Medicaid Developments in a Dynamic Policy Environment

National Association of Medicaid Directors
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NAMD
National Association of Medicaid Directors

Overview

- Background and context
- State considerations in:
  - Affordable Care Act repeal and replace
  - Medicaid structural reforms
- Discussion

National Association of Medicaid Directors (NAMD): Who are we?

- Represent 56 state and territorial Medicaid Directors
- Non-profit, bi-partisan association
- Core functions include:
  - Serving as consensus voice of Directors in Washington;
  - Facilitating peer-to-peer learning and sharing of best practices

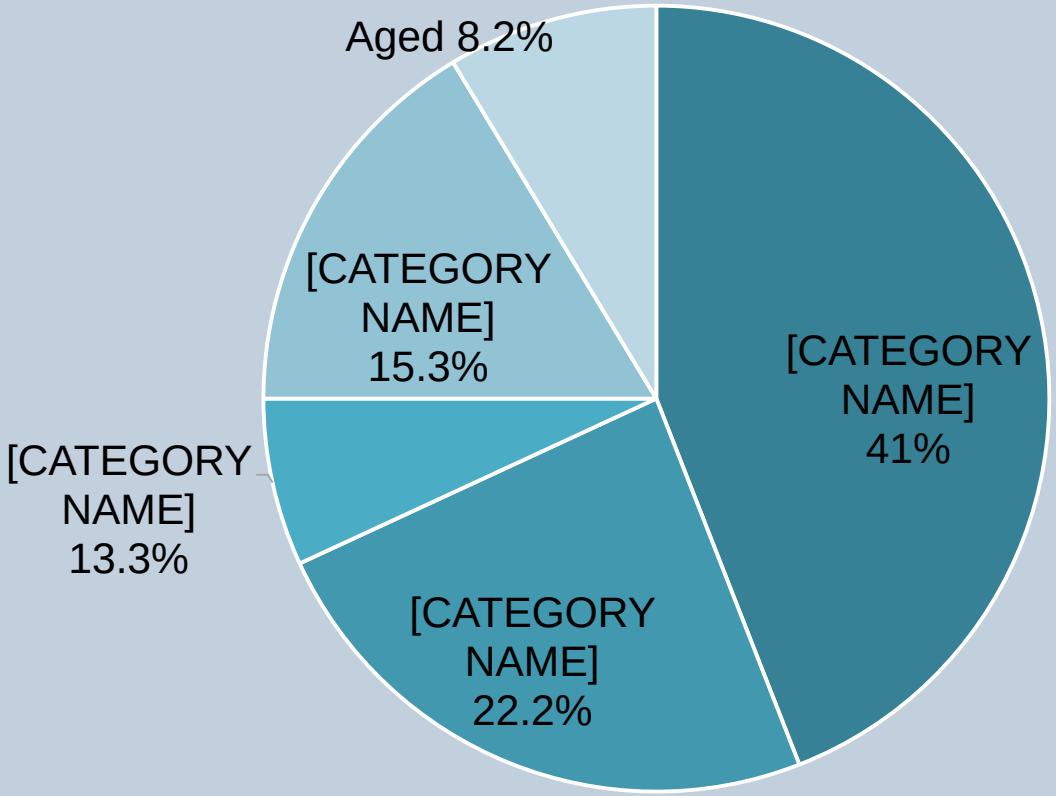
What is Medicaid?

- Nation's main public health insurance program for people with low income
  - Covers roughly **74.4 million people**, including 35.8 million children[1]
- Single largest source of public health coverage in the U.S.
  - Accounts for 16% of national health spending[2]
- Core source of financing for:
  - Safety-net hospitals
  - Health centers that serve low-income communities
  - Nursing homes
  - Community-based long-term care

1. CMS, *Medicaid & CHIP: November 2016 Monthly Applications, Eligibility Determinations and Enrollment Report* (January 18, 2017): link
2. MACPAC, "Historic and Projected National Health Expenditures by Payer for Selected Years, 1970-2024" (December 2015): link

Who is Medicaid?

