Expansion)¹⁰, Arkansas (\$444 million total from 2018-2021)¹¹, Michigan (\$1 billion from 2018-2021)¹², and Montana (over \$50 million).¹³ Nebraska projects savings of \$360 million over five years and a reduction of 4.3 percent annually in Medicaid outlays under a Medicaid Expansion that will add 94,000 people to Medicaid on October 1, 2020.¹⁴

These sizeable savings are both important and instructive. One cautionary note is that some of the state experiences cited here occurred over the time period in which the federal match under the Medicaid Expansion was higher than the 90 percent match that took effect on January 1, 2020. Yet, the offsets noted above are real, measurable, and have been validated by the states in question.

We will focus on two items that are available to fund and/or offset costs of the Medicaid Expansion – funding from existing state programs that do not receive federal match currently and revenue opportunities that other states have coordinated with an Expansion. We will first explain the policy approaches and then calculate estimates for Missouri.

State Savings and Revenue Opportunities

Most states historically covered the costs for the majority of mental health and substance abuse services, as well as health care services for justice-related populations, solely from state and local resources and federal grants. Over the years, and with the increased need for mental health and substance abuse programs and support, these state-only resources have become quite substantial. Almost all of the individuals served in these programs will become Medicaid eligible under Expansion. As a result, there are

opportunities to pay for certain benefits previously funded solely from state funds through Expansion funding which will be matched at the federal matching rate of 90 percent. We have not itemized the savings and revenue opportunities in this report because we do not have access to the extensive data we would need to reflect that amount of detail. We can say, however, that based upon other states' experiences and our own experiences, we fully expect that an Expansion program in Missouri can be designed that leverages savings and revenue opportunities and significantly exceeds the state's costs for the Expansion. For states facing significant budget pressures, this Medicaid Expansion funding source can provide substantial and lasting savings as described below:

- **Medicaid Spenddown.** People in the Medically Needy or "Spenddown" population are incurring large medical bills that will eventually qualify them for Medicaid through the "spenddown window." Many of these people with high out-of-pocket costs will ultimately lower their incomes to qualifying levels, where the state would receive the traditional federal match. The Center for Health Economics and Policy at Washington University projects savings of \$17.4 million in 2020 as a portion of this population enters Medicaid through the Expansion and Missouri would receive the 90 percent match.¹⁵
- **Disabled.** A portion of people with disabilities who applied for Supplemental Security Income (SSI) have not yet met the SSI disability standard (47 percent of applicants in Missouri) and in addition some people with disabilities elect not to apply for SSI through seeking disability status. A portion of these groups would enter Medicaid through the Expansion. Many would have eventually entered Medicaid through SSI, *but with a standard federal match rate*. Savings to Missouri from enrolling these people in the Expansion have been estimated at \$55 million in 2020.¹⁶
- **Medicaid for Pregnant Women Living in Poverty.** An estimated 94 percent of this population (19,000 women) would be eligible to be rolled into the Medicaid Expansion, allowing Missouri to obtain the higher federal match for this population and to provide uninterrupted health care coverage.¹⁷
- **Opioid Epidemic.** With overdoses now the leading cause of death for Americans under 50 years old, finding both prevention and treatment solutions for addiction is a huge priority for states. Medicaid Expansion allows the state to use 90 percent federal funds to pay for treatment that would otherwise frequently be funded with state dollars, thus freeing these state funds to go toward prevention and other state priorities.
- **Other substance use disorders.** In addition to the opioid crisis, states face a growing demand for treatment and prevention in other areas, including for treatment of alcohol, fentanyl and heroin addiction.
- **Mental Health Gaps.** Gaps in the mental health systems are frequently cited as an area that both political parties agree need more resources and fundamental reform. Federal Medicaid expansion funds can be used for newly covered populations needing a wide range of mental health services in lieu of limited state dollars.
- **Cost of care for incarcerated individuals.** Medicaid expansion can provide ongoing healthcare support to individuals transitioning from incarceration. This is critical to ensuring that ongoing medication and mental health services are immediately available to individuals once they are back

in the community. Achieving a high federal match for inpatient discharges for this population is a critical opportunity.

