Medicaid Reform:

Implications of Proposed Legislation

Medicaid and CHIP Payment and Access Commission
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Overview

- Past work examining Medicaid restructuring
- Key provisions of recent legislation
  - Medicaid expansion
  - Other Medicaid provisions
  - Disproportionate share hospital (DSH) and safety-net funding
  - Alternative financing structure
- Analysis of financing provisions
- Describe additional state flexibility under block grant

Past Commission Work

- June 2016 chapter examining alternative approaches to federal financing
- January and March 2017 meetings
  - Reviewed alternatives and design decisions
  - Provided illustrative examples
  - Summarized prior proposals
- Recent publications
  - Issue brief comparing methods for managed care rate setting and Section 1115 budget neutrality limits with national per capita caps
  - Facts sheets looking at state plan requirements and options regarding eligibility, benefits, and provider payment

Medicaid Provisions of American Health Care Act

American Health Care Act (AHCA) – H.R. 1628

- House bill to repeal and replace the Affordable Care Act and restructure Medicaid
- Congressional Budget Office (CBO) estimates:
  - Save approximately $840 billion (25 percent) in federal outlays for Medicaid over the 2017-2026 period
  - Lower enrollment by 14 million (17 percent) by 2026
- Pulled from floor prior to a vote on March 24, 2017
- Unclear what next steps will be

AHCA: Medicaid Expansion

- Codifies the expansion to the new adult group as optional and eliminates state option to expand above 133 percent FPL
- Reduces enhanced matching rates:
  - Eliminates enhanced matching rate for new adult group and for pre-ACA expansion states as of January 1, 2020
  - Existing enrollees who do not have more than a 30-day break in eligibility will continue to receive enhanced match

AHCA: ACA Repeal Provisions

- Ends requirement to cover older children (age 6-18) with incomes between 100 and 133 percent FPL in Medicaid (stairstep provision)
- Ends hospital presumptive eligibility (PE) and PE for adults
- Ends increased FMAP for home- and community-based attendants under Community First Choice
- Ends requirement to cover 10 essential health benefits in Medicaid

AHCA: Additional Medicaid Provisions

- Directs states to count qualified lottery winnings or lump sum incomes in determining eligibility
- Eliminates state option to establish higher home equity limit for eligibility for long-term services and supports
- Eliminates retroactive eligibility requirement
- Requires six-month eligibility redeterminations for new adult group and individuals with incomes above 133 percent FPL (under ACA-established pathway)
- Provides state option to establish a work requirement for non-disabled, non-elderly, non-pregnant adults

AHCA: DSH and Safety Net

- Repeals DSH allotment cuts for non-expansion states (scheduled to begin in 2018)
- Maintains scheduled DSH allotment cuts for expansion states for FY 2018 and 2019 and repeals cuts scheduled to begin in 2020
- Provides a five-year $10 billion pool for safety-net funding for non-expansion states to make additional provider payments in amounts proportional to population with income below 138 percent FPL

AHCA: Financing Alternatives

- Shifts federal Medicaid financing from an open-ended match to a per capita cap
- States have the option to use a block grant for:
  - non-elderly, non-disabled, non-expansion adults only
  - children and non-elderly, non-disabled, non-expansion adults

Financing Alternatives

Overview of Financing Provisions

- Describe per capita cap and block grant provisions in American Health Care Act (AHCA)
- Present illustrative examples of how certain elements affect calculation of per capita cap
  - enrollment mix
  - level of supplemental payments
  - differential growth factors

Per Capita Cap Calculation

Excluded Populations

- Individuals covered using CHIP funding
- Individuals who receive services under Indian Health Services
- Individuals who receive services under the Breast and Cervical Cancer Treatment program
- Partial benefit enrollees
  - emergency services
  - family planning
  - dually eligible only receiving Medicare cost-sharing assistance (partial duals)
  - Individuals enrolled in premium assistance
- Enrollees covered under block grant option

Excluded Expenditures

- DSH
- Medicare cost sharing
- Safety net provider payment adjustments in non-expansion states
- Vaccines for children
- Administration

Enrollee Groups

- Covered eligibility groups
  - aged
  - disabled
  - children
  - non-expansion adults
  - new adult group
- Number of enrollees for a year is defined as average monthly enrollees or full-year equivalent (FYE)