Estimated Enrollment by Population Category, Fiscal Year 2015[1]



1. Centers for Medicare & Medicaid Services, Office of the Actuary, *2016 Actuarial Report on the Financial Outlook for Medicaid* (2016).

How much does it cost?

- Total Medicaid spending in FY 2015 **$509 billion**[1]

- Almost two-thirds of all Medicaid spending for services is attributable to the **elderly and persons with disabilities**, who make up just one-quarter of all Medicaid enrollees.[2]

    - **Dual eligible beneficiaries** alone account for almost 40% of all spending, driven largely by spending for long-term care.

- The 5% of Medicaid beneficiaries with the highest costs drive more than **half of all Medicaid spending**.[3]

1. Kaiser Family Foundation, *Medicaid Enrollment & Spending Growth: FY 2016 & 2017* (October 2016): link
2. Kaiser Family Foundation, "Medicaid Moving Forward" (March 9, 2015): link
3. Ibid.

The Change of Administration

Key Administration Leadership

Tom Price

Secretary of HHS

- Confirmed by vote of 52-47
- Previous support for block granting Medicaid
- Indicated willingness to work with Congress on IMD exclusion
- Support for innovation, but concerns about some CMMI models

Seema Verma

Nominee for CMS Administrator

- Confirmation pending
- Prior work with states/CMS on Medicaid waivers
- Noted concern with administrative burden on states in Medicaid
- Signaled interest in revisiting Medicaid managed care rule
- Broadly supports efforts to overhaul Medicaid

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CMCS Director, TBD

What's being considered?

Affordable Care Act repeal and replace

- Adult Medicaid coverage expansion
- Coverage/affordability pathways in individual market
- Other ACA provisions that would impact Medicaid

Structural changes to Medicaid

- Financing (block grants, per capita caps)
- Benefits/covered populations/other program parameters

The Latest: House GOP Framework

Medicaid

- Ends Medicaid expansion over period of time
  - States receive enhanced match for period
    - Match to normal FMAP
- Converts Medicaid to per cap but with state option for a block grant

Other Elements

- Age adjusted tax credits for coverage on individual market
- Transition period for those getting premium tax credits

PROSPECTS FOR PASSAGE "AS-IS" ARE LOW

Medicaid Director role in a dynamic landscape….

- Medicaid Directors are the “expert mechanics”
- NAMD called on policymakers to create **workgroup of Directors** to provide technical expertise on proposals.

