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Web Briefing for Journalists: Medicaid's Future? Understanding Block Grants and Per Capita Caps

Presented by the Kaiser Family Foundation

February 23, 2017

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The basic foundations of Medicaid are related to the entitlement and the federal-state partnership.

Entitlement

Eligible Individuals are entitled to a defined set of benefits

States are entitled to federal matching funds

Federal

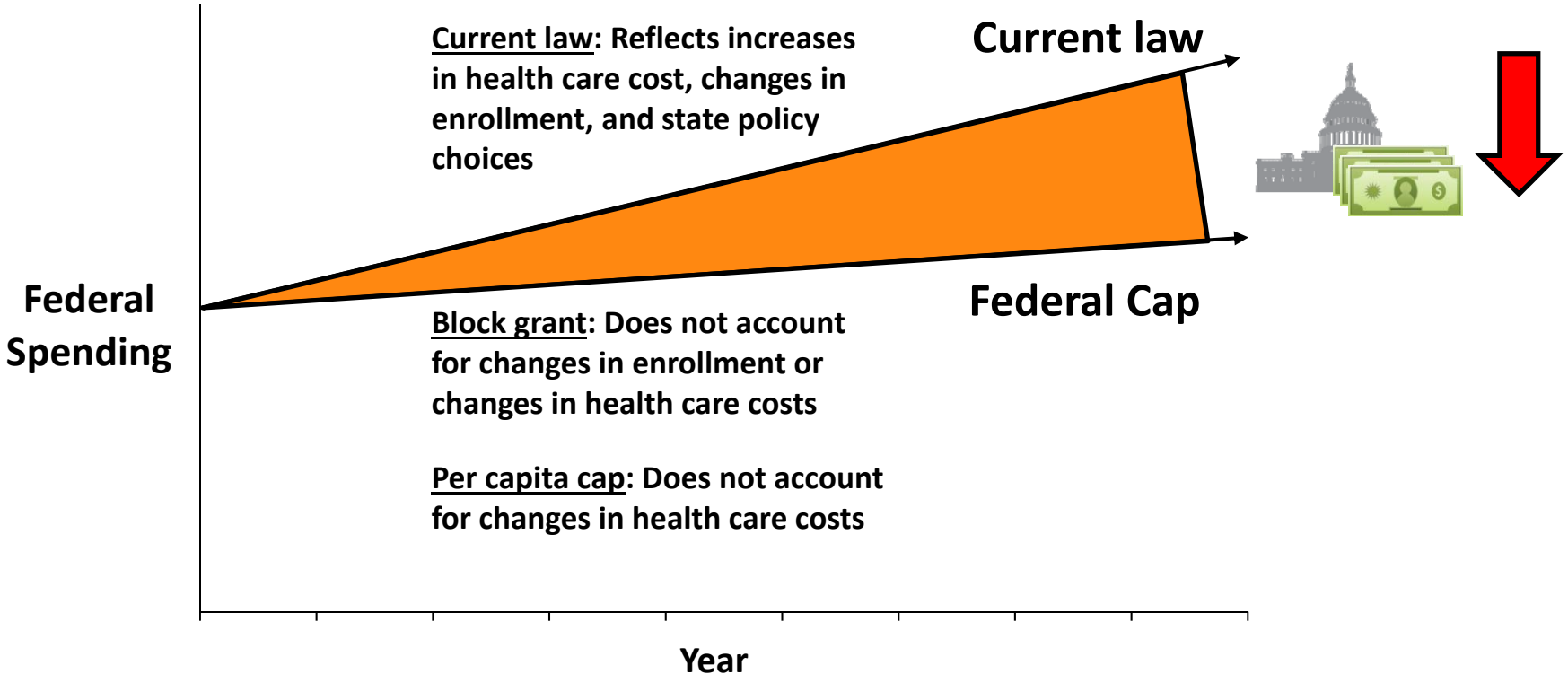
Sets core requirements on eligibility and benefits

Partnership

State

Flexibility to administer the program within federal guidelines

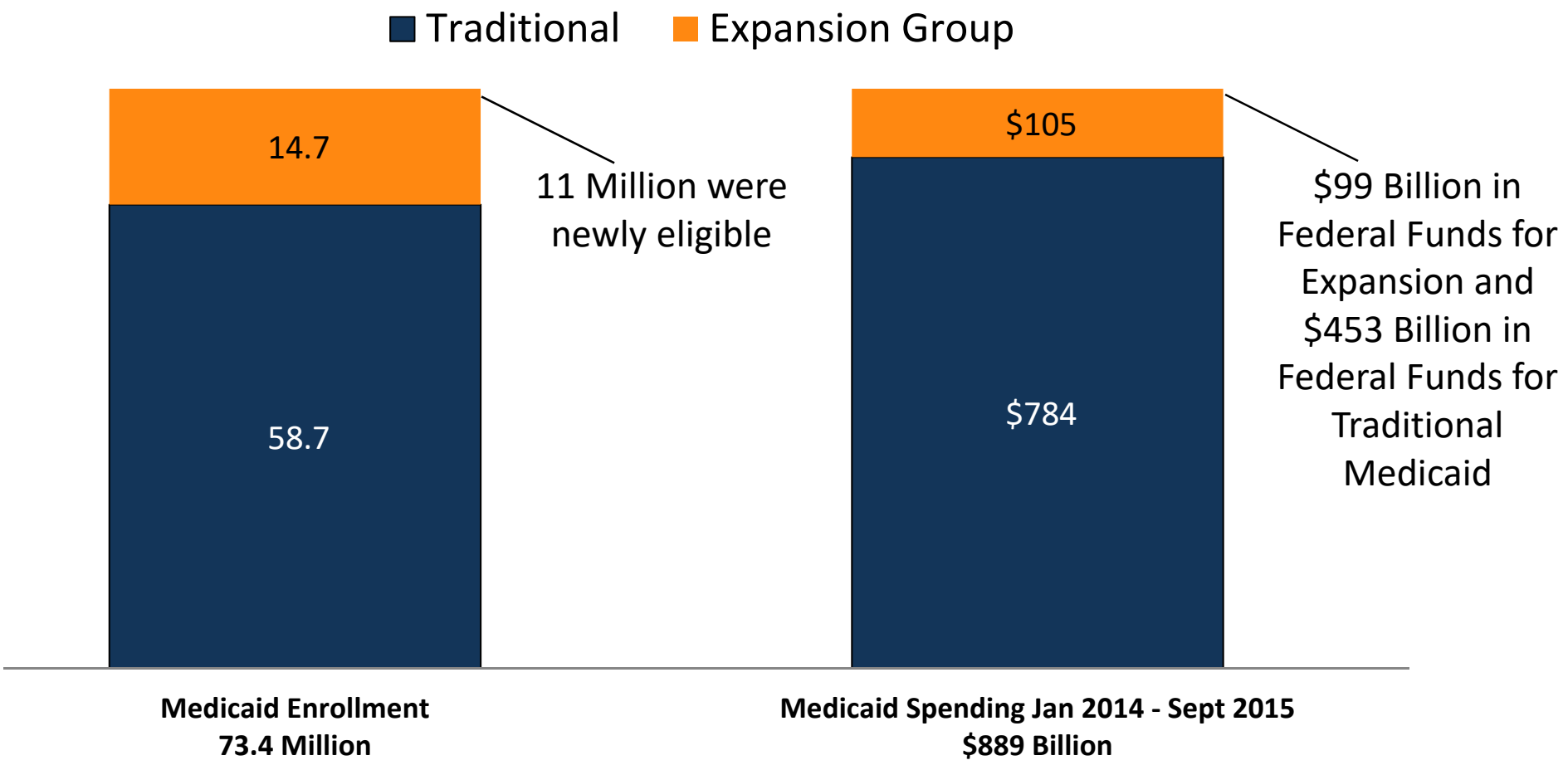
Proposals to convert Medicaid to a block grant or per capita cap could reduce federal spending by limiting growth to a pre-set amount and increase state flexibility in determining eligibility and benefits.



What details do you need to know to understand the proposals?