Base Years

- FY 2016 and FY 2019
- FY 2019 expenditures are constrained by FY 2016 experience
  - amount of FY 2019 non-DSH supplemental payments included in per capita cap based on proportion of non-DSH supplemental payments to total spending in FY 2016
  - FY 2019 actual spending compared to FY 2016 spending trended to FY 2019 using medical care component of consumer price index-all urban consumers (CPI-MC)

Growth Factors

- FY 2016 to FY 2019: CPI-MC
- FY 2019 to FY 2020 and subsequent years
  - aged and disabled per capita spending: CPI-MC + 1 percentage point
  - children, non-expansion adults, and new adults: CPI-MC

FY 2019 Experience by Enrollment Group

- FY 2019 enrollees
- FY 2019 spending excluding non-DSH supplemental payments
  - upper payment limit
  - uncompensated care pool, delivery system reform incentive payment, designated state health program or other supplemental payment under Section 1115 waiver expenditure authority

Non-DSH Supplemental Payment Adjustment

- Calculate ratio in FY 2016 of non-DSH supplemental payments to total payments
- Adjust the FY 2019 spending excluding non-DSH supplemental payments for each enrollee group by the FY 2016 non-DSH supplemental payment ratio
- This basically locks in the relationship between non-DSH supplemental payments to total spending in FY 2016 for future years

Trended FY 2016 Adjustment

- Calculate projected FY 2019 spending by multiplying FY 2016 overall spending per enrollee trended to FY 2019 at CPI-MC by number of FY 2019 enrollees
- Calculate ratio of projected FY 2019 total spending to actual FY 2019 total spending
- Apply this ratio to the non-DSH supplemental payment-adjusted FY 2019 spending per enrollee for each enrollee group to calculate provisional FY 2019 per capita cap target

Target Medical Expenditures

- First capped year is FY 2020
- Trend provisional FY 2019 per capita cap target for each enrollee group to FY 2020 by applicable trend factor
- Multiply FY 2020 per capita cap amount for each enrollee group by number of enrollees to calculate target total medical expenditures
- The federal share of any excess spending over the target amount is offset the following year on a quarterly basis

Illustrative Examples

- FY 2013 spending and enrollment from the Medicaid Statistical Information System (MSIS) by eligibility group, excluding:
  - limited benefit enrollees (emergency Medicaid, family planning, partial duals)
  - DSH, Medicare premiums and cost sharing
- FY 2015 spending and enrollment for new adult group from CMS-64 enrollment and spending data
- Spending per enrollee and enrollment trends by eligibility group using projections from CMS Office of the Actuary 2016 Medicaid report

Enrollment Mix

Change in Spending Per Enrollee by Enrollee Group, FY 2016–2019

Fiscal Year	CPI-MC	Change in spending per enrollee				
		Aged	Disabled	Child	Non-expansion adult	New adult
2017	3.8%	3.4%	4.2%	3.5%	5.0%	-6.3%
2018	4.3%	4.5%	4.5%	4.9%	5.3%	-3.3%
2019	4.2%	4.3%	4.7%	4.9%	5.3%	5.4%
FY 2016-2019 cumulative trend	**12.8%**	**12.8%**	**14.0%**	**13.9%**	**16.3%**	**-4.5%**

Notes: CPI-MC is the medical care component of consumer price index-all urban consumers. Annual change in spending per enrollee calculated using CMS Office of the Actuary projections for spending per enrollee.
Source: MACPAC analysis of CMS Office of the Actuary (OACT), 2017, 2016 Actuarial report on the financial outlook for Medicaid.

