Proposals to Cap State Medicaid Funding: Massachusetts Considerations

The Massachusetts Coalition for Coverage and Care
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Patti Boozang, Senior Managing Director
Cindy Mann, Partner

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Agenda

- Current Program Financing
- House Proposal to Cap Federal Medicaid Funding to States
- Implications for Massachusetts
- Discussion

Current Program Financing

Medicaid's Financing Structure Today

States receive federal funding for all allowable program costs

- Federal dollars guaranteed as match to state spending
- In total, states are estimated to receive $393 billion in federal Medicaid funds in FY2017 as a "match" to a projected $230 billion in state funds
- Matching rates vary by state, population, and service
- States claim federal dollars for medical and administrative services provided to Medicaid enrollees; states also claim federal dollars for DSH, UPL, GME payments and in some cases payments under waiver authority (e.g., Low-Income Pool payments)
- States must follow federal rules (or waiver terms & conditions)

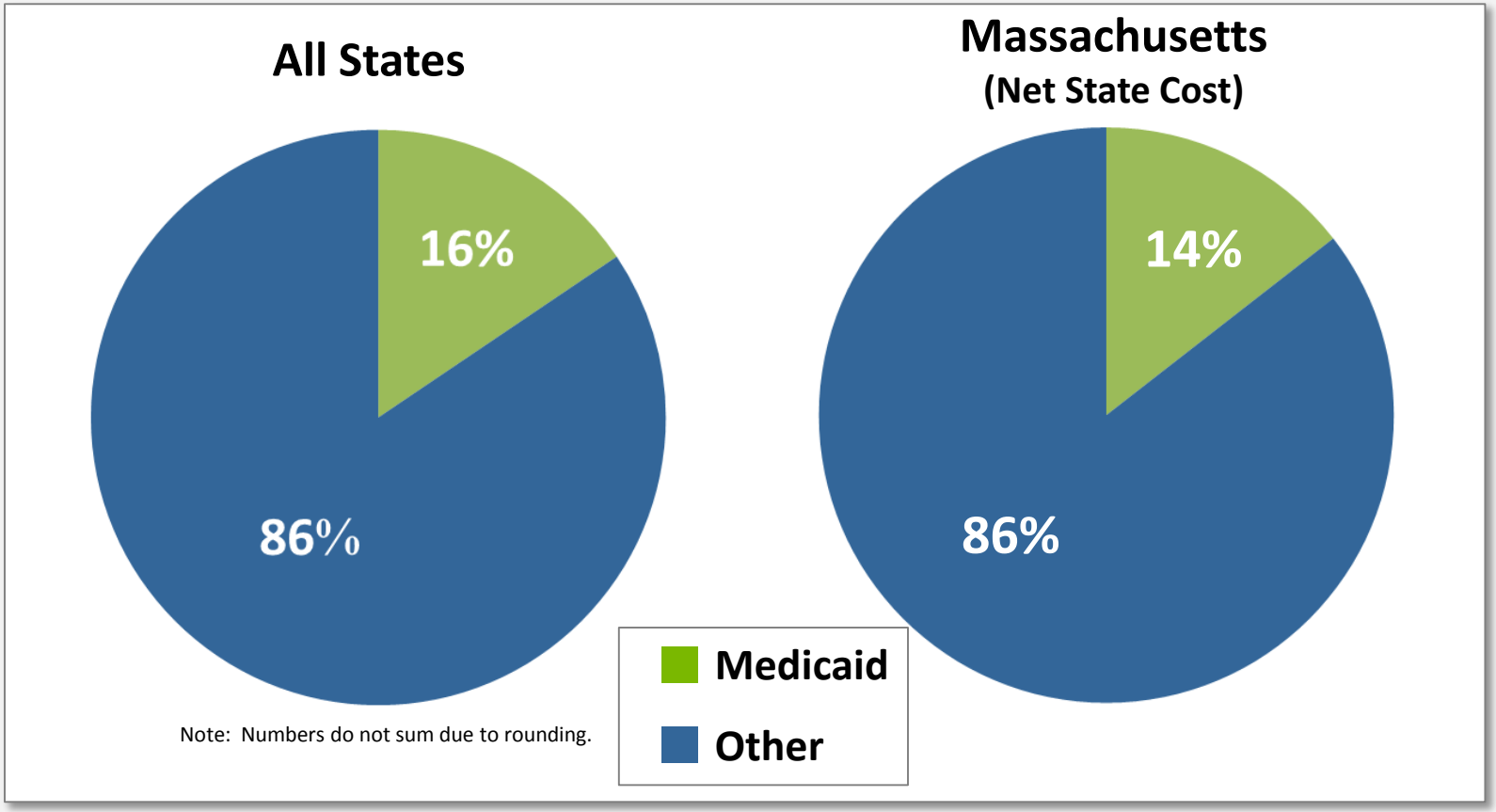
Massachusetts Key Facts

