Reshaping Medicaid: Navigating Proposed Policy Changes and Political Dynamics

Prepared for the Community Integration Leadership Institute

June 1, 2017
Agenda

- Medicaid Today
- American Health Care Act Key Takeaways
- Capped Funding Models
Medicaid Today
Medicaid is Major State Budget Item and Largest Source of Federal Revenue

NY Medicaid Spending as Share of Budget (State Funds Only), SFY 2015

- Medicaid, 16.6%
- Elem. & Sec. Education, 24.3%
- Higher Education, 10.5%
- Transportation, 8.0%
- Corrections, 3.1%
- Public Assistance, 1.2%
- All Other, 36.2%

Medicaid as a Share of Federal Funds to New York, SFY 2015

- Medicaid, 64.3%
- Elem. & Sec. Education, 7.5%
- Higher Education, 0.7%
- Public Assistance, 5.8%
- Transportation, 3.5%
- Corrections, 0.1%
- All Other, 18.1%

I/DD Population Is Approximately 2% of New York’s Medicaid Enrollment but 13% of Costs in 2015

NYS Medicaid Enrollment

- Non-I/DD: 4.8 M
- I/DD: 97,483

Total: 4.9 M Enrollees

NYS Medicaid Expenditures

- Non-I/DD: $52.8 B
- I/DD: $7.7 B

Total: $60.5 B

Medicaid is Primary Source of Funding for I/DD Supports and Services in New York State

Total Public Spending for I/DD Services in New York: FY 2000-2013

As spending for institutional services has declined, spending for Home and Community Based Services has increased as a proportion of total spending.

* Total Medicaid I/DD spending differs from total Medicaid I/DD spending on Slide 7 because the above graph includes “Related Medicaid” spending, which includes clinic rehabilitation, targeted case management, personal assistance and administration. Spending call out: https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628.pdf
85% of Medicaid Spending for Individuals with I/DDs is on Longer Term Care

Total Cost of Care (TCC) for Medicaid I/DD Claims in New York—Breakdown by Service Category

American Health Care Act (AHCA)
Overview
AHCA: Implications for Medicaid

- Reduces federal Medicaid funding by $834 billion over 10-years, largely to finance ACA tax cuts
- Phases out enhanced funding for Medicaid expansion, resulting in significant losses to coverage and federal funding
- Dramatically alter federal Medicaid financing, shifting costs and risk to states
AHCA: Federal Medicaid Funding Cuts

Projected Change in Federal Medicaid Outlays (FYs 2017 – 2026)

- CBO projected that the AHCA would reduce federal Medicaid spending by $834 billion from 2017-2026

- New York could see at least 14% ($44 B) of its federal funds cut during 2020-2026 if it maintains its expansion, and nearly 30% ($92 B) if it only covers “grandfathered” individuals


* CBO estimates the projected change in federal Medicaid outlays in 2017 to be between -$500 million and $500 million.

** Manatt Medicaid model. Assumes medical CPI is 3.7% and state maintains expansion coverage only for “grandfathered” individuals.
AHCA: Impact on Coverage

Estimated Decrease in Enrollment Assuming Coverage is Maintained Only for "Grandfathered" Expansion Adults, FYs 2017-2026

- By FY 2026, the 32 states with Medicaid expansion would have seen a decrease of 14 million enrollees.
- By FY 2026, New York could see a decrease of 2.2 million Medicaid expansion enrollees—essentially the entire Medicaid expansion population.

* CBO estimates the projected change in Medicaid enrollment in 2017 is between zero and 500,000.
New York Is One of 31 States & D.C. That Have Expanded

Expansion states received $72.6 billion in total federal expansion funding in 2016

- Washington: $2.8 B
- California: $20.8 B
- New Mexico: $1.4 B
- New York: $8.2 B
- Kentucky: $3.0 B
- Ohio: $3.4 B
- Michigan: $3.3 B
- Arkansas: $1.4 B
- North Dakota: $251 M

Note: Federal funding does not reflect enhanced funding provided by the ACA to states that expanded before the ACA ("early expansion states"). Total federal funding for all expansion adult enrollees (not just those that are newly eligible) from January 2014 - June 2015 was $78.8 billion.