- **Breast and Cervical Cancer Treatment.** State Medicaid programs cover women whom CDC-affiliated clinics have diagnosed with breast or cervical cancer. Under a Medicaid Expansion, a state could cover all adults with the 90 percent federal match with incomes under 138 percent of the FPL, regardless of their diagnosis or where this diagnosis was made. In Missouri, uninsured women who receive such diagnoses at a Missouri Show Me Healthy Women Project provider are eligible to enroll in Medicaid and receive services for their disease. If Missouri adopted the Expansion, the women now in these programs with incomes less than 138 percent of the FPL could be treated as newly eligible under the Expansion, and Missouri would receive a 90 percent federal match for them.
- **Provider Taxes.** Many states impose a tax on managed care organizations (MCOs), and this is a possible financing option for Missouri. Medicaid expansion would increase the potential revenue derived from an MCO tax as the eligible population enrolled in MCOs would increase, thus increasing MCO payments. Missouri already has well established provider taxes on hospitals and pharmacies, and increased provider revenue resulting from a Medicaid expansion will result in increased state revenues derived from these taxes. In the case of the hospital provider tax, the state is estimated to receive an additional \$30 million in revenue at the current tax rate as a result of increased payments to hospitals for services provided to expansion patients.
- **State Sales Tax.** Missouri could expect an increase in sales taxes as a result of the Medicaid Expansion, as other states have experienced. As noted above, the infusion of billions of dollars in new money from outside the state, enhanced through the “multiplier effect,” will generate a chain of new spending in the state. While there will be some loss of sales tax, as occurs when consumers and businesses make online purchases from out-of-state companies, much of the new spending will be subject to the Missouri sales tax.

The bottom line is that, based upon states experiences and our experiences, we fully expect that an Expansion program in Missouri could be designed to budget for savings and revenue opportunities that significantly exceed the state’s costs of the Expansion. It is critical to note that these offset savings do not occur without considerable organizational and operational adjustments. Many providers who may be previously accustomed to receiving grants with less complicated billing requirements, will most likely have to convert to billing for a Medicaid service for a Medicaid beneficiary as well as working with an MCO billing organization. Lastly, in November 2019, CMS officially proposed a comprehensive regulation on Medicaid fiscal accountability. The rule addresses a variety of issues including Medicaid supplemental payments, methods of financing the nonfederal share (including provider taxes and donations), and state reporting requirements. While this is separate matter relative to Expansion, it is an important variable that can be managed within the context of an Expansion consideration.

Other State Economic Benefits

Up to this point, we have concentrated on “hard” savings that can be calculated and included in fiscal notes as part of the state’s budget process. We now turn to other important benefits that are more indirect but still critical.

- **Health Care In-State Investment.** As health care providers and insurers receive the new payments, they can be encouraged to invest in reforms in the delivery and payment systems. This investment could be directed to promising new approaches to care management for individuals with complex medical and social needs. As people with multiple chronic illnesses, which frequently involve both physical and behavioral health conditions, receive better medication management, receive care from a health home that fosters both clinical and community-based prevention, and receive follow-up care after an inpatient stay, avoidable ER visits, hospital admissions, and readmissions will decline. Real-time alerts sent to primary care physicians when their patients enter the ER, or are admitted to a hospital, can also improve care management. All of these best practices translate into substantial savings for both public and private payers.
- **Jobs and Earnings.** Several studies found that enrollment in Medicaid Expansion had favorable effects on an individual's ability to seek and sustain work, as well as on-job growth, and a growth in volunteer work.¹⁸ In Louisiana the Expansion funding created and supported 19,195 jobs while creating and supporting personal earnings of \$1.12 billion.¹⁹ In Colorado the infusion of new federal money associated with the Expansion supported over 31,000 additional jobs in the FY 2015-2016 period.²⁰ In Ohio, an in-depth statewide survey of Medicaid Expansion enrollees found that:
 - Among employed enrollees in the Expansion population, 83.5 percent said that access to Medicaid makes it easier to work.
 - Among the unemployed enrollees in the Expansion population, 60 percent said that access to Medicaid makes it easier to look for work.
 - Among the Expansion population, the proportion employed rose from 43.2 percent in 2016 to 49.6 percent in 2018.
 - Among those employed, 50.9 percent had full-time jobs; 31.9 percent worked between 20 and 35 hours per week.
 - Some 49.1 percent said that having access to Medicaid also made it easier to pay for necessities, including groceries, rent, or mortgage payments, or to pay down debt.
 - Just under 30 percent said their financial situation improved after enrolling in Medicaid, almost four times the proportion who said it got worse (7.7 percent); 61.6 percent said it was the same.²¹

Section 2: Case Studies

The Impact of Medicaid Expansion in Arkansas, Indiana and Ohio.

The remaining section of this report presents evidence from the experience of states that have adopted the Medicaid Expansion. Our findings below are based upon HMA’s interviews with state leaders with direct experience with the Expansions in their states. The literature search is national in scope and the interviews focus on three states—Ohio, Indiana, and Arkansas.

Introduction

To understand how Missouri may fare under Medicaid Expansion, HMA examined the experience of three states with government leadership largely in Republican hands that have adopted Expansion—Arkansas, Indiana, and Ohio. We examined key stakeholders’ perceptions of the most prominent concerns expressed by Expansion opponents, strategies to address these concerns, actual experience, and lessons that emerged. We conducted in-depth semi-structured interviews with key leaders and experts with direct knowledge of how the Medicaid Expansion played out in these comparison states.

Table 3 list interviewees by state.