- **$13.7 B** total spending FY15 *(all funds)*
- **50%** federal match rate (avg.)

Source: Congressional Budget Office (CBO), 10-year Budget Projections, https://www.cbo.gov/about/products/budget-economic-data; Social Services Estimating Conference, Office of Economic & Demographic Research (EDR); Federal Medical Assistance Percentage (FMAP) FY17, http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/; Total Medicaid Spending FY15, http://bluecrossfoundation.org/sites/default/files/download/publication/MassHealthBasics_Chartpack_FY2015_FINAL_1.pdf

Massachusetts Medicaid Spending as Share of State Budget In-Line with National Averages

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



Note: Numbers do not sum due to rounding.

Sources: RWJ Foundation, Manatt analysis, "Data Points to Consider When Assessing Proposals to Cap Federal Medicaid Funding: A Toolkit for States," accessed at: http://statenetwork.org/resource/data-points-to-consider-when-assessing-proposals-to-cap-federal-medicaid-funding-a-toolkit-for-states/

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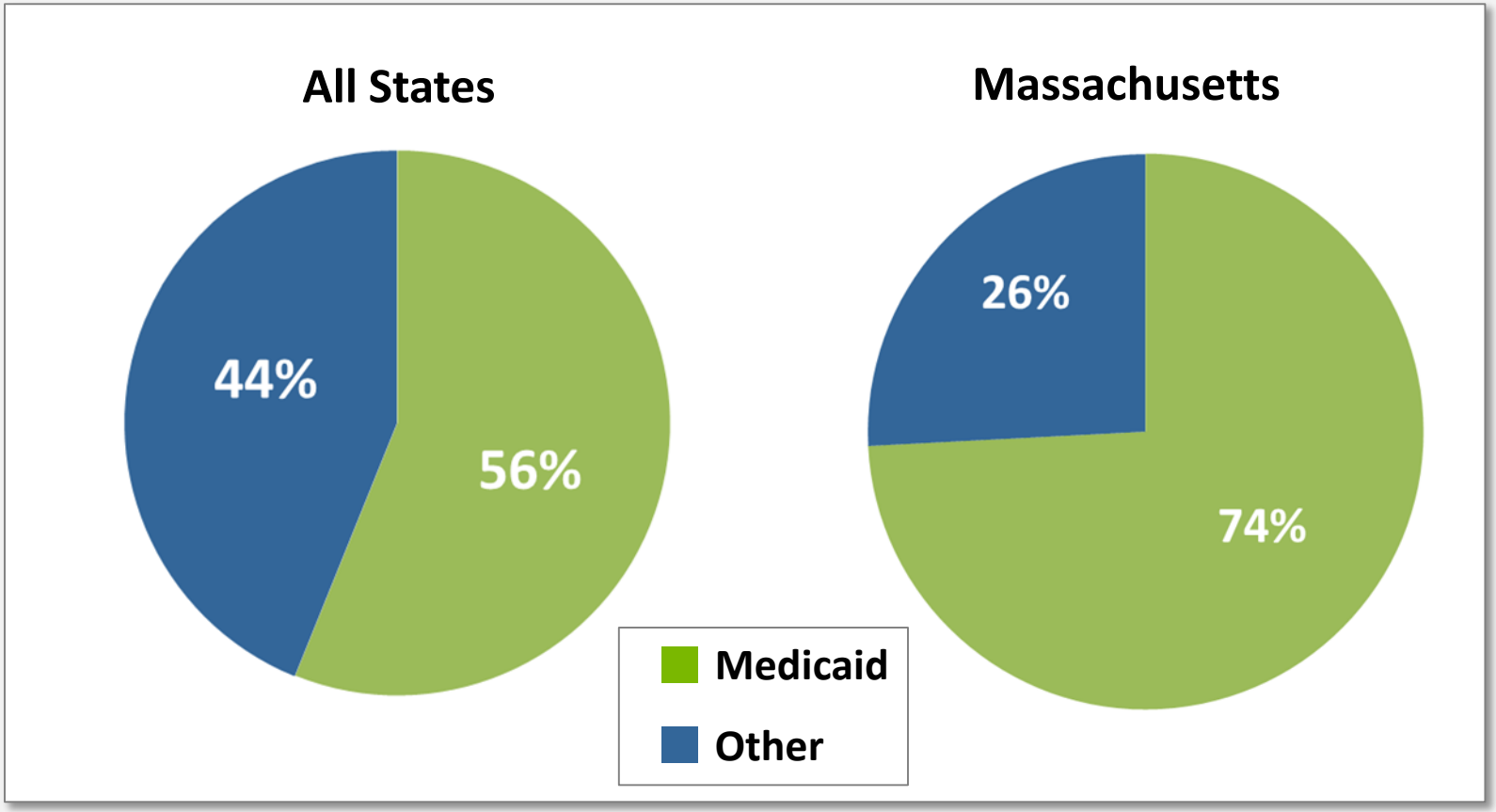
Federal Medicaid Dollars as a Share of Federal Revenues