AHCA Treatment of Medicaid Expansion

- Maintains authority for Medicaid expansion up to 133% of the FPL, but eliminates access to enhanced funding for non-expansion states as of March 1, 2017; regular match still available

- Eliminates enhanced federal Medicaid funding for existing expansion states in 2020 except for “grandfathered” adults:
  - Starting in 2020, enhanced match available only to “grandfathered” individuals enrolled on December 31, 2019 and who do not have a break in eligibility of more than a month
  - Option for expansion states to limit enrollment to grandfathered individuals for whom enhanced matching rate is available; not obligated to cover new enrollees
  - Reduction to enhanced match for “leader states” (including New York) that expanded coverage to adults prior to the ACA

- Requires that states redetermine eligibility for expansion adults every six months

- Eliminates authority to provide Medicaid coverage for individuals with incomes > 133% FPL

- Lowers the minimum income eligibility level for children ages 6 and older from 133% FPL to 100% FPL (the required pre-ACA level), effective January 1, 2020

Capped Funding Models
## Medicaid’s Financing Structure

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Block Grants</th>
<th>Per Capita Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Federal Funding</strong></td>
<td>Open ended</td>
<td>Aggregate cap</td>
<td>Per enrollee cap (by eligibility group)</td>
</tr>
<tr>
<td><strong>Risk</strong></td>
<td>Federal government and state share enrollment and spending risk</td>
<td>States bear risk of both enrollment and spending risk</td>
<td>States bears spending risk</td>
</tr>
<tr>
<td><strong>Annual Trend</strong></td>
<td>Determined by health care costs in the state and individual state spending decisions</td>
<td>National trend rate</td>
<td>National trend rate</td>
</tr>
<tr>
<td><strong>Ability to Accommodate Medical Advances or Public Health Crises</strong></td>
<td>Federal payments automatically responsive</td>
<td>Federal payments not responsive</td>
<td>Federal payments not responsive</td>
</tr>
<tr>
<td><strong>Spending Outside of Cap</strong></td>
<td>N/A</td>
<td>House AHCA puts spending for certain eligibility groups in the cap</td>
<td>House AHCA excludes supplemental payments (e.g. DSH)</td>
</tr>
<tr>
<td><strong>State Flexibility</strong></td>
<td>State flexibility subject to federal minimum standards; Section 1115 waivers provide additional flexibility</td>
<td>Increased flexibility, but likely with some minimal benefit and accountability standards</td>
<td>Increased flexibility, but likely some minimal benefit and accountability standards</td>
</tr>
<tr>
<td><strong>State Spending Requirements</strong></td>
<td>State spending required; Match rates vary by population, services</td>
<td>Uncertain</td>
<td>State match likely</td>
</tr>
</tbody>
</table>
Overview of AHCA Block Grant Option

- States may opt to receive a block grant beginning in FY 2020
- Election applies for 10 year period
- States may choose to apply block grant to 1) non-expansion, non-disabled adults or 2) those adults plus children
- Federal funding amount calculated by multiplying base year per capita spending by the state’s FY 2019 enrollment in the eligibility group and FY 2019 average FMAP
- Base year amount trended forward at CPI-U – a lower trend rate than under the per capita cap
- State match required to draw down federal funds; CHIP FMAP applies
- Few Medicaid coverage requirements apply; significant latitude regarding eligibility, benefits (including EPSDT), cost-sharing and delivery system (but must comply with mandatory minimum eligibility levels for pregnant women and children)
Overview of AHCA Per Capita Cap Provisions

- Imposes an aggregate cap on total Medicaid funding starting in FY 2020
- Aggregate cap built from per capita caps for five eligibility categories: elderly, blind/disabled, children, expansion adults, and other non-elderly/non-disabled adults
- Per capita cap for each eligibility group set based on state historical spending in FY 2016 trended forward to FY 2019, and actual FY 2019 spending and enrollment
- Trend factor for aged, blind and disabled is growth in medical CPI + 1 percentage point; for children and adults it is growth in medical CPI
- DSH payments are outside the cap; UPL and waiver payments are subject to the cap
- State match required, with federal match provided for state expenditures up to cap
- To extent state’s total Medicaid expenditures are higher than the cap, state would be required to repay the federal amount in the following year
Key Considerations in Evaluating Capped Funding Models

**Base Funding**
- Eligibility Levels
- Covered Benefits
- Payment Rates

**Trend Rates**
- National Benchmark Selection
- State Population & Eligibility Group Changes
- Medical Inflation

**State Share**
- State Match Requirements
- Enhanced Federal Match
- IGTs & Provider Tax Restrictions

**Supplemental Payments & Waivers**

**Flexibility**
Capped Funding Locks in Disparities Across States

Spending Per Full Benefit Medicaid Enrollee, FY 2011

New York Enrollee Medicaid Spending Varies by Category

State Ranking of Medicaid Spending (Federal and State) per Full Benefit Enrollee, FY 2011