Table 3: Interviewees by State

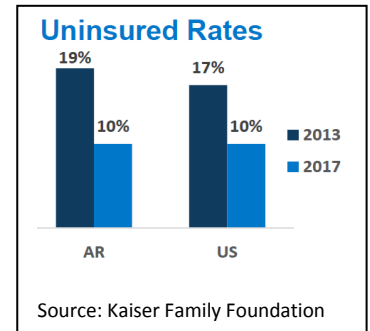
State	Interviewees
Arkansas	<ul style="list-style-type: none"> ▪ Ray Hanley, CEO, Arkansas Foundation for Medical Care; former Arkansas Medicaid Director ▪ Andy Allison, Deputy Director for Strategic Planning, IL Department of Healthcare and Family Services; former Arkansas Medicaid Director
Indiana	<ul style="list-style-type: none"> ▪ Senator Luke Kenley, former Chairman of the Indiana Senate Appropriations Committee and State Budget Committee Chairman ▪ Rob Damler, Principal and Consulting Actuary - Milliman, Inc. (involved in financial projections and analyses in Indiana and other states) ▪ Joe Moser, former Indiana Medicaid Director; Principal at Health Management Associates
Ohio	<ul style="list-style-type: none"> ▪ Tim Keen, Senior Advisor to the Ohio Auditor of State; former Director, Ohio Office of Budget and Management ▪ Greg Moody, Executive in Residence, Ohio State University John Glenn College of Public Affairs; former Director, Ohio Governor’s Office of Health Transformation ▪ Tracy Plouck, Assistant Clinical Professor, Ohio University; former Director, Ohio Medicaid Department and former Director, Ohio Department of Mental Health and Addiction Services

Arkansas Medicaid Expansion: the “Private Option”

In 2013, with the first Republican legislature in 140 years, then-Governor Mike Beebe (D) signed the state’s Medicaid Expansion into law. Through an 1115 waiver, Arkansas accepts federal funds through the Affordable Care Act for eligible low-income residents to buy private insurance through the state’s Marketplace. The plan initially included Health Savings Accounts (HSAs), which ended in 2016 after limited implementation. The state added work requirements that were halted by a federal court in March 2019. Continuing to fund the expansion requires support from 75 percent of the legislature every year, which has been achieved since implementation.



<i>Expansion Implemented</i>	2014
<i>Total Medicaid Enrollment</i>	967,200
<i>Expansion Group Enrollment</i>	Newly Eligible: 318,300 Not Newly Eligible: 10,200
<i>(FY 2017) Source: Kaiser Family Foundation</i>	



Key Stakeholders involved in Expansion in Arkansas shared the following lessons about strategies, expectations, and experience:

Early Concerns and How They Were Addressed

‘Don’t expand a broken system’ - Arkansas engaged in comprehensive provider payment reform in advance of and in conjunction with Expansion, introducing financial incentives to “fix” the Medicaid system. Also, supporters led by the Governor and Medicaid Director developed the Private Option that built on private insurance rather than expanding the existing fee-for-service Medicaid program. “[Expansion was an opportunity to] rethink who you pay for what, and how to introduce financial incentives into Medicaid.”-AA

‘It’s too expensive and will divert funds from truly needy people’ - Before the cost concern could get traction, the administration conducted and released fiscal impact analyses using conservative assumptions (e.g., inflating national estimates of expected new enrollment) that still projected significant savings to the state. To help finance the state share, Arkansas used premium taxes, largely on the Marketplace plans enrolling the Expansion population.

‘It’s Obamacare, it’s socialism’ - After initially offering a traditional Expansion, the Beebe administration proposed a model with elements that were politically acceptable to most conservatives. The Expansion involved purchasing private health plans, using HSAs, and work requirements (HSAs later ended as administrative expenses were too high).

‘It creates dependency among able-bodied people’ - The administration and proponents focused on the message that the state needs the healthiest workforce it can get. Expansion is not welfare but creates the ability for people to access primary care and other care to be healthy and able to work.

Key Strategies and Supports

Leverage Support from Key Legislators. Certain legislators worked very hard to make Expansion happen; they engaged in long conversations with the administration to understand the design features and to make sure they could “own” and advocate for every aspect of the model. Their support reportedly played an important role in the ultimate passage. Elements that helped bring conservative legislators on board included purchasing private health plans, using HSAs and work requirements.

Work with CMS. Planners worked closely with CMS to design a model that would be approved both by the federal government and the courts. *“We had real-time, up-to-the-minute conversations with [CMS] so that legislation would promise everything but not more than could be granted and upheld”-AA*

Engage a Broad Coalition. “AR Works” included 35 provider, advocacy, and faith-based groups supporting Expansion, including AARP’s large volunteer network. Some had relationships and would engage with policymakers. *“It was not hard to get stakeholders on board”-RH*

Post-Implementation Opposition

Some state leaders attempted to roll back Expansion, but CMS rejected a proposed cut in eligibility to 100 percent of the FPL. **The current Governor and most legislators continue to support Expansion (achieving a supermajority to continue funding it each year) and understand the negative impact its revocation would have on the state budget, and on the state itself.**

Impacts

Despite more participants and higher early monthly per person insurance payments than expected, the state experienced significant savings.