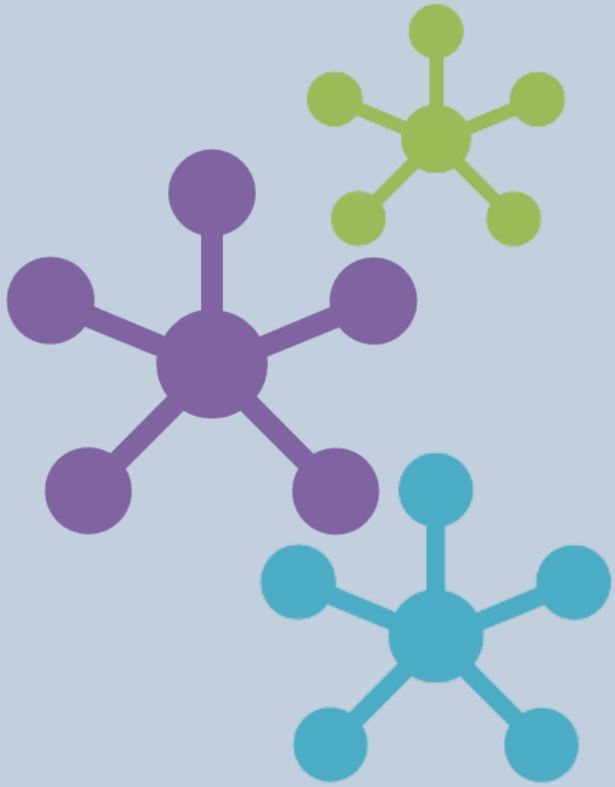
The ACA and Medicaid Reform

- Several policies from the ACA have become **inherently woven** into the fabric of the current health care system.
- Any substantive changes to Medicaid's financing structure must be done in close consideration of the **complex and interconnected web** of statutory and regulatory requirements.
- Change must come from fundamental reform of the underlying health care system, especially with respect to **how care is delivered and how financial incentives are aligned**.

State Considerations in Affordable Care Act Repeal & Replace Initiatives

Key issues to consider in ACA repeal and replace:

1. Modified Adjusted Gross Income (MAGI) Eligibility Standard
2. Prescription Drug Rebates
3. Health Home Programs
4. Changes to Home- and Community-Based Services
5. Medicaid Emergency Psychiatric Demonstration (MEPD)
6. Preventive Services
7. Children's Coverage
8. Adult Medicaid Coverage Expansion
9. State-Led Innovation Supported through SIM out of CMMI
10. Medicaid-Medicare Coordination Office (MMCO)
11. Program Integrity Provisions



Modified Adjusted Gross Income (MAGI)

- **What did the ACA do?** Required states to implement a new standard for determining income-based eligibility for the Medicaid program.

- **What did this requirement mean for states?** States had to dedicate substantial resources to implement this standard by making significant IT systems and policy changes, including standing up new eligibility and enrollment systems.

- **Policymakers should consider** how revising the income eligibility standard could come at a significant cost to states and the federal government, and possibly force states to re-procure eligibility systems once again.

Prescription Drug Rebates

- **What did the ACA do?** Required pharmaceutical manufacturers to provide rebates for drugs dispensed to Medicaid beneficiaries receiving care from a managed care organization (MCO).

- **What did this requirement mean for states?** Some states have carved the pharmacy benefit into their comprehensive managed care contracts, while others, which had already carved in pharmacy services, reflected the costs savings in capitation rates and state budgets.

- **Policymakers should consider** how a policy change could open the door for manufacturers to recover rebates on previously paid managed care claims. Such a change would also require complex and costly IT systems changes.

Health Home Programs

- **What did the ACA do?** Section 2703 of the ACA created health home programs which provide coordinated care and linkage to needed social supports for individuals with chronic conditions, providing federal up-front federal investment.

- **What did Section 2703 mean for states?** Twenty-one states have implemented health home programs under Section 2703. States are standing up these programs with enhanced federal support in the first eight fiscal quarters of the program for health home services.

- **Policymakers should consider** the extent to which health home programs rely on ongoing federal support.

Home- and Community-Based Services (HCBS)

- **What did the ACA do?** Expanded the authority for states to provide HCBS through state plan authority under Section 1915(i) (rather than though a HCBS waiver). It also created the Community First Choice (CFC) option for state Medicaid programs under section 1915(k) of the Social Security Act.

- **What did these changes mean for states?** Five states currently have approved 1915(k) SPAs.

- **Policymakers should consider** the implications of potential changes to HCBS authorities under section 1915(i) or 1915(k); policymakers should work with states to better understand these changes.

Medicaid Emergency Psychiatric Demonstration (MEPD)

- **What did the ACA do?** Authorized the MEPD under Section 2707, permitting Medicaid reimbursement to participating private psychiatric facilities for treatment of Medicaid beneficiaries, ages 21 to 64, with psychiatric emergency medical conditions.

- **What did this mean for states?** Eleven states participated in this demonstration to test the cost effectiveness of delivering emergency psychiatric services in institutions for mental disease (IMDs); yet, current statutory parameters have prevented states from continuing this demonstration.

- **Policymakers should consider** continuing to test the cost-effectiveness of delivering specialized inpatient psychiatric services in IMDs given their demonstrated value.