<table>
<thead>
<tr>
<th>#</th>
<th>Total</th>
<th>Children</th>
<th>Adults*</th>
<th>Disabled</th>
<th>Aged</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MA</td>
<td>$11,091</td>
<td>VT</td>
<td>$5,214</td>
<td>NM</td>
</tr>
<tr>
<td>2</td>
<td>NY</td>
<td>$10,307</td>
<td>AK</td>
<td>$4,682</td>
<td>MT</td>
</tr>
<tr>
<td>3</td>
<td>RI</td>
<td>$9,541</td>
<td>NM</td>
<td>$4,550</td>
<td>AK</td>
</tr>
<tr>
<td>4</td>
<td>AK</td>
<td>$9,481</td>
<td>RI</td>
<td>$4,290</td>
<td>AZ</td>
</tr>
<tr>
<td>5</td>
<td>DC</td>
<td>$9,083</td>
<td>MA</td>
<td>$4,173</td>
<td>VT</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>VT</td>
<td>$7,951</td>
<td>AZ</td>
<td>$7,167</td>
<td>NY</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>WV</td>
<td>$6,821</td>
<td>NY</td>
<td>$2,707</td>
<td>CT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>AL</td>
<td>$4,976</td>
<td>NV</td>
<td>$1,940</td>
<td>FL</td>
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<tr>
<td>48</td>
<td>FL</td>
<td>$4,893</td>
<td>MI</td>
<td>$1,926</td>
<td>CA</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>IL</td>
<td>$4,682</td>
<td>IN</td>
<td>$1,858</td>
<td>NV</td>
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<td></td>
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<tr>
<td>50</td>
<td>GA</td>
<td>$4,245</td>
<td>FL</td>
<td>$1,707</td>
<td>ME</td>
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<tr>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>NV</td>
<td>$4,010</td>
<td>WI</td>
<td>$1,656</td>
<td>IA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. Average</td>
<td>$6,502</td>
<td>$2,492</td>
<td>$4,141</td>
<td>$18,518</td>
<td>$17,522</td>
</tr>
</tbody>
</table>

* Includes low-income parents and pregnant women.

- States with high per enrollee spending dedicate 2 or 3 times as much funding per person as states with low per enrollee spending.
- Wide range in per capita spending poses challenges in setting state-specific funding caps.
- States are locked into base year spending decisions, with limited or no ability to increase provider rates, plan premiums or respond to public health crises or new technologies or cures.
- Per enrollee spending reflects base year enrollee mix within each eligibility category; future enrollee mix may include greater percentage of high-need, high-cost individuals (e.g. additional frail elderly in aged eligibility group).

Source: Manatt analysis of Kaiser Family Foundation, Medicaid Spending per Full-Benefit Enrollee, as included in the Robert Wood Johnson Foundation, “Data Points to Consider When Assessing Proposals to Cap Federal Medicaid Funding: A Toolkit for States”, available at: [http://www.statenetwork.org/resource/data-points-to-consider-when-assessing-proposals-to-cap-federal-medicaid-funding-a-toolkit-for-states/](http://www.statenetwork.org/resource/data-points-to-consider-when-assessing-proposals-to-cap-federal-medicaid-funding-a-toolkit-for-states/). New Mexico’s spending per aged enrollee was not available. Enrollees were identified as having full benefits if for each month they were enrolled in Medicaid they also received full benefits or received Medicaid benefits through an alternative package of benchmark equivalent coverage.
AHCA: Per Capita Cap Trend Rate

Proposed national growth trends varied across eligibility groups

Average Annual Growth in Medicaid Spending per Full-Benefit Enrollee Relative to National Benchmarks (FYs 2000 – 2011)

<table>
<thead>
<tr>
<th>Per Capita Caps</th>
<th>Optional Block Grants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
<td><strong>Adults</strong></td>
</tr>
<tr>
<td>5.3%</td>
<td>5.6%</td>
</tr>
<tr>
<td>4.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>CPI-Med</td>
<td>CPI-Med +1</td>
</tr>
</tbody>
</table>

AHCA Proposed Benchmarks:

- **Per capita caps**
  - CPI-Med (adults & children)
  - CPI-Med +1% (aged & disabled)

- **Optional block grants** (children & adults only)
  - CPI-U

National Trend Rates Compared to New York Trend Rates (2000 to 2011)

Average Annual Change

Cumulative Change

New York

National

Children: 3.0% 2.9% 4.3% 3.7%
Adults: 2.9% 2.5% 4.0%
Disabled: GDP* CPI M-CPI

Children: 39.0% 37.0% 59.0%
Adults: 41.0%
Disabled: 36.8%
Aged: 30.6%
GDP*: 53.5%
CPI: 53.5%
M-CPI: 53.5%

*GDP per capita

Proposed national caps would have reduced New York Medicaid spending below actual levels for many eligibility groups between 2000 and 2011.