Effect of Enrollment Mix in Expansion versus Non-Expansion States

- Assumed the same spending per enrollee for each enrollee group for both expansion and non-expansion states
- Changed the distribution of enrollment between eligibility groups to match the average distribution of enrollees in expansion and non-expansion states
- Because the trend for the new adult group is projected to be lower than the CPI-MC trend, enrollment in new adult group affects the trended FY 2016 spending to FY 2019 spending ratio

Trended FY 2016 Adjustment In Non-Expansion State

Data element	Total	Aged	Disabled	Child	Non-expansion adult	New adult
FY 2016 enrollees (millions)	6.2	0.5	1.1	3.6	0.9	
Percent of FY 2016 enrollees		8.5%	18.1%	58.6%	14.8%	
FY 2016 spending per FYE	$8,366	$17,942	$21,689	$3,444	$6,075	
FY 2016 spending per enrollee trended to FY 2019	$9,438					
FY 2019 enrollees (millions)	6.5	0.6	1.2	3.8	1.0	
Percent of FY 2019 enrollees		8.9%	17.9%	58.2%	14.9%	
FY 2019 spending per enrollee	$9,572	$20,230	$24,731	$3,923	$7,068	
Ratio of trended FY 2016 spending per FYE to actual FY 2019 spending per FYE	98.6%					

Notes: FY 2016 and FY 2019 enrollment and spending per enrollee were calculated by trending FY 2013 Medicaid Statistical Information System (MSIS) data using projections from the CMS Office of the Actuary (OACT). FY 2016 spending per enrollee trended to FY 2019 using the medical care component of CPI-U projections from OACT.
Sources: MACPAC analysis of MSIS data as of December 2015, CMS-64 financial management report net expenditure data, and OACT, 2017, 2016 Actuarial report on the financial outlook for Medicaid.

Trended FY 2016 Adjustment In Expansion State

Data element	Total	Aged	Disabled	Child	Non-expansion adult	New adult
FY 2016 enrollees (millions)	6.2	0.4	0.7	2.2	1.2	1.6
Percent of FY 2016 enrollees		7.2%	11.9%	36.2%	18.7%	26.0%
FY 2016 spending per FYE	$7,804	$17,942	$21,689	$3,444	$6,075	$5,927
FY 2016 spending per enrollee trended to FY 2019	$8,803					
FY 2019 enrollees (millions)	6.5	0.5	0.8	2.3	1.2	1.8
Percent of FY 2019 enrollees		7.4%	11.6%	35.2%	18.5%	27.3%
FY 2019 spending per enrollee	$8,595	$20,230	$24,731	$3,923	$7,068	$5,663
Ratio of trended FY 2016 spending per FYE to actual FY 2019 spending per FYE	102.4%					

Notes: FY 2016 and FY 2019 enrollment and spending per enrollee were calculated by trending FY 2013 Medicaid Statistical Information System (MSIS) data using projections from the CMS Office of the Actuary (OACT). FY 2016 spending per enrollee trended to FY 2019 using the medical care component of CPI-U projections from OACT.
Sources: MACPAC analysis of MSIS data as of December 2015, CMS-64 financial management report net expenditure data, and OACT, 2017, 2016 Actuarial report on the financial outlook for Medicaid.

Trended FY 2016 Adjustment in Expansion State with 20 Percent Decrease in New Adult Group Enrollees

Data element	Total	Aged	Disabled	Child	Non-expansion adult	New adult
FY 2016 enrollees (millions)	6.2	0.4	0.7	2.2	1.2	1.6
Percent of FY 2016 enrollees		7.2%	11.9%	36.2%	18.7%	26.0%
FY 2016 spending per FYE	$7,804	$17,942	$21,689	$3,444	$6,075	$5,927
FY 2016 spending per enrollee trended to FY 2019	$8,803					
FY 2019 enrollees (millions)	6.2	0.5	0.8	2.3	1.2	1.4
Percent of FY 2019 enrollees		7.9%	12.2%	37.2%	19.5%	23.1%
FY 2019 spending per enrollee	$8,764	$20,230	$24,731	$3,923	$7,068	$5,663
Ratio of trended FY 2016 spending per FYE to actual FY 2019 spending per FYE	100.4%					