- What happens with the ACA Medicaid expansion?
- What are the federal savings targets?
- What is the base year for a block grant or per capita cap?
- What are state matching requirements?
- What new flexibility would states be given to administer their programs?

What happens with the ACA Medicaid expansion?



NOTES: Enrollment data for January through March 2016 for 30 states that implemented the Medicaid expansion as of January 2016 (Louisiana expanded Medicaid in on 7/1/16 and has no data reported. There is no data reported for North Dakota. Enrollment data reflect the highest enrollment for each state during the quarter. Spending data for January 2014 through September 2015.
SOURCE: KCMU analysis of data from Medicaid Budget and Expenditure System (MBES).

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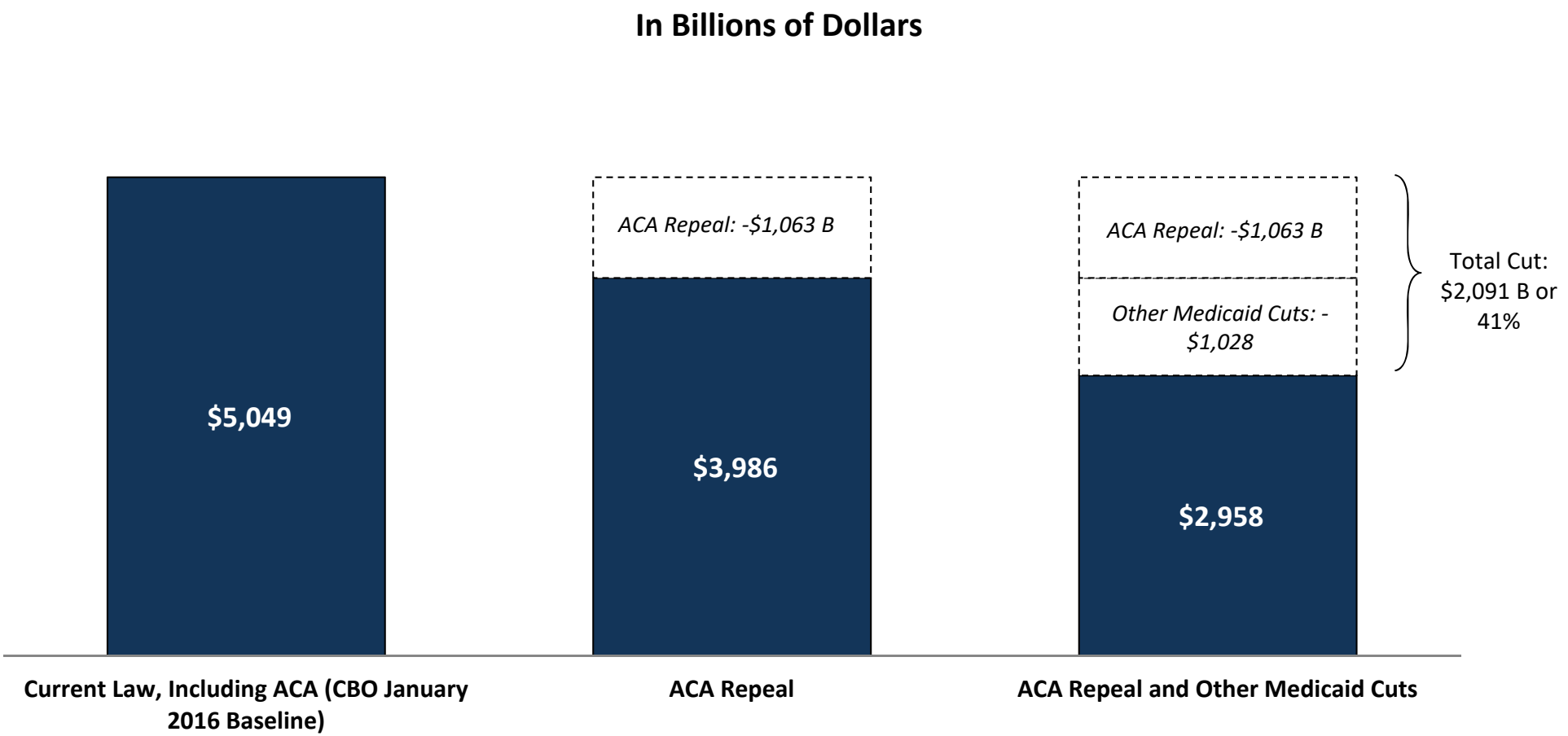
What are the federal savings targets?



Source: Kaiser Program on Medicaid and the Uninsured Estimates of the House Budget Committee Budget Resolution from March 2016 using the CBO January 2016 Baseline and Estimates from the Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026 for the Medicaid ACA Estimates

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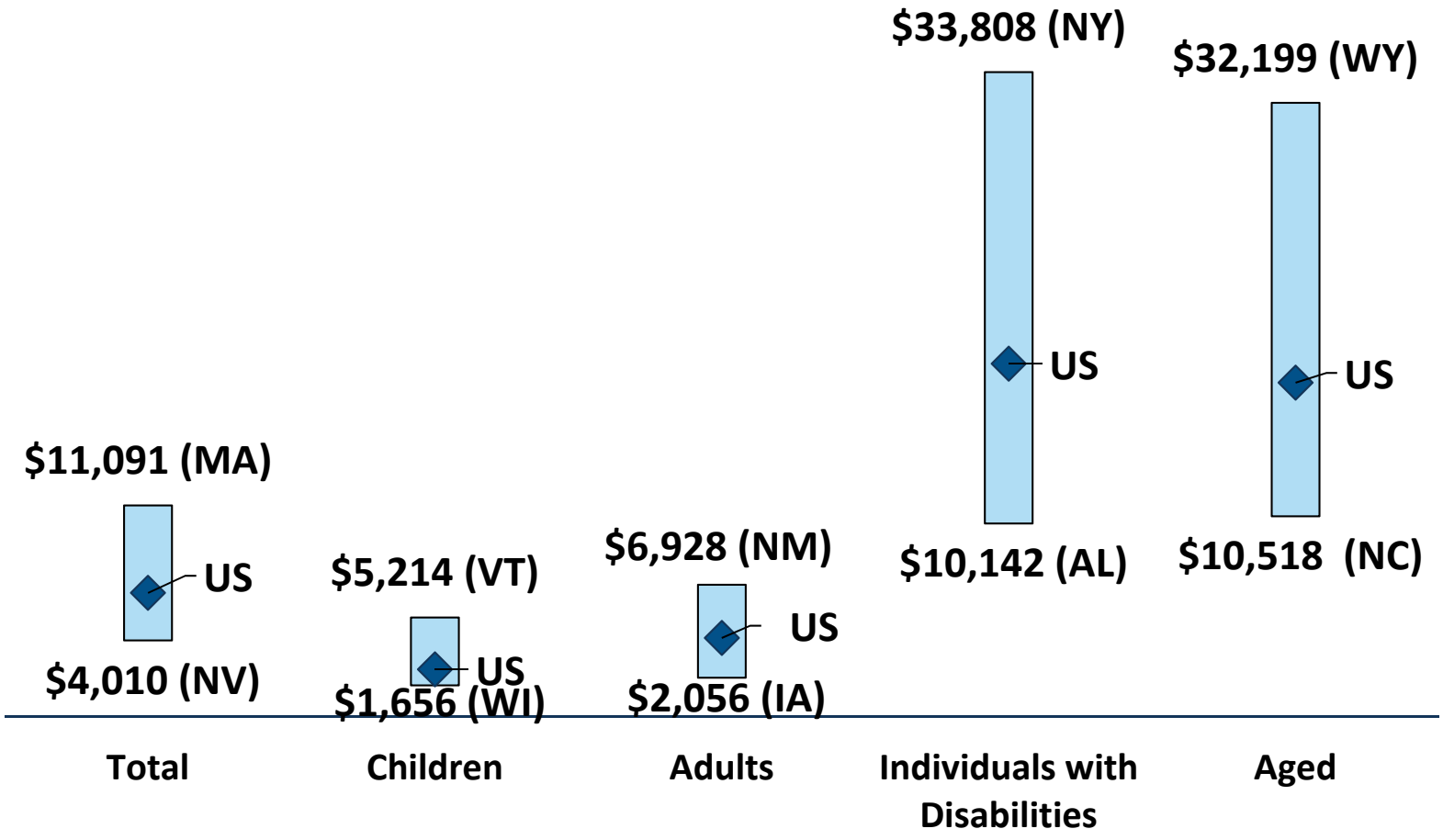
What is the base year?