Sources of Federal Funds, SFY 2015



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House Proposal to Cap Federal Medicaid Funding to States

Medicaid's Financing Structure

	Current	Block Grants	Per Capita Cap
Federal Funding	Open ended	Aggregate amount	Per enrollee amount
Risk	Federal and state government share enrollment and spending risk	State bears enrollment and spending risk	States bears spending risk
Annual Trend	Determined by costs and individual state spending decisions	National benchmark trend rate (likely below medical inflation)	National benchmark trend rate (latest proposal is medical inflation)
Responsiveness to Medical Advances or Public Health Crises	Responsive	Not responsive	Not responsive
Spending Outside of Cap	N/A	Proposals to date would put most or all spending in the cap	Latest proposal would exclude admin, DSH and spending for certain limited-benefit populations
State Flexibility	State flexibility subject to federal minimum standards; Section 1115 waivers provide additional flexibility	Increased flexibility, but likely with some minimal benefit and accountability standards (e.g. mandatory service coverage for elderly and disabled populations)	Increased flexibility, but likely some minimal benefit and accountability standards
State Spending Requirements	State spending required; Match rates vary by population, services	Uncertain	State match likely but not certain

Per Capita Caps Differ from 1115 Waiver Budget Neutrality

States operating under 1115 waivers are subject to per person and trend rate "caps" to assure budget neutrality

- Waiver caps are set to ensure budget neutral federal spending over course of the waiver; they are not designed to achieve federal savings
- Waivers are requested by states; they are not imposed by the federal government and are not applied to populations not affected by the waiver
- Waiver growth rates can be adjusted to reflect unexpected costs and are not subject to an aggregate cap

Key Considerations for Capped Funding

Base Funding

- Eligibility Levels
- Covered Benefits
- Payment Rates

State Share

- State Match Requirements
- Enhanced Federal Matches
- IGTs & Provider Tax Restrictions

Trend Rates

- National Benchmark
- State Population & Eligibility Group Changes
- Medical Inflation