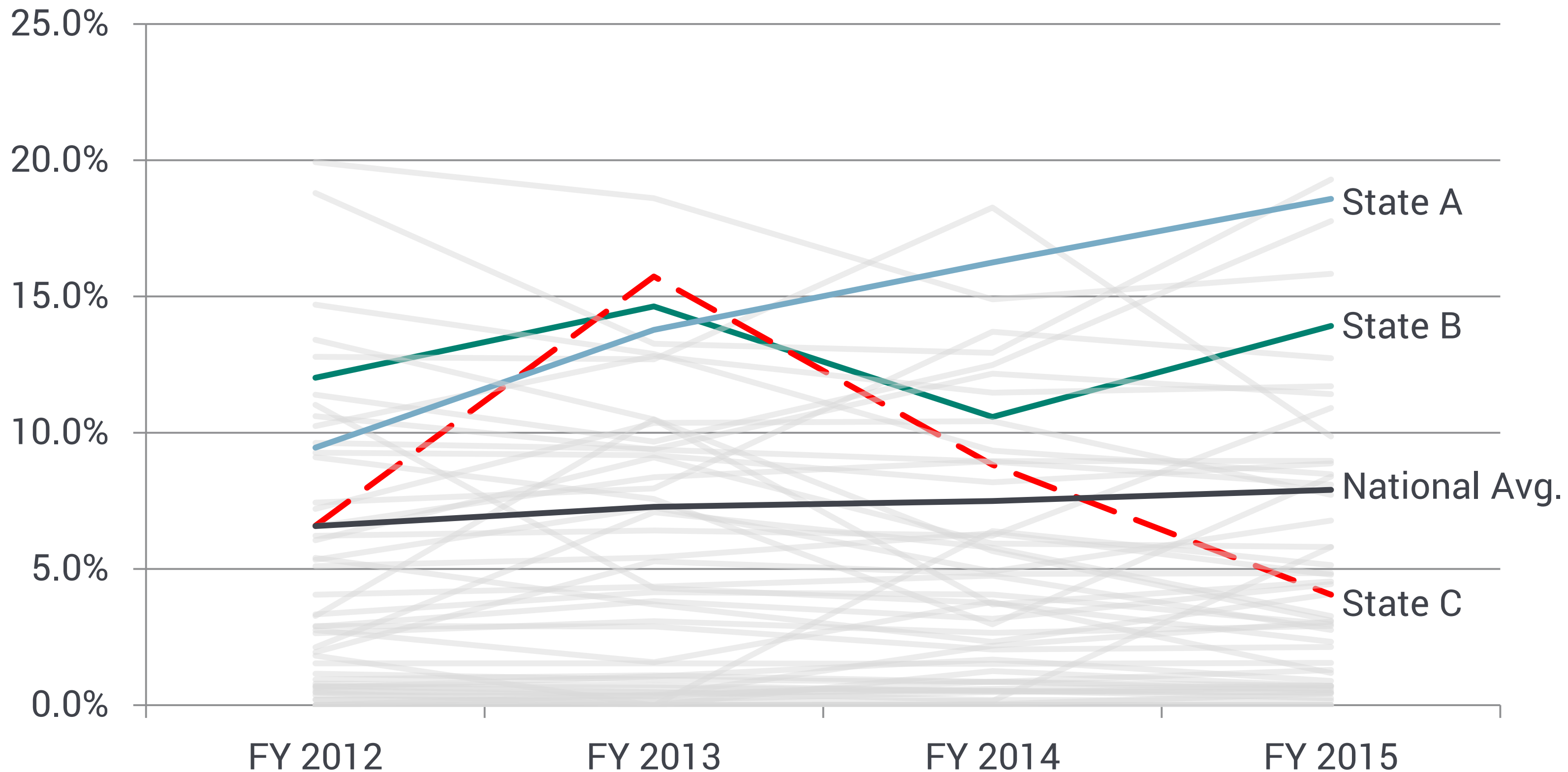
Notes: FY 2016 and FY 2019 enrollment and spending per enrollee were calculated by trending FY 2013 Medicaid Statistical Information System (MSIS) data using projections from the CMS Office of the Actuary (OACT). FY 2016 spending per enrollee trended to FY 2019 using the medical care component of CPI-U projections from OACT.
Sources: MACPAC analysis of MSIS data as of December 2015, CMS-64 financial management report net expenditure data, and OACT, 2017, 2016 Actuarial report on the financial outlook for Medicaid.