Per enrollee spending by enrollment group 2011



NOTE: Spending per capita was calculated only for Medicaid enrollees with unrestricted benefits or those enrolled in an alternative package of benchmark equivalent coverage. Outliers are included in the figure, but not marked as outliers.
SOURCE: KCMU and Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports.

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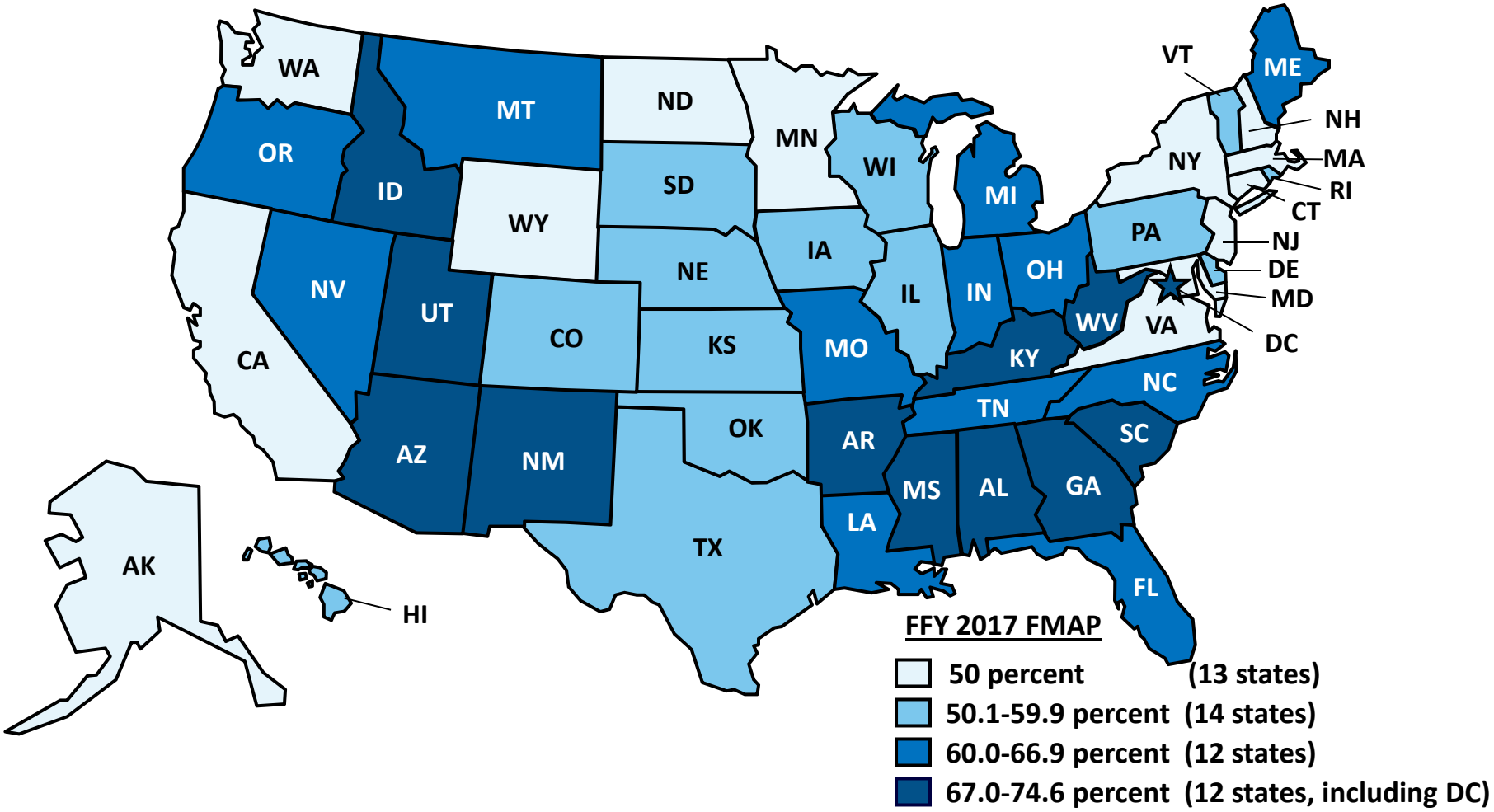
What are state matching requirements?



NOTE: FMAP percentages are rounded to the nearest tenth of a percentage point. These rates are in effect Oct. 1, 2016-Sept. 30, 2017. These FMAPs reflect the state's regular FMAP; they do not reflect the FMAP for newly eligibles in states that adopted the ACA Medicaid expansion.
SOURCE: Federal Register, November 25, 2015 (Vol. 80, No. 227), pp 73779-73782, available at https://www.gpo.gov/fdsys/pkg/FR-2015-11-25/pdf/2015-30050.pdf.

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What new flexibility would be given to states?

Federal government sets minimum standards, but states have flexibility in many areas:

- **Eligibility:** All states have expanded eligibility for children; 32 states implemented the ACA expansion to adults, and many states have expanded eligibility for pregnant women, seniors, and people with disabilities. However, eligibility varies across groups and states.
- **Benefits:** All states offer optional benefits, such as prescription drugs, dental, therapies, rehabilitative services, and long-term care services in the community, but how many and which optional benefits are offered vary across states as do the limits on covered benefits.
- **Premiums and cost sharing:** Most states charge cost sharing for certain Medicaid enrollees within established limits. A limited number of states charge premiums (mostly through Section 1115 waivers).
- **Delivery system and provider payment:** States choose which type of delivery system to use and how to pay providers; many are testing payment models to improve care coordination and outcomes.
- **Waivers:** Beyond flexibility in the law, a number of states are using waivers to address various priorities and emerging issues.

Summary of recent GOP proposal for Medicaid

- **Repeal Current Expansion** - states could maintain expansion, but states would be reimbursed at the traditional match rate
- **Per Capita Cap –** A federal Medicaid allotment will be available for each state to draw down based on its traditional FMAP
  - Federal allotment = the product of the state's per capita allotment for major beneficiary categories —aged, blind and disabled, children, and adults—multiplied by the number of enrollees in each group
  - Per capita allotments for each group will be determined by each state's average Medicaid spending in a base year, grown by an inflationary index
  - Some federal payments, including DSH and administration excluded from the total allotment
- **Block Grant -** States would have the choice to receive federal Medicaid funds in the form of a block grant or global waiver
  - Base year would be set and states would transition individuals currently enrolled in the Medicaid expansion into other coverage
  - States have flexibility but would be required to provide required services to the most vulnerable elderly and disabled individuals who are mandatory populations under current law
- **Repeal ACA Medicaid DSH Cut**

The impact of a block grant or per capita cap will depend on funding levels, but reducing federal Medicaid funds could:

- Shift costs and risks to states, beneficiaries, and providers if states restrict eligibility, benefits, and provider payment

- Lock in historic spending patterns
  - If expansion funding is cut, the impact could be even greater for the 32 states that expanded Medicaid

- Limit states' ability to respond to rising health care costs, increases in enrollment due to a recession, or a public health emergency such as the opioid epidemic, HIV, Zika, etc.

Medicaid plays a central role in our health care system.