Preventive Services

- **What did the ACA do?** Amended section 1905(a) of the Social Security Act to incorporate preventive services into the Medicaid benefit.

- **What did this mean for states?** This change has provided states with additional flexibility in their benefit design around preventive services, while also driving changes around autism services in Medicaid, which has created complexity in the program.

- **Policymakers should consider** the importance of preventive services as well as the impact of the section 1905(a) amendment.

Children's Coverage

- **What did the ACA do?** Increased children's eligibility under Medicaid to a uniform percentage of the federal poverty level, or FPL (previously children were covered at different eligibility levels based on age).

- **What did this mean for states?** For some states, this policy change displaced CHIP funding, and along with the enhanced FMAP for CHIP, led to an expansion of coverage to additional children under CHIP. Children that moved from CHIP to Medicaid as a result of this change have received a higher CHIP federal matching percentage (FMAP).

- **Policymakers should consider** implications for children's coverage.

Adult Medicaid Coverage Expansion and Federal Matching Percentage

- **What did the ACA do?** Gave states the option to expand Medicaid coverage to childless adults.

- **What did this mean for states?** Thirty-two states have adopted the Medicaid expansion to childless adults under the ACA. States operationalized the expansion based on a structure where the federal government finances 100% of costs for this population for the first two years, phasing down to 90% by 2020.

- **Policymakers should consider** implications for adult coverage as well as state budgets, which are often implemented on a biennium and reflect the current ACA structure. In FY 2015, states received an estimated $58 billion in federal funding for this coverage expansion.

State-Led Innovation Supported through CMMI

- **What did the ACA do?** Created the Center for Medicare and Medicaid Innovation (CMMI).

- **What did this mean for states?** The State Innovation Model (SIM) initiative out of CMMI has fueled 35 states' efforts to build the infrastructure needed to transform the health care system.

- **Policymakers should consider** how to ensure continuity and ongoing investment in state-led transformation of the health care delivery system.

Medicaid-Medicare Coordination Office (MMCO)

- **Background:** The MMCO has begun to address the bi-furcation in coverage and care for individuals served by Medicare and Medicaid and facilitate state efforts to coordinate with Medicare and improve care for dually eligible individuals.
  - 13 states are participating in MMCO's Financial Alignment Demonstrations, which are testing new coordinated financing and administrative alignment for dually eligible beneficiaries.
- **Policymakers should consider** the structure for Medicaid/Medicare coordination for duals going forward, and the future of successful innovations to align the financing and administration of services.