Non-DSH Supplemental Payment Adjustment

Non-DSH Supplemental Payments

- States' proportion on non-DSH supplemental payments to total spending is variable from year to year
- Per capita cap formula applies the same non-DSH supplemental payment proportion to each enrollee group based on total spending

Non-DSH Supplemental Payments as a Percent of Total Spending, FY 2012–2015



Notes: Non-DSH supplemental payments include supplemental payments made under the upper payment limit and uncompensated care pool, delivery system reform incentive payment, designated state health program, and other supplemental payments made under Section 1115 wavier authority. Total spending excludes disproportionate share hospital payments and Medicare premiums and coinsurance.
Source: MACPAC analysis of FY 2012–2015 CMS-64 financial management report net expenditure data.

Variation in Non-DSH Supplemental Payment Adjustment

	Total	Aged	Disabled	Child	Non-expansion adult	New adult
FY 2019 actual spending per enrollee	$9,020	$20,230	$24,731	$3,923	$7,068	$5,673
FY 2019 non-DSH supplemental payment as percent of total spending	10.0%	7.9%	11.0%	12.1%	12.9%	2.0%
FY 2019 actual spending per enrollee excluding non-DSH supplemental payments	$8,118	$18,634	$22,019	$3,447	$6,154	$5,562
Adjusted spending per enrollee under per capita cap calculation						
FY 2019 spending per enrollee assuming 5% non-DSH supplemental percentage in FY 2016	$8,545	$19,615	$23,178	$3,629	$6,478	$5,855
FY 2019 spending per enrollee assuming 15% non-DSH supplemental percentage in FY 2016	$9,550	$21,923	$25,905	$4,056	$7,240	$6,544

Notes: FY 2019 enrollment and spending per enrollee were calculated by trending FY 2013 Medicaid Statistical Information System (MSIS) data using projections from the Office of the Actuary.
Sources: MACPAC analysis of MSIS data as of December 2015, CMS-64 financial management report net expenditure data, and CMS Office of the Actuary (OACT), 2017, 2016 Actuarial report on the financial outlook for Medicaid.

Growth Factors

Spending per enrollee trend by enrollment group, FY 2020-2025

Fiscal Year	AHCA trend (CPI-MC + 1 percent)	Aged	Disabled
2020	5.2%	4.1%	4.8%
2021	5.2%	3.9%	5.0%
2022	5.2%	4.0%	5.1%
2023	5.2%	4.1%	5.2%
2024	5.2%	4.3%	**5.3%**
2025	5.2%	4.4%	**5.3%**

AHCA trend (CPI-MC)	Child	Non-expansion adult	New adult
4.2%	**4.8%**	**5.2%**	**5.6%**
4.2%	**4.8%**	**5.1%**	**5.5%**
4.2%	**4.9%**	**5.2%**	**5.5%**
4.2%	**4.9%**	**5.2%**	**5.5%**
4.2%	**5.0%**	**5.3%**	**5.6%**
4.2%	**5.0%**	**5.3%**	**5.6%**

Notes: AHCA is American Health Care Act. CPI-MC is the consumer price index – medical component. CPI-MC is projected to be 4.2 percent from FY 2020-2025. Bold number indicate that enrollee group trend is greater than AHCA trend.
Source: MACPAC analysis of CMS Office of the Actuary (OACT), 2017, 2016 Actuarial report on the financial outlook for Medicaid.

Block Grant Financing

Block Grant Option

- Option for 10-year block grant starting no earlier than FY 2020
- Block grant funds can only be used to provide health care assistance to those covered under block grant
- Block grant population options
  – non-elderly, non-disabled, non-expansion adults only
  – children and non-elderly, non-disabled, non-expansion adults