Health Insurance Coverage For 1 in 5 Americans

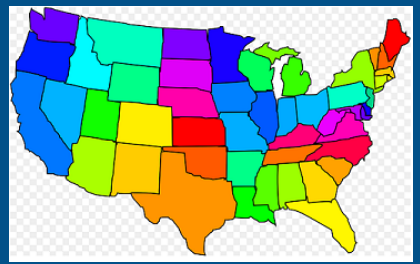
Assistance to 10 million Medicare Beneficiaries

> 50% Long-Term Care Financing

MEDICAID

Support for Health Care System and Safety-Net

State Capacity to Address Health Challenges



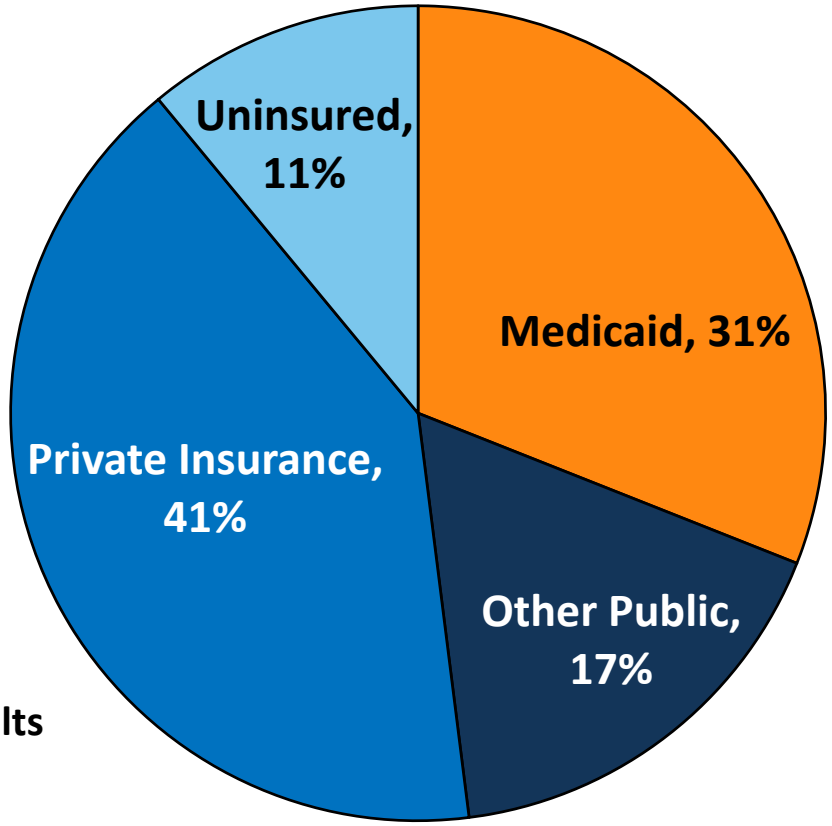
Medicaid plays a key role for seniors and people with disabilities.

- For low-income Medicare beneficiaries, Medicaid pays premiums and cost-sharing and provides additional benefits, most notably long-term care.

- Medicaid covers long-term care services in nursing homes and the community which are typically not covered by private insurance or Medicare and too costly to afford out-of-pocket.

- Medicaid covers services that enable people with disabilities to work and live independently in the community.

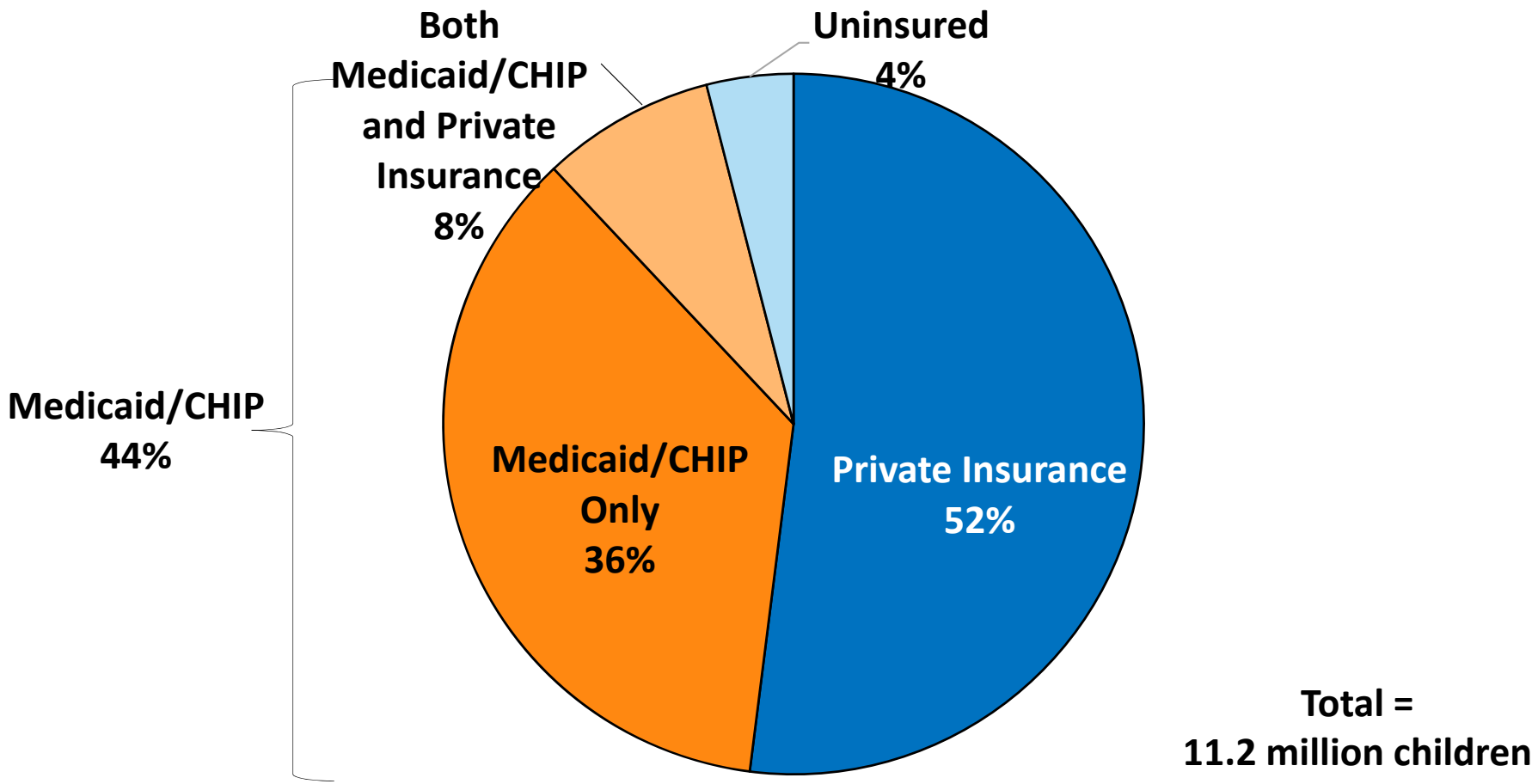
Medicaid covers more than three in 10 nonelderly adults with disabilities, 2015.



Total = 22.1 million nonelderly adults with disabilities

NOTES: Includes adults ages 18-64. Excludes those in long-term care facilities. Disability includes limitation in vision, hearing, mobility, cognitive functioning, self-care, and/or independent living. Other public includes those with Medicare (excludes Part A only), military or Veterans Administration coverage (excludes Tricare), and other government or state-sponsored health plans. Medicaid includes those dually enrolled in Medicare and Medicaid. SOURCE: KFF analysis of 2015 National Health Interview Survey data.

Medicaid covers more than four in 10 children with special health care needs, 2009-2010.



NOTES: Public insurance includes Medicaid, CHIP, Medicare, and Medigap. CDC, Design and Operation of the National Survey of Children with Special Health Care Needs, 2009-2010, https://www.cdc.gov/nchs/data/series/sr_01/sr01_057.pdf. Omits responses reported as "refused," "don't know" or missing (<1%). Includes children ages 0-17.
SOURCE: National Survey of Children with Special Health Care Needs (2009-10), http://childhealthdata.org/learn/NS-CSHCN.