- Initial savings came largely from transferring pregnant women -- insuring them before they got pregnant -- and the medically needy population to the Expansion program, which draws a much higher federal match
- **Direct offsets/savings to the state included a reduction in the uncompensated care appropriation for the university hospital; a cut in the Medicaid medically needy program; and a reduction in funds formerly allocated for the uninsured (e.g., community health and mental health centers, health department, hospital DSH)**
- Interviewees noted that rather than the Expansion necessitating pulling funds from other areas (such as education) or increasing state income taxes, Arkansas was able to use **savings from Expansion toward cutting state income taxes** (e.g., a 2015 middle class income tax cut was estimated to provide relief of \$33.7M in FY16 and more than \$100M per year from FY17-FY20)
- The indirect effects of the large infusion of federal funds are harder to quantify but reportedly have had myriad benefits to the state

“Each federal dollar turns over two to three times...jobs created, income tax, sales, tax...benefits to rural infrastructure...”-RH

Rural Hospitals and Infrastructure

Expansion supported rural hospitals and broader rural infrastructure; Arkansas experienced fewer hospital closures than non-expansion states.

Provider Workforce

Using MCOs in the Marketplace for the Expansion enrollment meant contracted providers were paid market rates, addressing concerns about potential provider shortages.

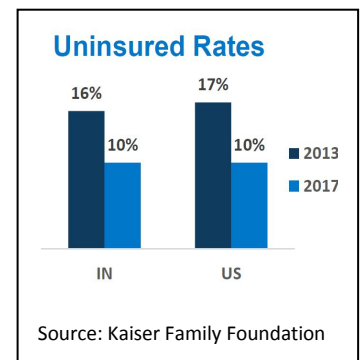
Lessons

- Be prepared to address Expansion opponents’ concerns by providing facts and examples from other states’ experience to make valid projections and counter myths based on anecdotes.
- It is possible to find political common ground and ideological compromise —all sides may have to accept some elements they deem less than ideal.

- Establish a very broad coalition that favors expansion and is willing to talk to policymakers, then maintain that coalition to support implementation.
- Be honest about the weaknesses in the Medicaid program, and address how Expansion will be used to improve the financing or health care delivery system. Expansion is an opportunity for a tremendous infusion of federal dollars.
- Work with CMS to get what you can, but do not let state legislative language promise more than could be upheld in the courts.

Indiana’s HIP 2.0 Expansion Model

Indiana expanded its Medicaid program in February 2015 under then-Governor Mike Pence through a Section 1115 waiver called the Healthy Indiana Plan (HIP) 2.0, based on the redesign of an earlier, pre-ACA Medicaid expansion. “Consumer driven” features include member contributions to an HSA-like Personal Wellness and Responsibility (POWER) Account whereby members decide how to use their account to meet their \$2,500 deductible and get a refund of dollars not spent, encouraging them to utilize health care services wisely. “Personal responsibility” incentives include penalties for contribution nonpayment (loss of certain benefits for those below 100 percent of the FPL and a “lock out” of coverage for six months for those above 100% FPL), and higher copays for non-emergent use of the ER. The 2018 waiver added new incentives to promote healthy behaviors. Indiana began phasing in a work/community engagement reporting requirement in July 2019, but enforcement was suspended in Oct 2019 until a federal lawsuit is resolved.



<i>Expansion Implemented</i>	<i>2015</i>
<i>Total Medicaid Enrollment</i>	<i>1,362,300</i>
<i>Expansion Group Enrollment</i>	<i>Newly Eligible: 322,700</i> <i>Not Newly Eligible: 161,800</i>
<i>(FY 2017)</i>	<i>Source: Kaiser Family Foundation</i>

Early Concerns and How They Were Addressed

Key stakeholders involved in Expansion in Indiana shared the following about strategies, expectations, and experience:

‘How would it be viewed if we, as a Conservative administration and legislature, expand an entitlement?’ - Faced with concerns over the renewal of the existing HIP program, the Governor’s plan built on HIP’s conservative principles. The initial 100 percent federal match, and support from conservatives in Washington, DC, also helped to promote the plan at home.

“Monthly contributions and lockout for non-payment –these types of guardrails were necessary to get a lot of conservative Republicans to go along with the program.” -LK

Also, Indiana’s Governor has more authority and discretion to design and pursue waivers than in many other states. With support from a five-person State Budget Commission, the Governor was able to pursue Expansion without overwhelming support from legislators. Later established in statute at the request of Governor Pence, the program is not re-debated with each legislature and would be difficult for future

governors to dismantle unilaterally. *“In Indiana, once issues are in the budget and an accepted program, unless it is failing dramatically, it is not a point of contention again”-LK*

‘Will the federal government approve the consumer-driven model?’ CMS pushed back on some proposed restrictions but was eager to get more Republican-led states on board with Expansion. Despite much conflict over details, CMS ultimately approved the model.