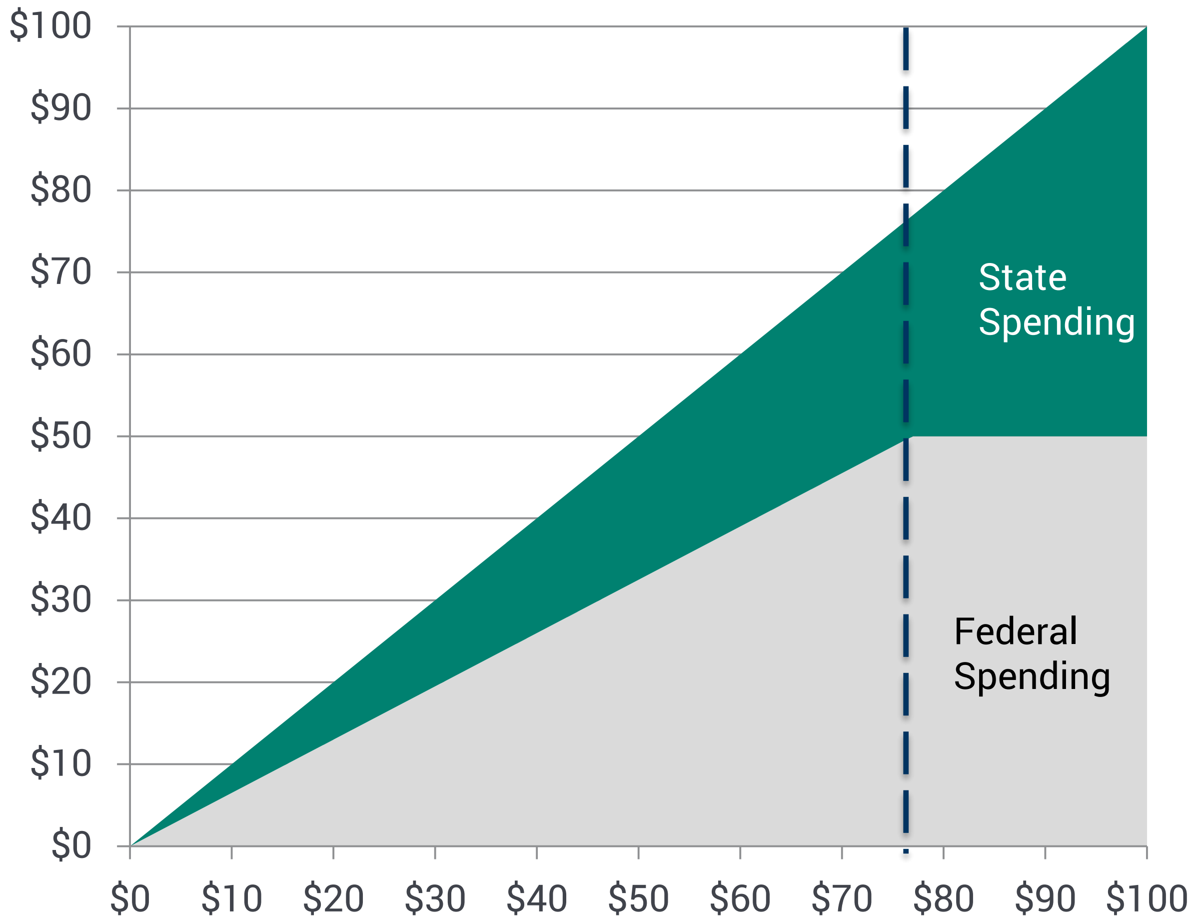
Block Grant Amounts

- For initial fiscal year, the sum of the products of:
  - target per capita medical assistance expenditures for such year for each enrollee group as calculated under per capita cap formula
  - number of enrollees for such enrollee group for FY 2019
  - average federal medical assistance matching percentage (FMAP) for FY 2019
- For subsequent years, block grant amount for prior fiscal year is increased by annual increase in consumer price index-all urban consumers (CPI-U)
- Unused block grant amounts may be rolled over to the next fiscal year