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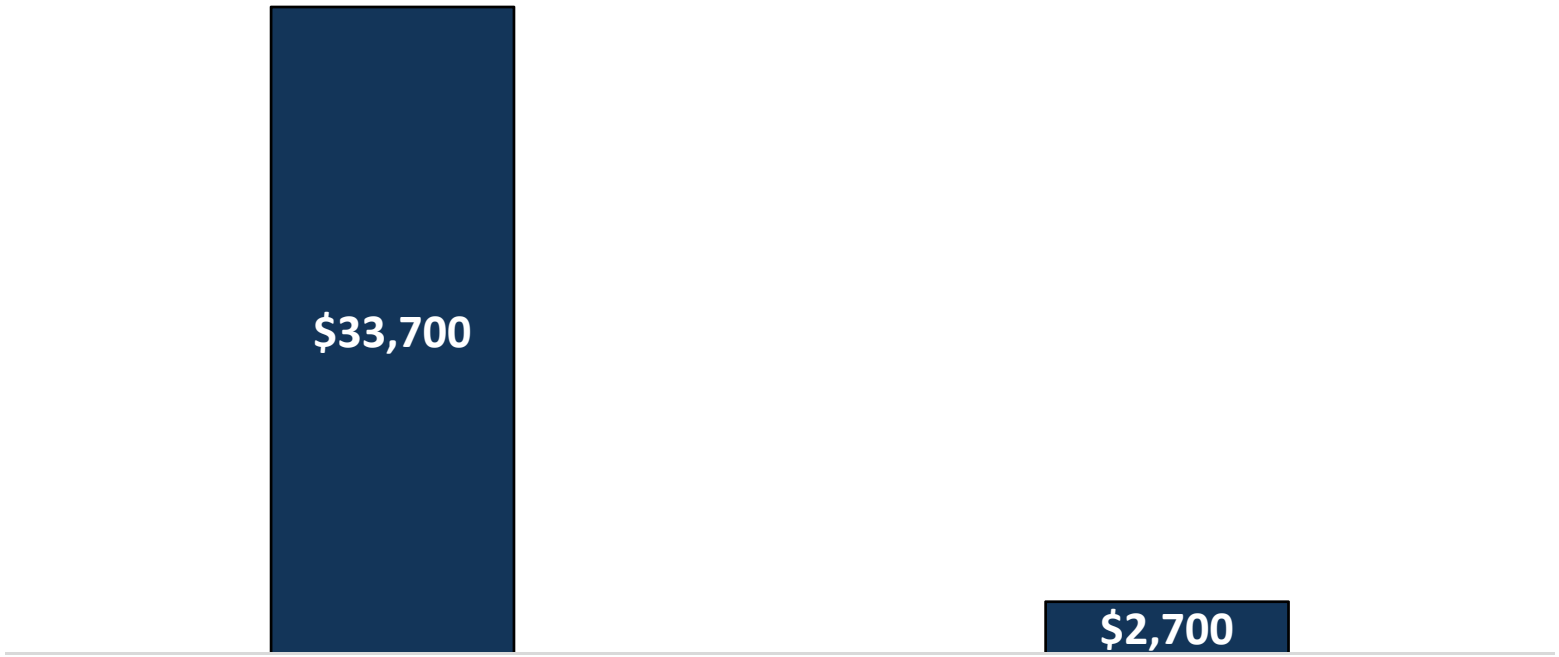
Medicaid spending per enrollee is over 12 times higher for children who use long-term care services compared to those who do not, FY 2011.



NOTES: Includes children under age 21 eligible through poverty-related pathways and children under age 18 eligible through disability-related pathways. Includes fee-for-service spending for institutional services (nursing facilities, ICF/IDD, ICF/IMD) and HCBS (home health, personal care, and home and community-based waiver services). FY 2010 data is used for 10 states that are missing 2011 data (FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT). SOURCE: Kaiser Family Foundation and Urban Institute estimates based on FY 2011 and 2010 MSIS and CMS-64 reports.

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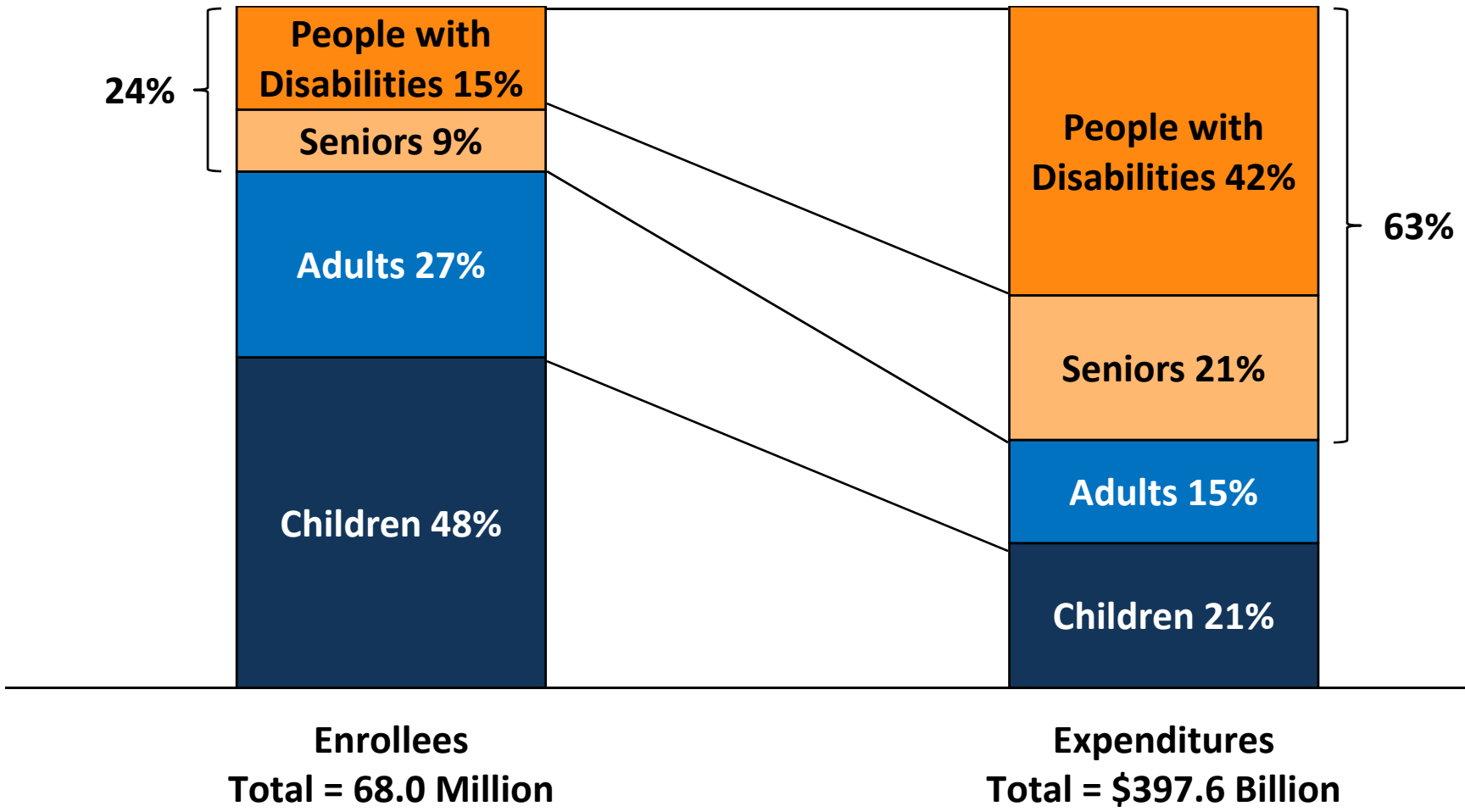
Seniors and people with disabilities account for 24% of Medicaid enrollment but 63% of spending, FY 2011.



NOTE: People with disabilities include children and nonelderly adults. SOURCE: KFF/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT, but adjusted to 2011 CMS-64.