“Politically, we were able to keep our homegrown Healthy Indiana program and allow the Governor to call it a model for other states.” -JM

‘How to come up with the state financing share in perpetuity without increasing individual income taxes?’ - Planners used the cigarette tax from HIP 1.0, supplemented by an increase in the hospital provider tax structured to increase (up to the cap) or decrease based on the program’s costs. The hospital association was a willing partner, given that the large losses from uncompensated care were threatening the existence of some of the hospitals.

‘Fear the federal government will pull out of financing and leave Indiana with an “uncontrollable mandate”’ - HIP 2.0 designers included protections whereby the state can terminate the waiver immediately if the FMAP changes or the state’s ability to collect the hospital assessment changes.

‘There is inadequate provider capacity for a large influx of covered people’ - To ensure provider participation and expand capacity, HIP 2.0 would pay providers Medicare rates, and the traditional Medicaid program’s rates would increase to 75% of Medicare rates. FQHCs were able to absorb more primary and preventive visits.

Key Strategies and Supports

“People in decision making power had to find a practical solution.” - LK.

Compelling Messages from the Governor:

- There was a group of low-wage workers just above the Medicaid eligibility line without employer coverage
- With HIP 2.0, enrollees have skin in the game—they are incentivized to be more engaged in their personal health, exhibit healthy behaviors and take ownership over their health care decisions
- HIP 2.0 helps educate enrollees on the concepts of private coverage (premiums, benefit structure, etc.) to prepare them for moving off Medicaid and into employer coverage
- Without Expansion, Hoosiers’ federal tax dollars would continue to be redistributed to Expansion states

Broad support: Because Indiana is a conservative state, Expansion advocates knew they would have to accept some of the HIP features they otherwise would not support in order to see Expansion passed. Consumer advocates got on board and were very helpful in relaying their support to the Obama administration.

Consumer Education: The state invested a few million dollars and engaged all stakeholders in advertising and educating people about HIP 2.0. The hospital association was instrumental in getting the message out in communities. Still, along about half of Expansion enrollees reportedly understood the POWER account, and fewer understood the entire model.

Impacts

Take-up Rates. Early enrollment was faster than expected (reflecting a 73% take-up rate among those eligible²²) but then leveled off, with lower growth in recent years associated with a strong economy and low unemployment.

Financing and Offsets. The program had no substantial impact on the state budget or General Fund because the state share was funded through the cigarette tax (continued from HIP 1.0) and hospital provider tax that was increased from 4.5 percent to 5.5 percent, calculated to cover the new costs. The cigarette tax covers about 42 percent, and the hospital tax 58 percent of the costs. Both the hospital assessments and the revenues have been lower than expected due to lower than anticipated annual enrollment increases.

- Behavioral health expenditures: general revenue only payments to Community Mental Health Clinics (CMHCs) declined; and a Substance Use Disorder (SUD) waiver allowed short-term IMD stays under Medicaid aligned with Expansion (as many individuals with SUD are childless adults and were covered through Expansion)
- Indigent Fund expenditures: the state reduced this line item by \$50 million per year
- Correctional Health expenditures: incarcerated individuals hospitalized beyond 24 hours were enrolled in Medicaid temporarily via the Expansion, resulting in some savings to the state

Administrative Costs. The health plans are conducting many of the administrative tasks, and administrative costs are built into the fees charged to the hospitals (capped at \$170 per member per year). The state estimated that the POWER account, copays and contributions result in about a five percent savings vs. traditional Medicaid, and these savings outweigh the additional administrative costs of these components.

Premiums and Individual Responsibilities. Most of the Expansion population were already employed and reportedly were willing to pay into the POWER account and the scaled ER copays, especially knowing that the alternative was no coverage or fewer benefits. Throughout the life of the program, between 60- and 70 percent of program enrollees have made their monthly required contributions.²³ *“Anyone who has financial accountability will take in interest in how it works... you could point to the shared responsibility of government, hospitals, and patients.”- LK*

Healthier workforce. Interviewees felt that expansion made Indiana more competitive for employers who want to locate to states with a healthy workforce versus some states in the south that have not implemented Expansion, such as Texas or Florida.

Health system stabilization. Expansion reportedly allowed for investments in the health care workforce and stabilized revenues for hospitals; Indiana has not had hospital closures until one rural hospital closed last year.

