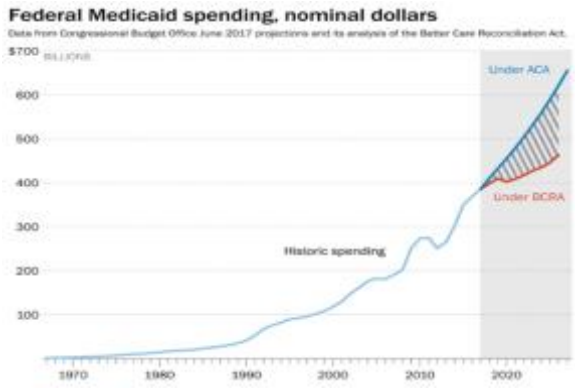
Response to Graham-Cassidy

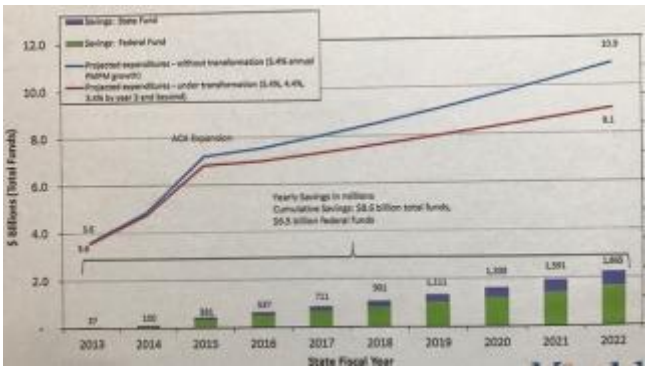
The latest effort to repeal the Affordable Care Act–a block grant to states, which ends in 2026–reflects the same kind of irresponsible cost-shifting that characterized previous efforts. The Graham- Cassidy proposal cuts funding for Medicaid; financial assistance for low income workers buying private insurance; removes current protections for those with pre-existing medical conditions, ends the authority to cover childless adults, as well as funding for the expansion population, which will leave at least 15 million people without coverage.

This effort is driven by two things: the politics of delivering on a campaign slogan ("Repeal and Replaced Obamacare"); and the cost of Medicaid. Only the second reason has merit. Eventually, Congress will have to take action to reign in the overall cost of both Medicaid and Medicare, which have become major drivers of our $20 trillion national debt. Addressing cost, however, does not required cutting enrollment or benefits, as Oregon has clearly demonstrated.

Current federal reimbursement for Medicaid is open-ended; that is, if the state spends more because enrollment increases or the cost per member increases federal payments automatically go up. Without efforts to control cost, the latest CBO estimate is that Medicaid spending will rise at 6-7% annually through 2025. The chart below shows this trend compared to the recently-failed Better Health Reconciliation Act (BCRA) in the Senate. BCRA would have reduced the cost of Medicaid to the federal government by $722 billion over ten years by simply reducing payment to the states—leading to a huge decrease in enrollment.



In 2012, Oregon applied for a waiver to demonstrate that the overall Medicaid inflation rate could be reduced from 5.4% to 3.4% per member per month by implementing a new care model—the Coordinated Care Organizations (CCOs)—without reducing enrollment or benefits; and while meeting rigorous metrics around outcomes, quality and patient satisfaction. Oregon received a one-time investment of $1.9 billion to make the transition to the new care model. After five years, the CCOs have met all the quality and outcome metrics, paid back the initial investment and realized a net cumulative savings of $1.8 billion; projected to grow to $8.6 billion over ten years.



These two charts look similar, but are actually very different. The CBO chart reflects a reduction in Medicaid spending under BCRA from simply *cutting payment to states*—the same approach embraced by the Graham- Cassidy proposal—which will result in a dramatic reduction in enrollment. The Oregon chart reflects *cost savings* to the state and federal government from reducing the average Medicaid trend rate two percentage points by implementing a new care model *without* reducing enrollment or benefits and while meeting rigorous outcome and quality metrics.

If every state followed Oregon's lead and reduced the Medicaid trend rate by two percent per member per month (while maintaining quality and outcomes without reducing enrollment or benefits) the cumulative ten-year total fund savings would be in the same ballpark of what the Republicans are seeking to save, but accomplishes it without bankrupting states or taking coverage away from 15 million Americans.

To achieve this level of success nationwide, a number of elements are required:

- Problems in the individual commercial market (which represents only about seven percent of the insured population) should be addressed along the lines proposed by Governors Kasich, Hickenlooper and others.
- CMS should assess each state to determine its individual Medicaid profile on enrollment, benefit and payment.
- States should then be given the *individualized* initial investment necessary to transition to a new care model, while covering the eligible ACA expansion population and its essential health benefits. This will give those states that did not expand Medicaid a more fiscally stable platform upon which to expand health care coverage to those without it.
- Within these parameters, states should be given expedited waivers and two years to bring their Medicaid per person cost trend two percentage points below CMS predictions, while meeting rigorous metrics around outcomes, quality and patient satisfaction.
- In year three, any provider group that accepts Medicaid payments under an ACO should be included in the definition of "Alternative Payment Model" (APM) within the MACRA program.

The Oregon CCO model demonstrates that it is possible to bend down the Medicaid cost curve while maintaining coverage and benefits, which gives us the opportunity and a path to move beyond the partisan gridlock that has plagued us for a decade.