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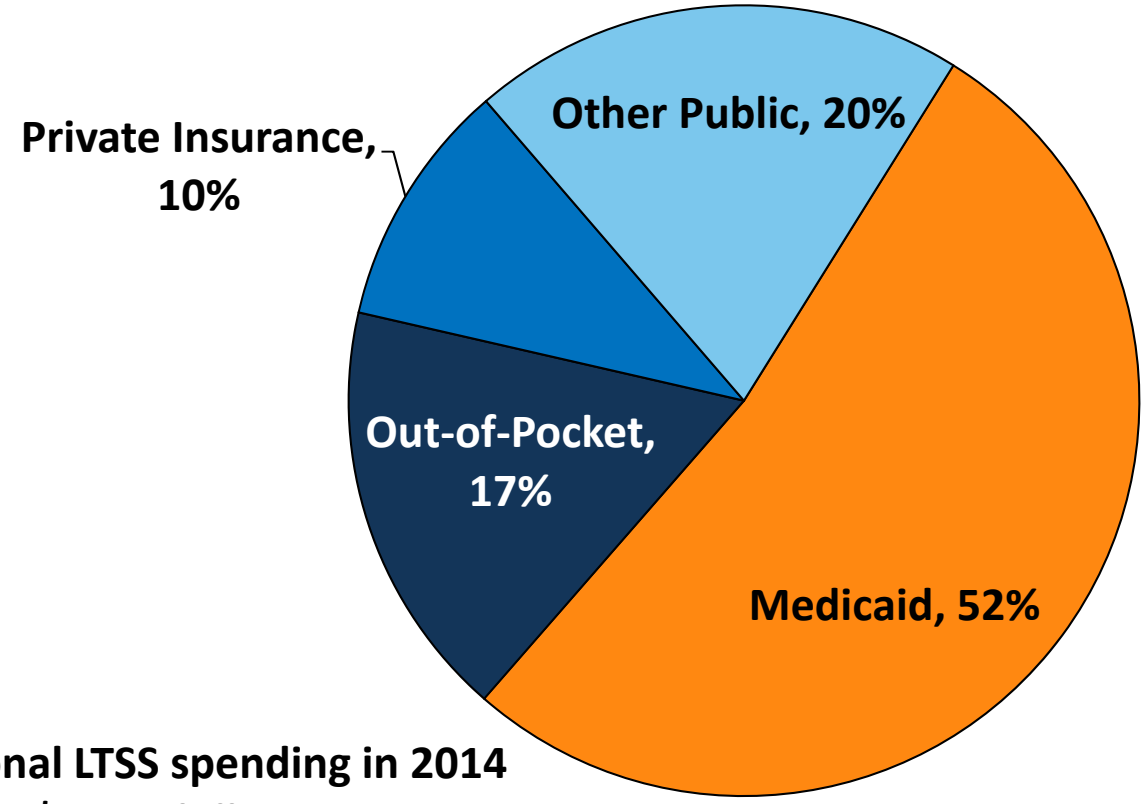
Medicaid is the primary payer for long-term services and supports, 2014.



Total national LTSS spending in 2014 = $313.6 billion

NOTE: Total LTSS expenditures include spending on residential care facilities, nursing homes, home health services, and home and community-based waiver services. Expenditures also include spending on ambulance providers and some post-acute care. This chart does not include Medicare spending on post-acute care ($75.6 billion in 2014). All home and community-based waiver services are attributed to Medicaid.
SOURCE: KFF estimates based on CMS National Health Expenditure Accounts data for 2014.

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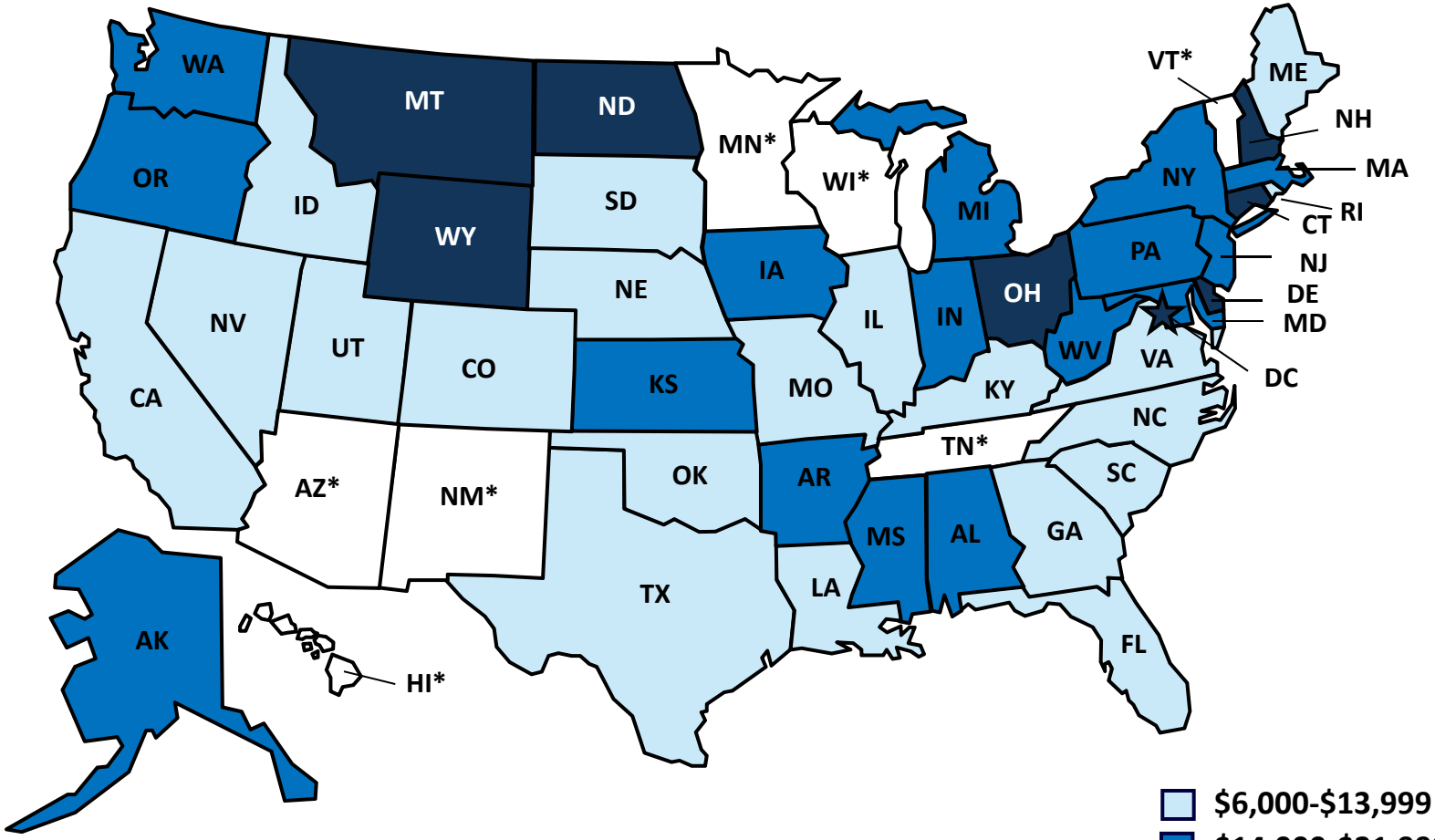
Medicaid per enrollee spending on long-term care for seniors varies by state, FY 2011.



National Average = $12,836*

- $6,000-$13,999 (20 states)
- $14,000-$21,999 (16 states)
- $22,000-$29,999 (7 states & DC)

NOTE: Includes spending for full benefit seniors. *Excludes spending for AZ, HI, MN, TN, NM, VT, and WI due to data reliability issues.
SOURCE: KFF and Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports. Because 2011 data were unavailable, 2010 data was used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT.