Lessons

- The loud voices at either end of the spectrum represent relatively small numbers of people. If you run a responsible program that helps people, the majority are willing to go along.
- Leverage the influx of federal dollars from the Expansion to reform the health care delivery and payment systems – e.g., negotiating better payment models with providers. (Indiana did not reportedly take advantage of this opportunity.)
- Late expanders have the advantage of looking at data from early expanders in the region to support more accurate projections on take-up, costs, etc.
- Consider and plan for mechanisms to enable the state to afford its share of costs in the short and long term, or to pull back if the federal share goes away.
- Expansion and related programs are easier to implement when the economy is good, when there is low unemployment and low demand for social services. But be aware that during a strong

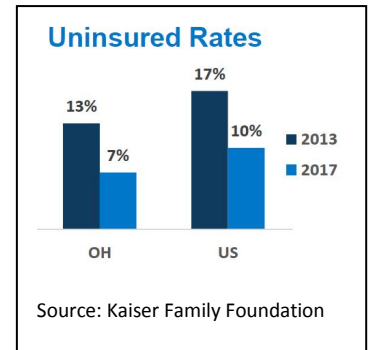
economy, Medicaid enrollment may be down but cost per person will be higher because enrollees are more likely to have high medical needs.

Ohio's Medicaid Expansion

In 2013, the federal government approved then-Governor John Kasich's (R) State Plan Amendment laying out Medicaid Expansion for Ohio. The state's General Assembly's Controlling Board²⁴ voted 5-2 to increase the appropriation necessary to receive Expansion funds, leading to implementation on January 1, 2014. The Republican House and Senate approved budgets that included the Expansion in 2015, 2017 and 2019. In 2017, the legislature passed work requirements (with some exemptions) that CMS approved in 2019 and which are scheduled to begin in 2021.



<i>Expansion Implemented</i>	2014
<i>Total Medicaid Enrollment</i>	3,087,800
<i>Expansion Group Enrollment</i>	Newly Eligible: 655,000 Not Newly Eligible: 64,900
<i>(FY 2017) Source: Kaiser Family Foundation</i>	



Early Concerns and How They Were Addressed

Key stakeholders involved in Expansion in Ohio shared the following about strategies, expectations, and experience:

'Expansion would further 'swamp' the Medicaid system' -The Governor initially opposed expanding what he considered an inefficient Medicaid program, so the administration spearheaded an initiative that cut the number of managed care contracts and saved about one billion dollars of administrative overhead – reducing the spending growth rate from about nine percent to three percent per year.

"It was critical to get the fiscal shop in order and then when it became an option to expand, the Governor was much more comfortable.- GM

'The Republican majority in the state legislature will not vote for Expansion' -

Administration planners spoke with each legislator and learned that most supported Expansion but feared losing the primary if they voted for it. So, the Governor took a different path: he pursued a State Plan Amendment and worked with Ohio's Controlling Board to secure votes for the necessary appropriation, sparing the legislature from directly voting on Expansion. The administration did ask legislators to *not oppose* Expansion, which helped limit the level of opposition. In the next budget, the legislature enacted, and the Governor did not veto, work requirements, which are due to go into effect in 2021.

'The federal government will pull back on its commitment'-To help address conservatives' concerns, the administration incorporated protections, including a trigger that would force the Ohio legislature to vote on whether to keep the Expansion if federal funding went away.

Key Strategies and Supports

Coverage Gap. Governor Kasich reportedly became an ardent Expansion supporter when he saw the injustice of the coverage gap: people with incomes between 100 and 400 percent of the FPL were receiving exchange subsidies, while those with incomes below 100 percent were getting nothing. The Governor had the power to address this, and he also reportedly foresaw that voters would favor Expansion.

Compelling Messages:

- People who would be eligible for Expansion coverage include 29,000 veterans and their families, as well as “people we know.” *“We looked specifically for ‘real’ Ohioans ... to make clear this is your neighbors, people who are in your family’- TP*
- Expansion would help avoid cost-shifting, as well as loss of federal tax dollars to other states. *“If you don’t spend the money in Ohio, it will go elsewhere.”*
- Data shows better health outcomes for people with substance use disorders and mental illness who have insurance
- Expansion would enable people to enter and stay in the workforce. *“Expansion gives people the opportunity to be healthy, look for a better job that might offer health care, and move off Medicaid.” - TK*

Sheriffs were effective advocates. Despite a broad coalition favoring Expansion and providing monetary and organizational support, certain people who “spoke” to a conservative audience were most influential. County sheriffs, seeing untreated mental illness and substance use disorder for those in and leaving jails, were effective in arguing that there is insufficient behavioral health capacity in the community without the Expansion. *“We knew that Medicaid expansion would save money for the system but the community capacity argument was the more compelling one.”- GM*