Federal Payment from Block Grant

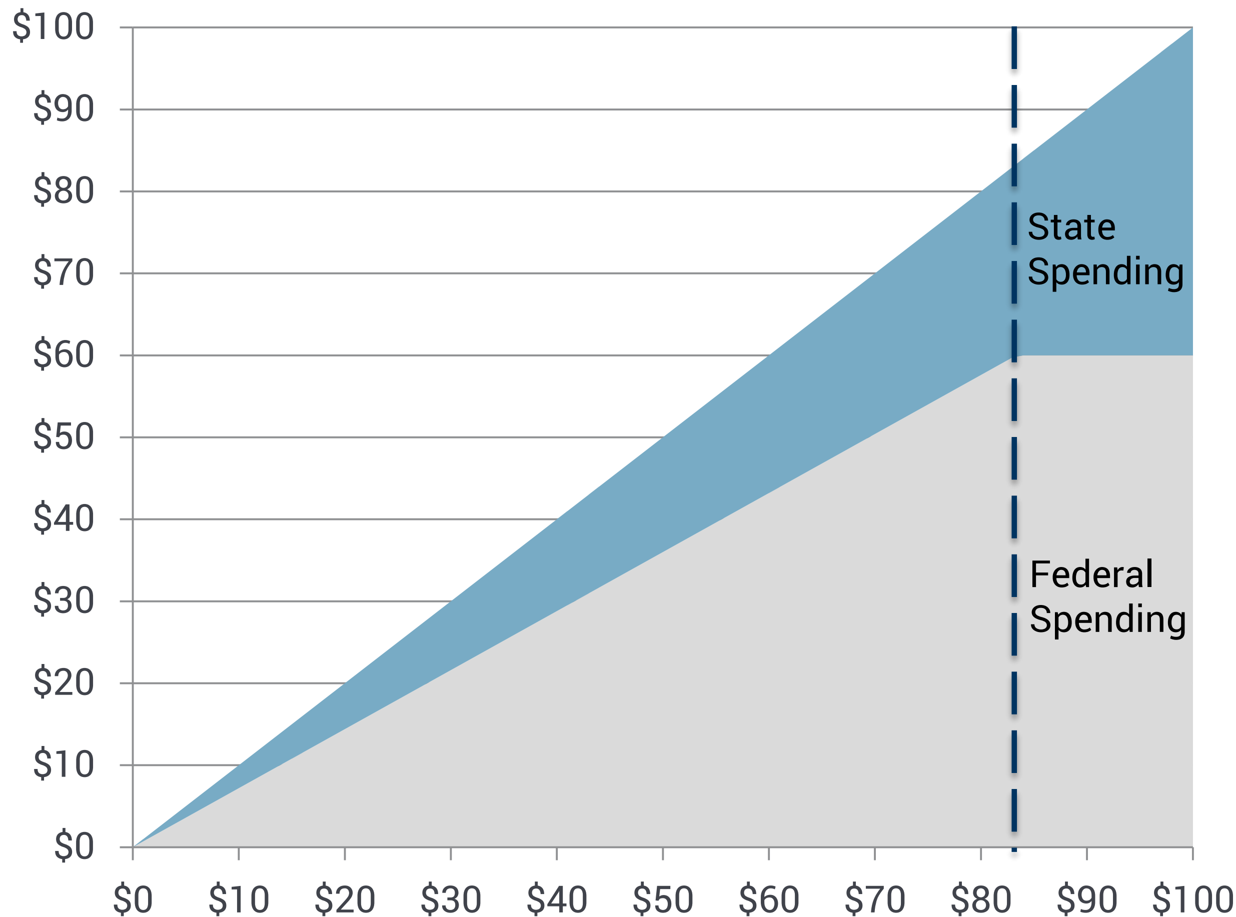
- State draws down from the block grant amount based on the CHIP enhanced FMAP(E-FMAP) rate for that fiscal year
- State is responsible for the remaining balance
- Higher FMAP means that federal dollars in block grant will be fully dispersed before a state reaches the projected total amount of spending

Split Between State and Federal Spending Under Block Grant – 50 percent FMAP



- $100 M total projected spending
- $50 M federal block grant amount
- 50% FMAP
- 65% E-FMAP

Split between State And Federal Spending Under Block Grant – 60 percent FMAP



- $100 M total projected spending
- $50 M federal block grant amount
- 60% FMAP
- 72% E-FMAP

Spending and Enrollment Growth by Enrollment Group, FY 2021–2025

Fiscal Year	AHCA trend (CPI-U)	Projected growth for children			Projected growth for non-disabled, non-elderly, non-expansion adults		
		Total spending	Enrollees	Spending per enrollee	Total spending	Enrollees	Spending per enrollee
2021	2.6%	**6.2%**	1.4%	4.8%	**6.4%**	1.2%	5.1%
2022	2.6%	**6.3%**	1.3%	4.9%	**5.8%**	0.6%	5.2%
2023	2.6%	**6.0%**	1.0%	4.9%	**5.9%**	0.6%	5.2%
2024	2.6%	**6.0%**	1.0%	5.0%	**5.9%**	0.6%	5.3%
2025	2.6%	**5.7%**	0.6%	5.0%	**5.9%**	0.6%	5.3%

Notes: AHCA is American Health Care Act. CPI-U is the consumer price index – all urban consumers.
Source: MACPAC analysis of CMS Office of the Actuary (OACT), 2017, 2016 Actuarial report on the financial outlook for Medicaid.