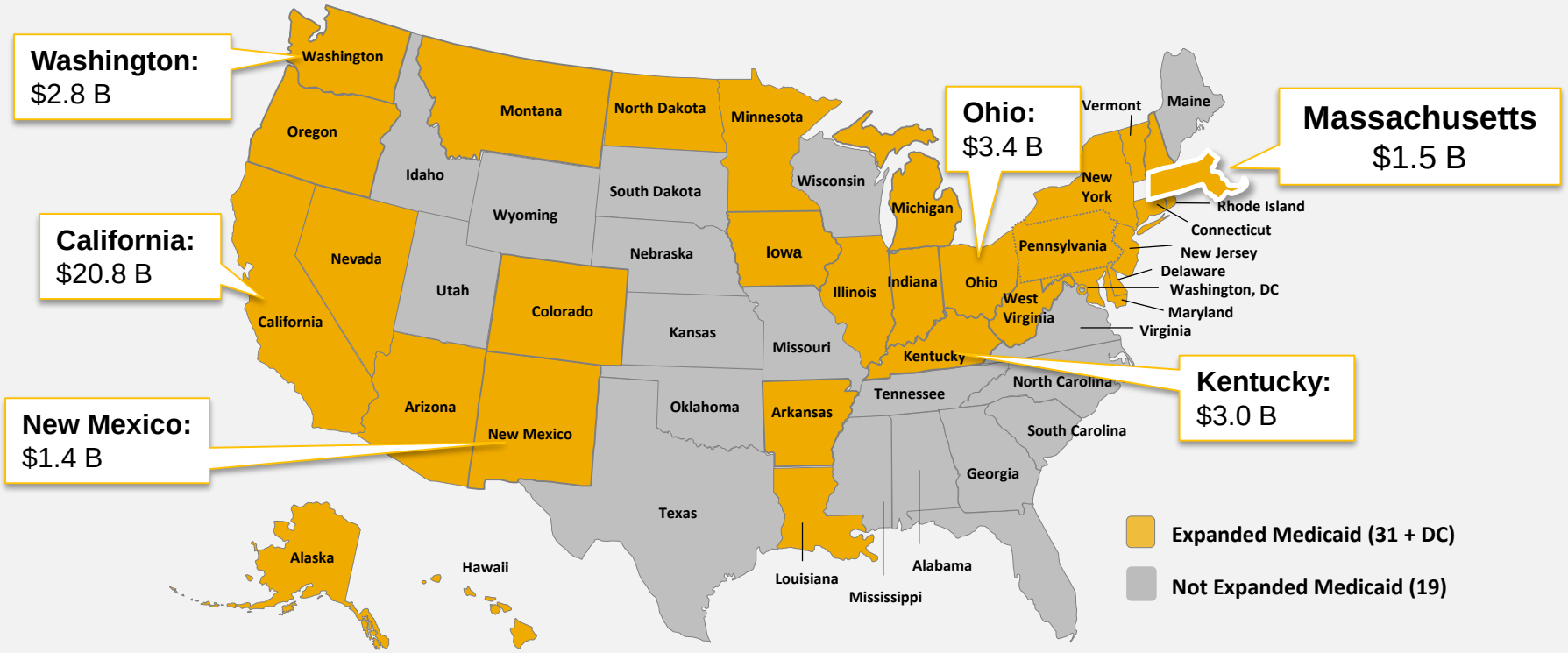
Supplemental Payments & Waivers

- DSH & GME Treatment
- Enhanced Federal Matches
- DSRIP, other waiver funds

Flexibility

Treatment of $72.6 B in Expansion Funding in a Capped Funding Model is Critical to Massachusetts

Examples of federal funds for expansion population (FY15)



Source: Manatt analysis based on December 2016 CMS-64 expenditure data. Data available online at: https://www.medicaid.gov/medicaid/financing-and-reimbursement/state-expenditure-reporting/expenditure-reports/index.html; Kaiser Family Foundation, Current Status of State Medicaid Expansion Decisions, July 2016. Available at: http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/. **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.

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American Health Care Act: Per Capita Cap Overview

- House repeal and replace legislation proposes an aggregate cap on Medicaid funding, starting in FY 2020; it is built up based on per capita caps for enrollees in five eligibility categories: elderly, blind/disabled, children, expansion adults, and other non-elderly/non-disabled adults
- Cap set for each enrollee group based on state historical spending. Overall or aggregate cap then set based on the number of people enrolled in each group multiplied by the cap for that group
  - e.g. a state that enrolls 100,000 children and is subject to a per capita cap of $3,000 per child would have $30,000,000 counted toward its aggregate cap
- States can use "savings" from one group to finance care for another
  - e.g. if state spending for people with disabilities is below the cap for that group, the state can use the "room" under the cap to finance care for seniors, children or other adults
- To the extent state spending exceeds the cap beginning in FY 2020, the state would re-pay excess expenditures to the federal government in the following year