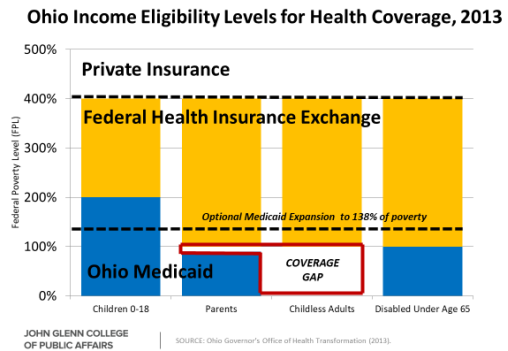
Financing Secured. The administration worked with CMS to guarantee financing for the state’s portion (relying on an existing 1 percent health insurance tax and converting an existing state sales tax to an open-ended 5.5 percent managed care plan per member per month tax, most on Medicaid MCOs). *“We made the determination [Expansion] would be affordable in out years...and that has been borne out, in contrast to beliefs of some legislators ”- TK*

Impacts

Detractors claimed that Expansion ‘blew up the budget,’ but analyses revealed savings that helped solidify the state’s finances and support other initiatives:

- The aggregate projected enrollment was close to projections, balancing an underestimate of newly eligible people enrolling and overestimate of the woodwork effect. Enrollment then declined by 11 percent in the first year and has been stable, with Expansion leading to a significant decrease in per member per month costs overall as new enrollees were typically lower cost than the existing Medicaid population.
- The state benefited financially (more than \$300 million annually) from revenue and savings generated by the Expansion, including savings from prison expenditures (\$18 million/year). *“Free money for a number of years is hard to pass up.”- GM*

Figure 2: Ohio Income Eligibility Limits and Coverage



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SOURCE: Ohio Governor's Office of Health Transformation (2013).

- A very small group of legislators have tried to repeal or scale back Expansion for political reasons, but they would need to fill a large budget hole; **opposition has reportedly decreased each year.**
- Hospital “community benefit” reports indicated uncompensated care declined as a result of the Expansion.
- Even though the state match for Expansion increased to 10 percent for 2020, the projected **effective match in Ohio will actually be 3 percent due to cost offsets** (e.g., drug rebates for Expansion members, enhanced FMAP for hospital upper payment limits (UPLs), health insurance premium taxes on larger number of insured). In 2021, Ohio’s expansion is estimated to cost \$5.3B (\$534M state share) and generate Ohio general fund savings/revenue of \$373M. The net cost of the expansion for Ohio is \$161M, which is 3 percent of the total cost, according to the Ohio Office of Budget and Management analysis (July 2018).

Figure 3: Ohio’s Share of Medicaid Expansion Costs (in Millions)

	SFY 2019	SFY 2020	SFY 2021
Total Group VIII cost	\$4,814	\$5,074	\$5,348
Match rate (state fiscal year)	6.5%	8.5%	10%
Ohio share of Group VIII cost	\$313	\$431	\$534
Drug rebates	(\$43)	(\$58)	(\$72)
DRC medical expense savings	(\$18)	(\$18)	(\$18)
Enhanced FMAP for hospital UPL	(\$40)	(\$38)	(\$36)
MCO member-month tax	(\$198)	(\$198)	(\$198)
MCO HIC tax	(\$45)	(\$48)	(\$50)
Net Impact on Ohio	(\$31)	\$72	\$161
Effective match rate	0%	1.4%	3.0%

Behavioral Health Restructured. Expansion helped to increase Ohio’s behavioral health system capacity by about 60 percent over five years.²⁵

- General Fund spending in clinical services that would be covered under Medicaid Expansion was shifted to fill in gaps, including in recovery housing subsidies, suicide prevention/community-based crisis intervention, addiction staff in prisons, programs for individuals diverted from or released from jails, and transportation. The prison system partnered with Medicaid and MCOs to enroll people before they left prison. *“It really helped to have the criminal justice system represented in our advocacy.” – TP*
- Over 70 percent of people enrolled in Expansion had at least one mental health or addiction service paid through Medicaid, reflecting pent up demand; with waiting lists for services two years post-Expansion, the state provided grants to expand capacity, including clinical supervision for practitioners trying to achieve licensure, and training to increase their scope of practice
- Medicaid “professionalized” behavioral health rates, which expanded capacity in general (hospitals, primary care) though some small providers struggled to hire practitioners with higher skills needed to benefit from the new rates

Health and Productivity: Emergency department use stabilized, and enrollees were better able to get and keep jobs as their chronic health conditions were more likely to be under control. Enrollees reported it was easier to work (84 percent) or if unemployed, easier to look for work (60 percent). A 2018 assessment found that 71 percent of members who moved off Expansion coverage had found work that offered health insurance.²⁶

Rural Hospitals and Infrastructure: Expansion supported rural hospitals and broader rural infrastructure. Ohio experienced fewer hospital closures than non-expansion states. *“Not only did Expansion not cause an access problem, it was the key to starting to address access problems in critical areas.”- GM*

Provider workforce: Expansion was accomplished through MCOs that were required (through standard network requirements in state contracts) to ensure enrollees had access to providers, which meant the MCOs paid market rates to ensure there was no shortage of providers.

Administrative efficiencies: Expansion was leveraged to build a new online eligibility system connected to income-based data (TANF, SNAP, child welfare), eliminating much county-level casework and improving efficiency.