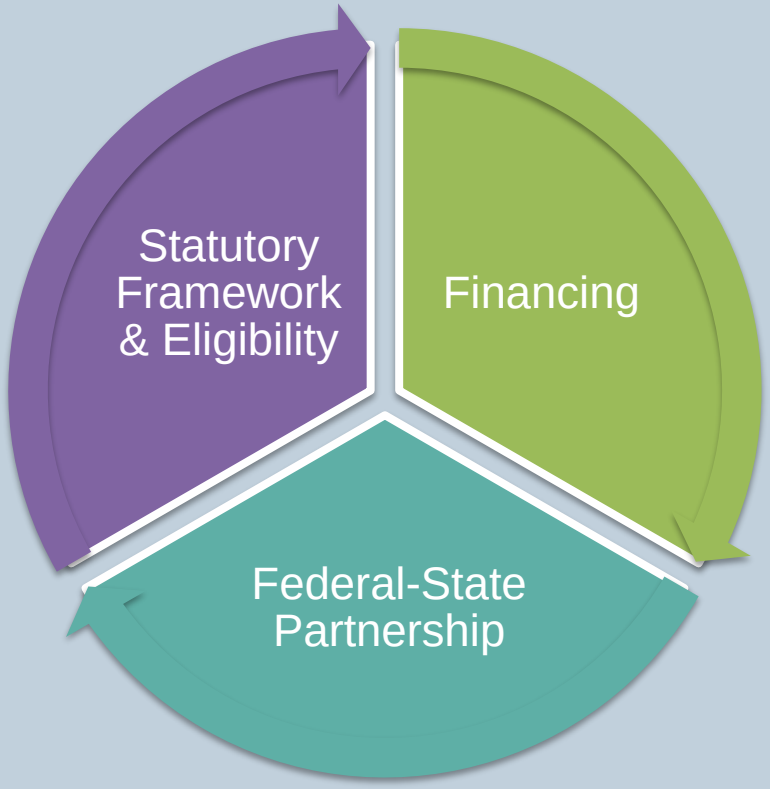
Program Integrity Measures

- **Background:** States have made changes in their program integrity approaches, processes and systems, implementing new provider screening requirements for providers that have demonstrated the highest risk rates of fraud, waste, and abuse.

- **Policymakers should consider** the value created by various program integrity tools, as well as how states can work within a menu of program integrity mechanisms to prevent fraud, waste, and abuse.

Key Considerations in Medicaid Structural Reform Proposals

NAMD also requested **lawmakers consider three main issues** in the development of proposals changing Medicaid's structure:



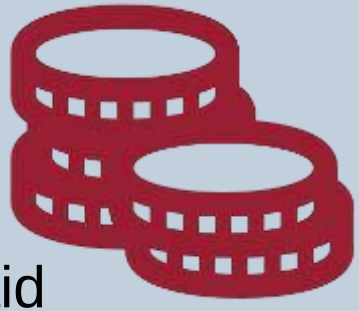
Statutory Framework and Eligibility: Questions

- What are the requirements for states in the framework for populations covered, services covered, and payment levels?
- How will the proposal impact eligibility and services for current enrollees?
- What are the health needs of those served by Medicaid and how will those needs be met under the proposal?

Statutory Framework and Eligibility: Other Issues

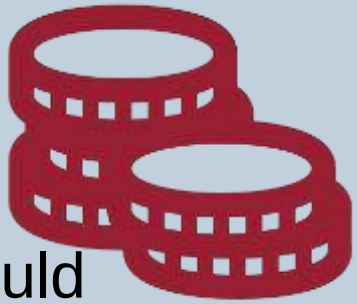
- Long-term care
  - Medicaid is currently the default long-term care program in the United States, and as demographics change, more Americans are expected to need long-term services and supports.
- Dually Eligibles
  - Approximately 40% of Medicaid spending is for low-income *Medicare* beneficiaries.
- Pregnant women and children
- Safety-net providers (i.e., FQHCs)

Financing: Questions



- What is in the federal funding formula for Medicaid program growth and how is that formula calculated?
- What is the state match requirement in the proposal for Medicaid?
- What is in the base used to set the federal match amount?
- What is the impact of the proposal on state approaches to finance the state share of the Medicaid program (i.e., provider taxes, intergovernmental transfers, upper payment limits)?

Financing: Questions (cont'd)



- What is in the federal funding formula that would be used during recessions or unforeseen cost surges?
  - For example, new developments in specialty pharmacy and future developments in biologics producing drugs with list prices approaching $500,000 per year.
- How does the proposal impact the financing structure for Medicaid IT systems?
- How would the financing approach impact the structure of CHIP, including Medicaid expansion CHIP programs, separate CHIP programs, or combination CHIP programs?

State and Federal Partnership: Questions

- What is the role of states in providing input on new federal rules related to Medicaid?
- What are the areas where additional state flexibility might be afforded?
- How does the proposal change the existing Medicaid regulatory structure (i.e., state plans, Section 1115 and other Medicaid waivers)?
- How does it impact existing federal Medicaid regulations and their implementation?

Recap

- Potential changes on the horizon for Medicaid
  - ACA repeal, replace, or repair?
  - Medicaid changes
- Focus on potential transfer of risk onto states
- Medicaid Directors have unparalleled technical expertise to offer in these discussions

Questions?

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