American Health Care Act: Per Capita Cap Base Funding

The process for establishing a per capita cap is complex

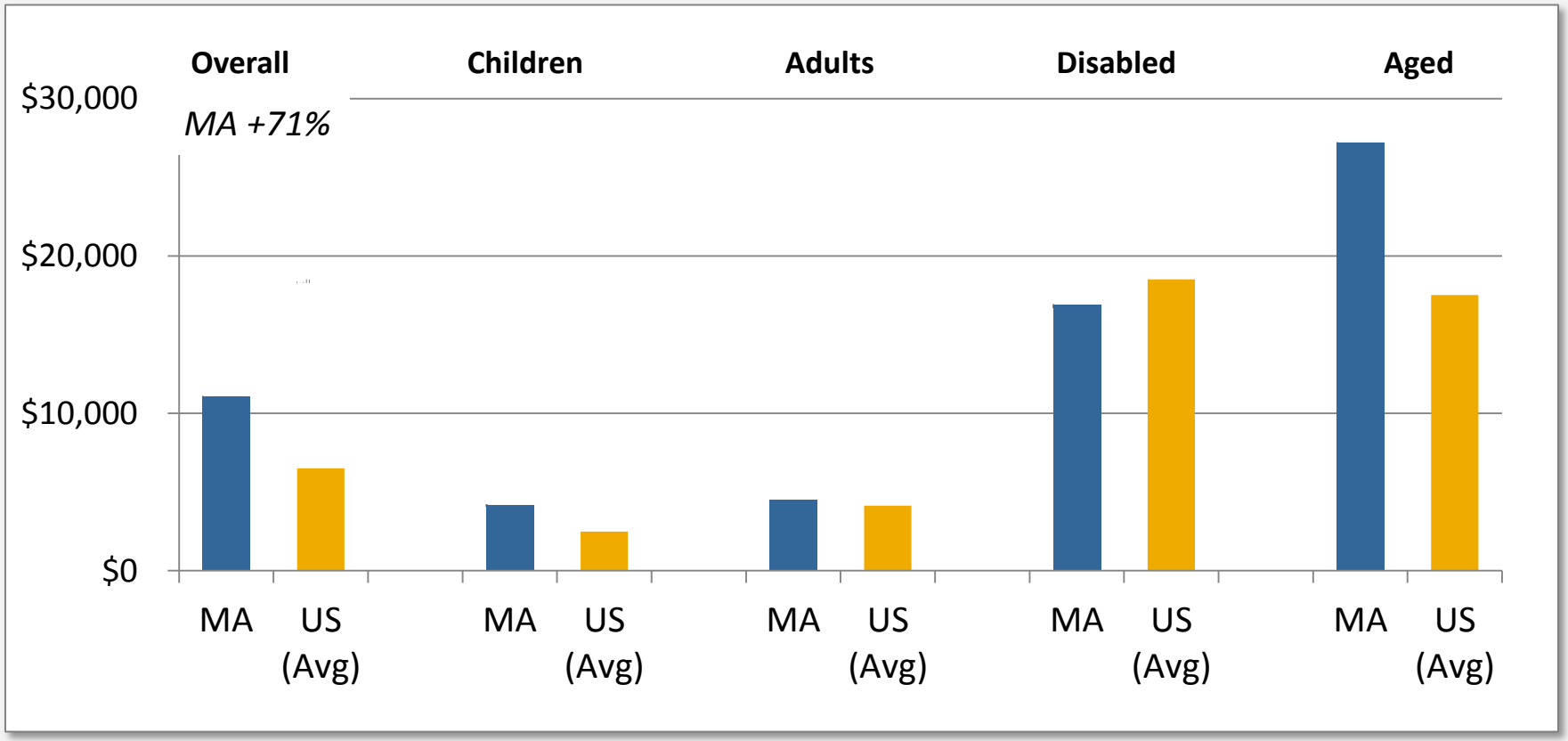
- **Step 1**: Establish a projected spending level for FY 2019 using average per capita FY 2016 spending as a base year indexed by CPI-medical to FY 2019 and multiplied by the number of enrollees in FY 2019.
- **Step 2**: Establish separate per capita spending limits for each enrollee group for FY 2020 and beyond, using actual FY 2019 spending adjusted based on comparison to projected spending level determined in Step 1.
- **Included spending:** Most medical assistance expenditures made on behalf of full benefit enrollees in the group
- **Excluded spending:** DSH, Medicare cost sharing, and new provider payment adjustments in non-expansion states
- **Adjustment for supplemental payments**: UPL supplemental payments are built into the base of per capita expenditure limits