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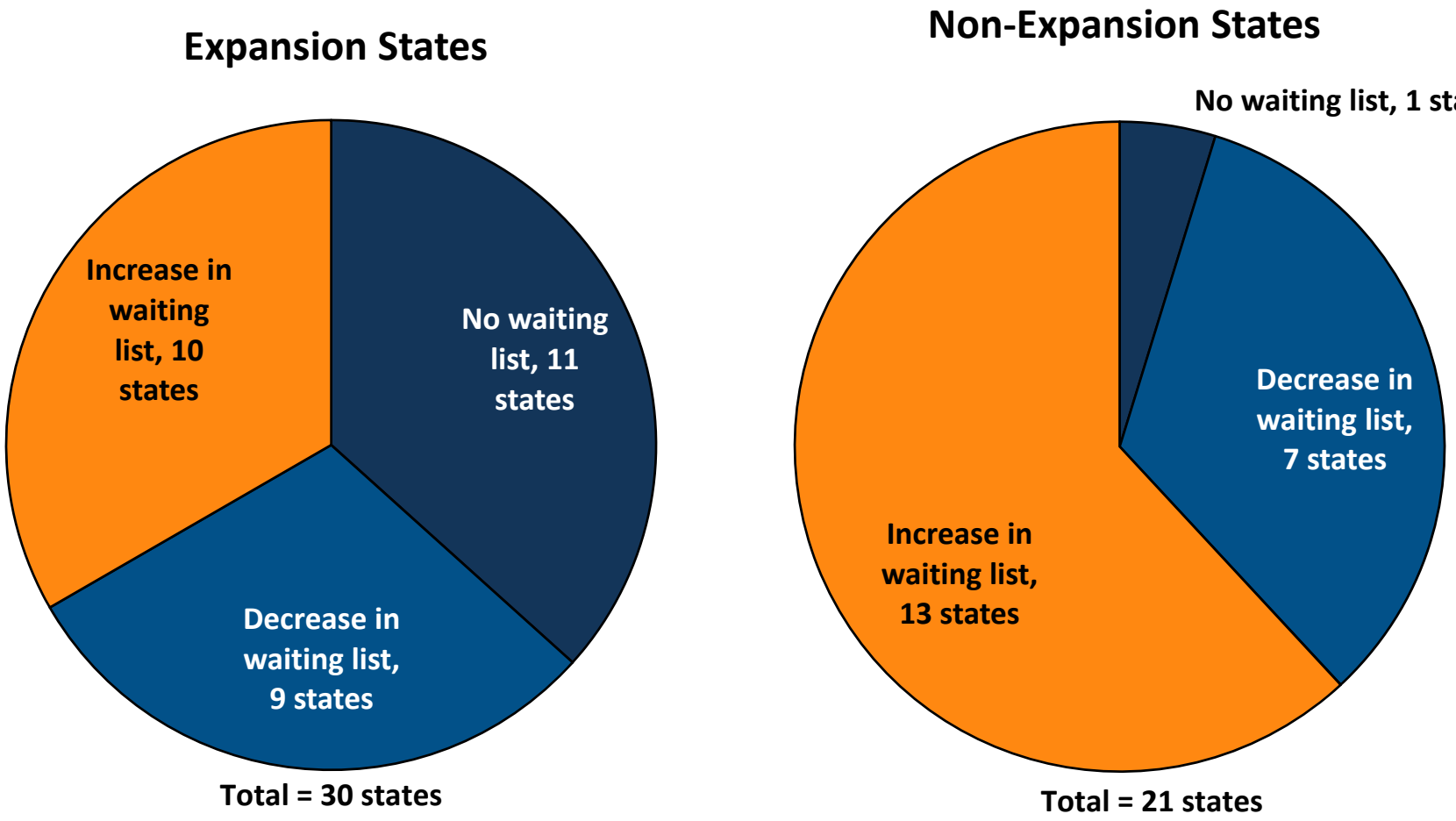
Most expansion states had no HCBS waiver waiting list or a decrease from 2014 to 2015, while most non-expansion states had a waiting list increase.



NOTES: Includes § 1915 (c) waivers. LA and MT expanded Medicaid in 2016 and are counted as non-expansion states for 2014 and 2015. Two expansion states and one non-expansion state separately report 2015 HCBS waiting lists for § 1115 waivers – these data were not collected for 2014.

SOURCE: Kaiser Family Foundation, *Medicaid Home and Community-Based Services Programs: 2013 Data Update* (Oct. 2016); Kaiser Family Foundation, *Medicaid Home and Community-Based Services Programs: 2012 Data Update* (Oct. 2015).

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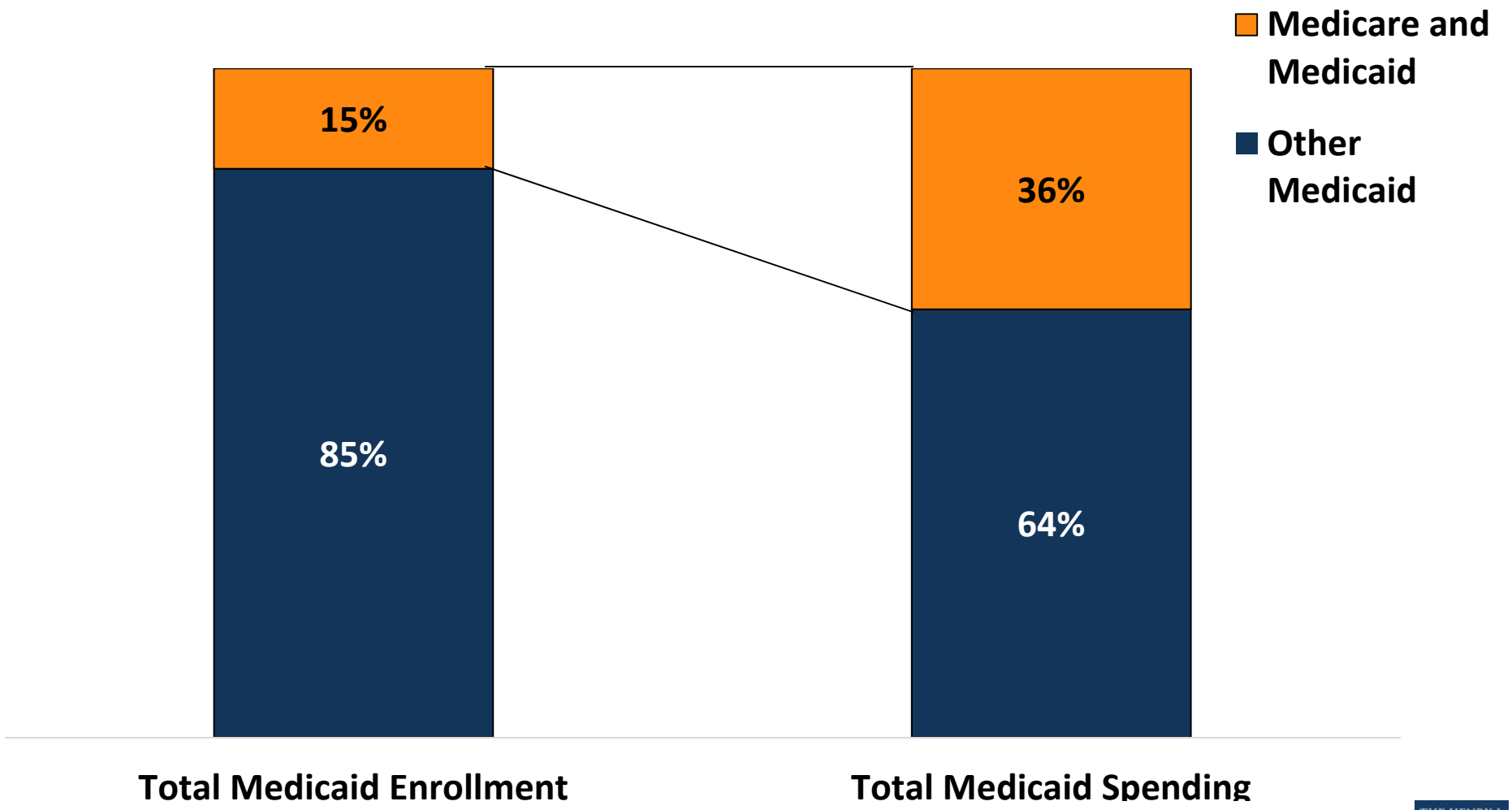
Medicare beneficiaries make up 15% of Medicaid enrollment but 36% of Medicaid spending, 2011.