Between 2001-2016, annual growth in the medical CPI ranged from a low of 2.4% to a high of 4.7%. Even a 0.1% difference in medical CPI can have a significant impact when calculating a state’s aggregate spending cap under a per capita cap model.

Actual Trend Rate Determines Impact of Per Capita Cap

If medical CPI is 3.7%...

<table>
<thead>
<tr>
<th>Aged</th>
<th>Disabled</th>
<th>Children</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,603.8</td>
<td>($961.6)</td>
<td>($3,725.6)</td>
<td></td>
</tr>
</tbody>
</table>

State must cut $6.153 billion to stay below cap

If medical CPI is 3.2%...

<table>
<thead>
<tr>
<th>Aged</th>
<th>Disabled</th>
<th>Children</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>($1,066.5)</td>
<td>($1,348.0)</td>
<td>($2,834.7)</td>
<td></td>
</tr>
</tbody>
</table>

State must cut $10.223 billion to stay below cap

Contribution to the impact of the cap in New York, 2026 (in millions)

Source: Manatt Medicaid model
Note: Includes federal and state spending. Cap amounts assumes that state maintains expansion coverage.
Contribution to Impact of Per Capita Cap Varies by Group, but Distribution of Cuts May Differ

**Room under cap (+) or excess spending (-) by eligibility group**

<table>
<thead>
<tr>
<th>Group</th>
<th>Contribution (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged</td>
<td>$137.8</td>
</tr>
<tr>
<td>Disabled</td>
<td>($1,603.8)</td>
</tr>
<tr>
<td>Children</td>
<td>($961.6)</td>
</tr>
<tr>
<td>Adults</td>
<td>($3,725.6)</td>
</tr>
</tbody>
</table>

**State must cut spending by $6.153 billion to stay below cap, or it faces clawback**

- **Aged**
  - Baseline: $25,554.9 million
  - Percentage: 28%

- **Disabled**
  - Baseline: $27,862.4 million
  - Percentage: 30%

- **Children**
  - Baseline: $9,152.2 million
  - Percentage: 10%

- **Adults**
  - Baseline: $30,177.2 million
  - Percentage: 32%

**Baseline spending, 2026 (in millions)**

- **Aged**: $25,554.9 million (28%)
- **Disabled**: $27,862.4 million (30%)
- **Children**: $9,152.2 million (10%)
- **Adults**: $30,177.2 million (32%)

**Contribution to impact of the cap, 2026 (in millions)**

- **Aged**: $137.8 million
- **Disabled**: ($1,603.8 million)
- **Children**: ($961.6 million)
- **Adults**: ($3,725.6 million)

Source: Manatt Medicaid model

Note: Includes federal and state spending. Cap amounts assume that state maintains expansion coverage.
Capped funding may require states to reconsider coverage of optional populations and services, with implications for the I/DD population.

In New York, optional services include home and community based services under 1915(c) waivers and personal care services under the State Plan.

Capped funding may require state to cap waiver enrollment and resort to waiting lists.

While schools must continue to comply with the federal Individuals With Disabilities Education Act, capped funding puts additional pressure on New York State’s ability to provide these services.

- Schools in New York now receive about $125 million in Medicaid reimbursement annually.

Are Federal Per Capita Caps Just MMC for States?

State Pays PMPM Premium to MCO

U.S. Pays Per Enrollee Per Year “Premium” to States
Establishing Per Cap Amount for MCOs

- Develop base rate off historic utilization and price data
- Apply appropriate trend adjustments
- Apply appropriate non-benefit costs
- Adjust to reflect changing landscape and program features
- Consider historical and projected MLR
- Apply risk adjustment methodology, if used

Source: 42 CFR 438.2-.7; Effective: Rating periods for contracts starting on or after 7/1/17
Establishing Per Cap Amount for States

Set base rate off historic spending broken down by eligibility group (i.e., children, adults, elderly, disabled)

Apply national trend rate
“Today is the first of what I am confident will be many historic days ahead as we move toward patient-centered healthcare instead of government-centered healthcare.

I have worked in the field of Medicaid for 20 years and have heard from many mothers like myself who have shared their struggles and their hopes for a more affordable, more sustainable healthcare system. It is important that our most vulnerable citizens, the aged, the infirm, the blind and the disabled have more choices, greater access and peace of mind when it comes to their healthcare.

The bill that was passed today is a great first step toward achieving this goal.”

Thank You!

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