Additional Block Grant Provisions

Other Design Parameters

- First specific legislative proposal granting enhanced state flexibility
- No changes to state flexibility under per capita cap
- No details on what additional flexibilities may be approved under Section 1115 waivers
- Differences from current law:
  - eligibility
  - benefits
  - cost sharing
  - provider payment
  - state plan approval
  - accountability and oversight

Eligibility

Block Grant

- Children and non-elderly, non-disabled, non-expansion adults or non-elderly, non-disabled, non-expansion adults only.
- If adults are included, state must cover currently mandatory pregnant women
- If children are included, state must cover deemed newborns and currently mandatory children

Current

- Mandatory and optional eligibility groups
- Specific rules governing eligibility determinations, including income counting, timeliness standards, and renewal periods

Benefits

Block Grant

- States must provide:
  - Health care for children under 18 years of age
  - Hospital care
  - Surgical care and treatment
  - Medical care and treatment
  - Obstetrical and prenatal care and treatment
  - Prescribed drugs, medicines, and prosthetic devices
  - Other medical supplies and services

Current

- States are required to cover certain benefits but may cover others at state option
- Mandatory benefits include:
  - EPSDT services for children under 21
  - Family planning services and supplies
  - Tobacco cessation counseling and prescription drugs for pregnant women
  - Certain types of providers, such as FQHCs and rural health clinics, certified pediatric and family nurse practitioners, freestanding birth centers, nurse midwives, nursing facilities, and home health
  - Medical transportation

Scope of Coverage

Block Grant

- State determines types of items and services; amount, duration, and scope of such services; cost sharing with respect to such services; and delivery system

Current

- State flexibility within federal requirements to define:
  - benefit packages
  - amount, duration, and scope
  - utilization management
- Comparability
- Statewideness
- Mental health parity
- Freedom of choice of provider

Premiums and Cost Sharing

Block Grant

- State determines cost sharing for services
  - Not clear how premiums are affected

Current

- Premiums not allowed for certain enrollees related to categorical and income eligibility
- Cost sharing not allowed for certain enrollees and types of services
- Total premiums and cost sharing for a Medicaid household not to exceed 5 percent of income
- Beneficiary protections against balance billing

Provider Payment

Block Grant

- Not specified

Current

- For FFS, rates must be “sufficient to provide access to care equivalent to general population”
- For managed care, capitation payments must be actuarially sound
- State flexibility to design payment methods and set rates within federal guidelines such as
  - Prospective payment for FQHCs
  - Upper payment limit

State Plan Approval

Block Grant

- State must submit a plan that specifies:
  - Applicable block grant category
  - Conditions for eligibility
  - Types of services; amount; duration, and scope of services; cost-sharing for services; and delivery system
- Plan is deemed approved unless, within 30 days, HHS determines it is incomplete or actuarially unsound

Current

- State plan must be approved by CMS and include the following:
  - Administrative processes
  - State-specific standards for eligibility determinations
  - Covered benefits
  - Optional groups, services, and programs
  - Provider payment methodology

Accountability and Oversight

Block Grant

- State shall contract with independent entity to conduct audits of its expenditures under block grant for each fiscal year to ensure funds are used consistent with statute
- State shall make such audits available to HHS Secretary upon request

Current

- Federal program integrity provisions, including suspension of payments in cases of potential fraud and routine audits
- Required reporting:
  - Quarterly expenditure reports (CMS-64)
  - Monthly MSIS & T-MSIS reporting
  - Enrollment and eligibility performance indicators
  - Form CMS-416 on EPSDT recipients
  - Medicaid Drug Rebate Program
  - Medicaid Managed Care Data Collection System
- Supporting documentation as requested by CMS

Medicaid Reform:

Implications of Proposed Legislation

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