Data Currency is a Challenge for Modeling and Developing Capped Funding Proposals

- No current, audited data are available for all 50 states on per capita spending by eligibility group
- Federal fiscal year (FY) 2011 is most recent year for which cross-state per enrollee spending levels and growth rates by eligibility group are publicly available
- The American Health Care Act requires states to provide enrollment and expenditures data by enrollee group in FY 2019, which will be used to establish a per capita limit for each enrollee group
- Lack of recent and reliable data is a major problem for stakeholders seeking to understand the potential implications of capped Medicaid funding models

Massachusetts Per Enrollee Spending

Massachusetts Medicaid Spending* per Full Benefit** Enrollee Compared to US Averages, FY2011



*Per enrollee numbers based on Kaiser analysis of spending from claims-based MSIS data adjusted to match aggregate CMS-64 totals. MSIS data exclude significant HCBS waiver spending; other unidentified exclusions may exist. It is unclear whether and how Kaiser's adjustments account for such discrepancies in total and by eligibility group, potentially impacting results shown.

**Full benefit enrollees may include individuals who do not rely upon MassHealth for primary, medical coverage. CommonHealth enrollees, for example, may have access to full MassHealth benefits, but may rely upon Medicaid as secondary coverage; their lower relative Medicaid claims experiences may deflate Disabled category PMPYs in Massachusetts, and potentially relative to other states that do not provide similar coverage.

Sources: RWJ Foundation, Manatt analysis, "Data Points to Consider When Assessing Proposals to Cap Federal Medicaid Funding: A Toolkit for States," accessed at: http://statenetwork.org/resource/data-points-to-consider-when-assessing-proposals-to-cap-federal-medicaid-funding-a-toolkit-for-states/

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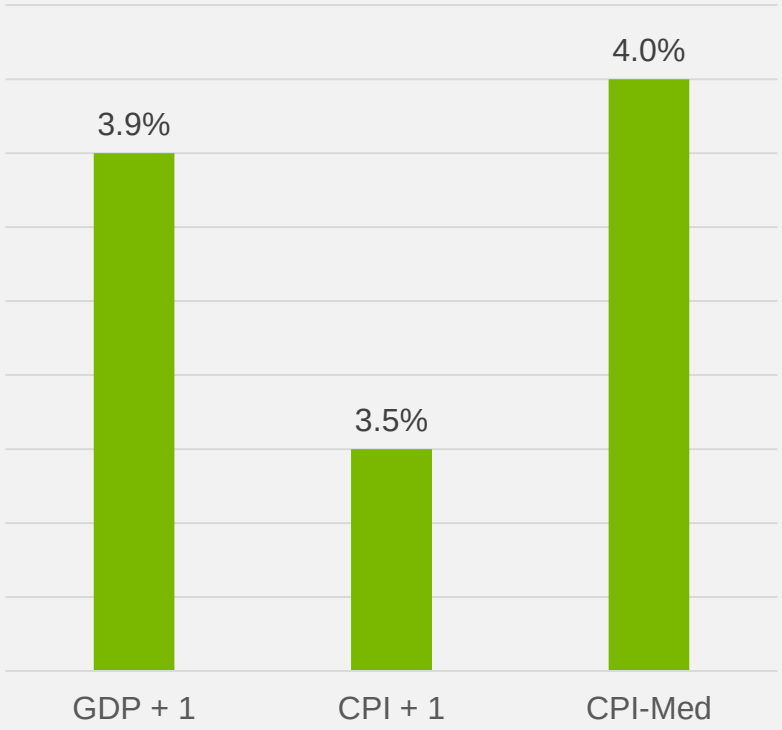
American Health Care Act: Per Capita Cap Waiver Spending