Lessons

- Take advantage of the experience in other states
- Start with a solid fiscal foundation, and examine how Expansion could fit into transforming and improving Medicaid payment and health care delivery, and redirect funds to address longstanding gaps
- Discuss the policy and budget impact simultaneously. Ohio’s budget office, Governor’s office, and agencies involved all worked very closely together.
- Be strategic in who is out front during the campaign. Consider what kind of advocacy makes it easier for people to vote “yes” (or remain quiet if they are a “no”) – e.g., local respected officials, local hospital leaders
- More complicated “bells and whistles” (e.g., 1115 waiver) can drag the process out, adding time and risks
- Keep financing straight-forward, building on existing mechanisms when possible
- Work to increase community-based provider capacity, so that when you expand you can meet demand

Summary and Conclusions

This study provides a targeted analysis of the economic impact of an ACA Medicaid Expansion in Missouri, with an emphasis on the effects on the state budget. As Missouri considers the costs and benefits of adopting the ACA Medicaid Expansion, state officials and private sector leaders should consider the experience of other similarly situated states that have taken this step in the past few years. HMA has examined the experience in three such states—Ohio, Indiana, and Arkansas—through interviews with leaders in those states. We have also conducted a literature search and reviewed numerous published reports and articles containing research findings on the impact of the Medicaid Expansion on state budgets, the economy, the work force, uncompensated care, and a wide range of state-only program savings that could offset some of the state costs of the Medicaid Expansion.

Our study found that a large portion of the states' share of the cost of enrolling and serving the new population, as well as other state costs that are affected by the Expansion, have been offset by savings in previously state-only outlays, existing Medicaid spending diverted to the higher match rate of the expansion, and existing revenue streams. Substantial savings have emerged in mental health and substance use disorder spending. Another important source of state savings involves the incarcerated population, including health spending while they are in prisons and assistance with making the transition back into the community. Further savings can be expected as people in the "Spendedown" window, awaiting the day when their very high out-of-pocket medical costs make them eligible for Medicaid through that path, are instead enrolled in the Expansion population with a higher federal match.

We learned the law enforcement community supported expansion (contrary to expectations). County sheriffs, who see first-hand the impact of untreated mental illness and substance use disorders for those in and leaving jails, effectively argued there is insufficient behavioral health capacity in the community without Expansion. The Expansion is perceived as facilitating redesign of a health care infrastructure that promotes effectiveness, the right balance between public and private insurance, and Medicaid program integrity.

Our study also found that, contrary to some predictions, Medicaid spending per capita did not soar following Expansion in the three states. Medicaid spending increases were mostly in line with nationwide trends. There was also a perception among state leaders, and supporting research evidence, that as poor and near-poor uninsured adults gained affordable health coverage through Medicaid, their ability both to search for work and to obtain and retain jobs increased, which provides a pathway to financial independence and some added state revenues.

A Medicaid Expansion in Missouri would bring a substantial infusion of new federal outlays into the state, with a positive impact on the state's economy. Many of the Expansion states have found that, if carefully designed, the state's 10 percent cost share can be responsibly financed, and provisions can be implemented to manage spending increases. Even setting aside the savings and revenue opportunities relative to the state cost, it is important to note that among all states that have expanded, none have voted to repeal Expansion, despite many opportunities to do so, strongly indicating that the Expansion creates positive effects on state budgets. The Expansion can help lift many adults out of poverty, reduce

the public-to-private cost shift, facilitate health system transformation, and improve health outcomes for large numbers Missourians.

¹ (Missouri State Auditor's Office 2019)

² (Centers for Medicare & Medicaid 2019)

³ (Federal Reserve Bank of St. Louis 2019)

⁴ (United States Census Bureau 2019)

⁵ (Census Bureau's American Community Survey 2018)

⁶ (Center for Health Economics and Policy 2019)

⁷ (Antonisse, et al. 2019)

⁸ (Missouri State Auditor's Office 2019)

⁹ (Center for Health Economics and Policy 2019)

¹⁰ (Commonwealth of Virginia Senate Finance Committee 2018)

¹¹ (The Stephen Group 2016)

¹² (Ayanian, et al. 2017)

¹³ (Bureau of Business and Economic Research, University of Montana 2018)

¹⁴ (Stoddard 2019)

¹⁵ (Center for Health Economics and Policy 2019)

¹⁶ (Center for Health Economics and Policy 2019)

¹⁷ (Center for Health Economics and Policy 2019)

¹⁸ (Antonisse, et al. 2019)

¹⁹ (Richardson, Llorens and Heidelberg 2018)

²⁰ (The Colorado Health Foundation 2016)

²¹ (The Ohio Department of Medicaid 2018)

²² (The Lewin Group 2016)

²³ (The Lewin Group 2017)

²⁴ (Ohio Office of Budget and Management 2019)

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