Treatment of waiver spending is unclear

- Waiver spending as part of a delivery system reform pool (commonly known as DSRIP waiver pools), uncompensated care pool, or designated state health program are not included in a state's base spending
- Waiver payments may continue, but the proposed legislation indicates that the new aggregate cap applies to Medicaid waiver spending; this may depend on the type of waiver spending
- Leaves significant open questions as to the impact on states' current and new waiver spending

American Health Care Act: Per Capita Cap Trend Rate

Proposed national growth trends will likely reflect slower growth than Massachusetts Medicaid spending growth



Proposed National Growth Trend Benchmarks:

HAEL Act: Proposed use of the Gross Domestic Product (GDP) plus one percentage point = 3.9%

Patient CARE Act: Proposed use of the Consumer Price Index (CPI) plus one percentage point = 3.5%

American Health Care Act: Proposes use of the CPI Medical Basket = 4.0%

American Health Care Act: Medicaid Expansion

The American Health Care Act proposes to:

- Maintain authority for Medicaid expansion up to 133% of the FPL
- Eliminate enhanced federal Medicaid funding in 2020 except for "grandfathered" adults:
  - Enhanced federal Medicaid match only for "grandfathered" new adults who enroll by December 31, 2019 and do not have a break in eligibility of more than a month thereafter
  - Reduction to enhanced federal Medicaid funding for "leader states" (including Massachusetts) that had expanded coverage to adults prior to the ACA
- Require that states redetermine eligibility for expansion adults every six months
- Impose civil monetary penalty for beneficiaries who knowingly misrepresent their incomes and use Medicaid services; providers would also be implicated

Based on states' experiences with enrollment freezes and more frequent re-determinations, the number of beneficiaries for whom a state can receive enhanced matching funds can be expected to dwindle rapidly. Within a year, up to a half or more of the grandfathered beneficiaries are likely to have left Medicaid.

Source: Manatt analysis of enrollment data in Arizona, Maine and Wisconsin after enrollment freezes were instituted

American Health Care Act: Other Medicaid Provisions

The proposed legislation would also make additional changes to the Medicaid program including:

- Reducing the minimum coverage standards for children age 6 and over to 100% FPL, effective January 1, 2020
- One year ban on Medicaid funds to Planned Parenthood, effective six months after enactment
- Eliminating EHB requirement in Medicaid as of January 1, 2020
- Ending retroactive coverage requirement effective October 1, 2017
- Ending the requirement that otherwise eligible Medicaid applicants who report they are citizens or in a satisfactory immigration status be covered for up to 90 days while they produce citizenship or immigration documents, effective six months after enactment
- Ending two provisions that provide people with temporary coverage pending a full review of their application, effective January 1, 2020
- Allowing states to disenroll high dollar lottery winners, effective January 1, 2020

New State Flexibility?

House capped funding proposals may be coupled with new state flexibility, including the ability to:

- **Make changes in coverage for mandatory and optional populations – beyond the "expansion" population:**
  - Capped enrollment
  - Waiting lists
- **Add new restrictions on eligibility and enrollment:**
  - Work requirements
  - Time limits
  - Open/closed enrollment periods
  - Monthly reporting and other paperwork requirements
- **Modify benefits or require premiums and/or copayments**
- **Impose fewer federal rules on managed care and scope of benefits**
- **Repurpose federal Medicaid funds:**
  - IMDs
  - Housing or other nonmedical needs
  - Other?

Conclusion

Capped funding proposals shift Medicaid financial risk to the states. Massachusetts, an expansion state leveraging substantial DSRIP and supplemental funds, has additional risks to consider.

- Potential loss/reduction of expansion funds
- Potential loss/reduction of non-DSH waiver funds
- With constrained resources and fewer federal rules, more competition for limited funds
- Potential loss of policy flexibility to adjust Medicaid program eligibility and/or benefit design standards with “locked-in” base and rate levels
- Potential disruption of efforts to move ahead with ongoing and proposed reforms targeted to reducing total cost of care (TCOC)

Discussion

Thank you!

Cindy Mann
Partner
CMann@manatt.com

Patti Boozang
Senior Managing Director
PBoozang@manatt.com