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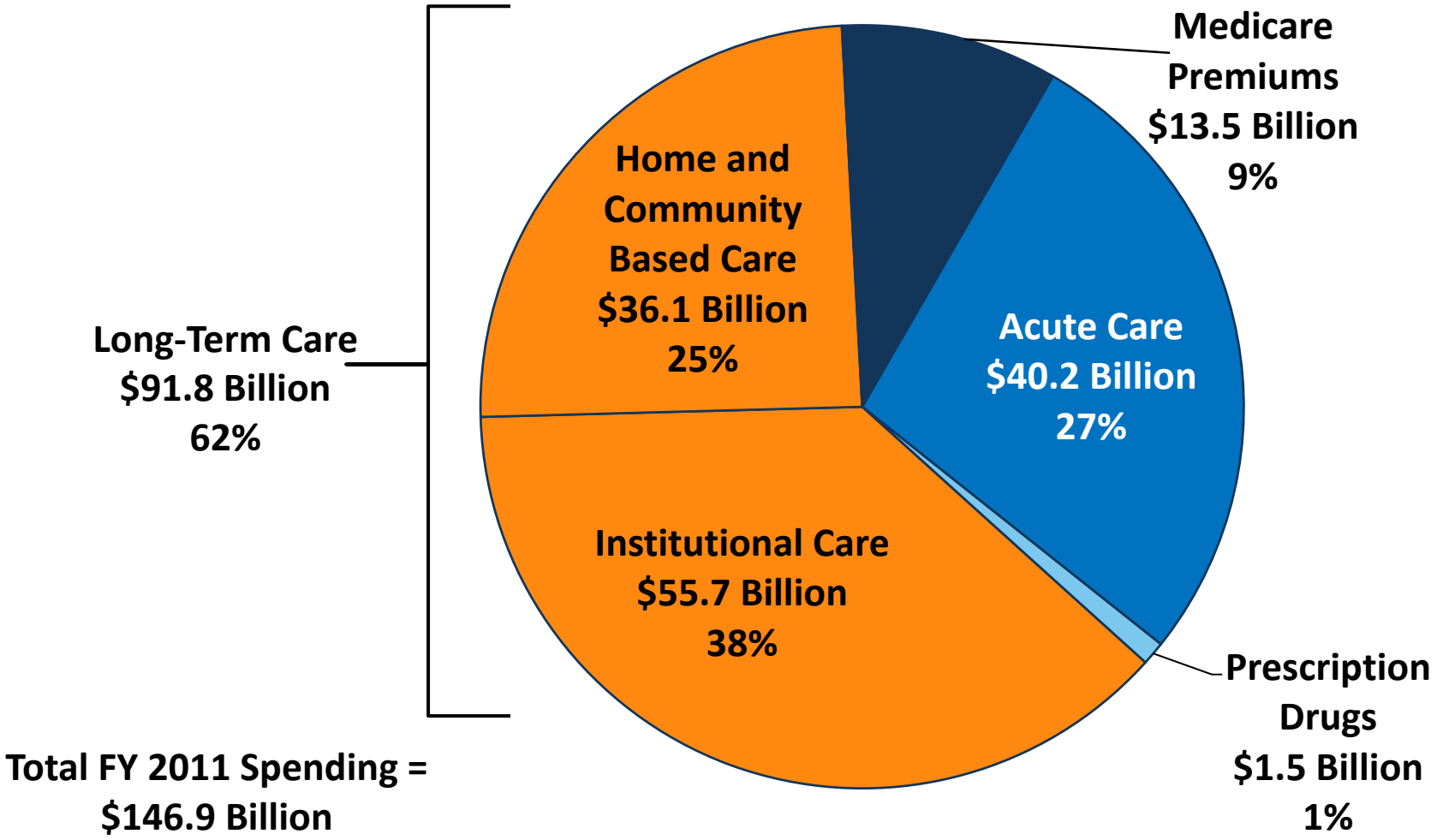
The majority of Medicaid spending for Medicare beneficiaries is for long-term care services, 2011.



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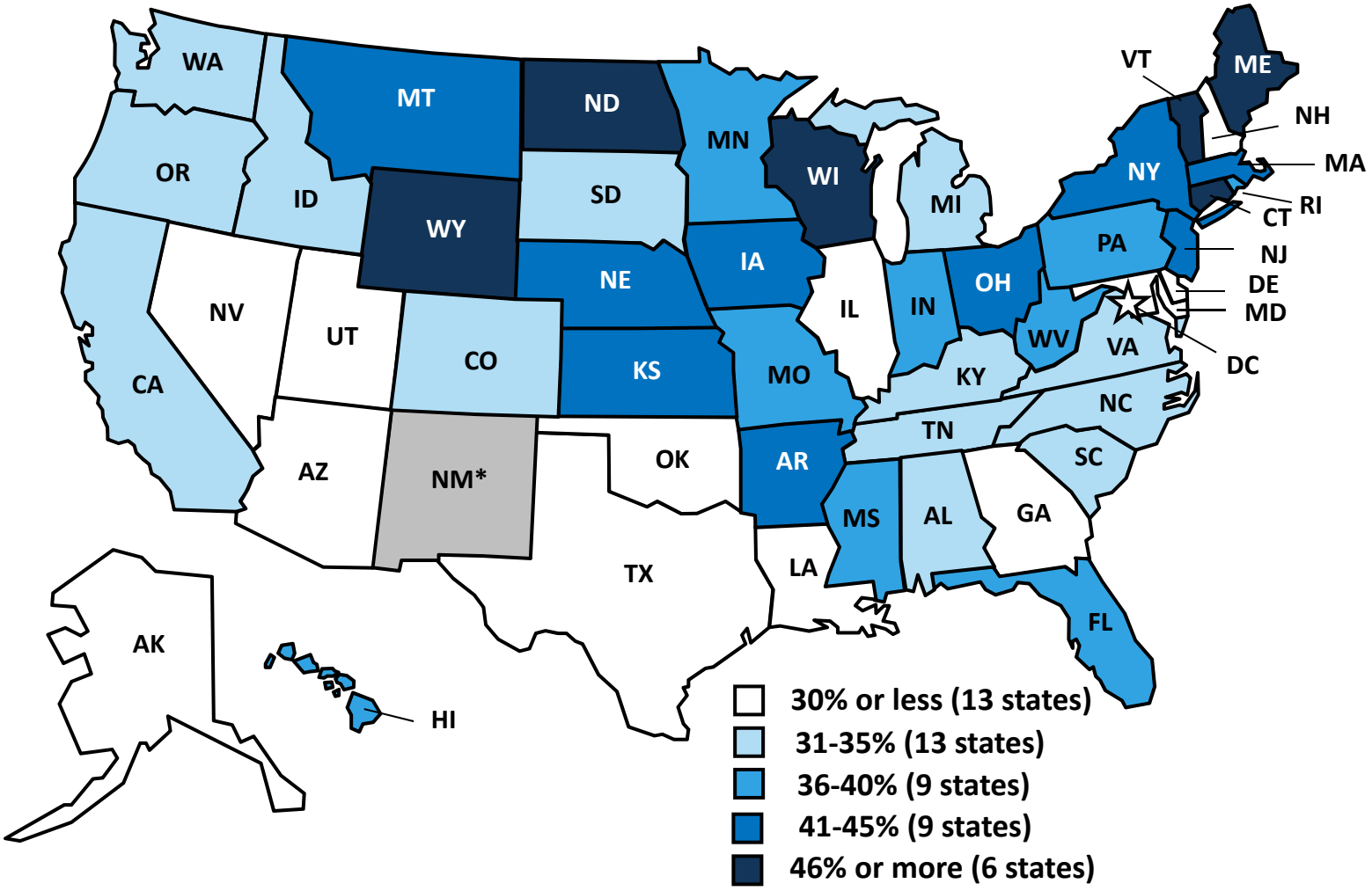
Medicaid spending for Medicare beneficiaries as a percent of total Medicaid spending varies by state, 2011.



NOTE: *NM data unavailable due to quality issues. SOURCE: Kaiser Family Foundation and Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports. Because 2011 data were unavailable, 2009 MSIS data were used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT, and then adjusted to 2010 CMS-64 spending levels.

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What's at stake in the Medicaid financing debate for seniors and people with disabilities?

- Under proposals that would reduce the amount of federal funding available to states compared to current law, states could have more program flexibility but with less federal funding may look to:
  - Limiting Medicaid eligibility, at a time when the population is aging and the need for long-term care services is expected to increase
  - Cutting costly services, such as long-term care in nursing facilities and the community, which is typically not available through private insurance or Medicare
  - Reducing provider reimbursement rates which already are low compared to other payers

Medicaid 101: Overview of Key Considerations for Directors and the States

National Association of Medicaid Directors
Matt Salo, Executive Director

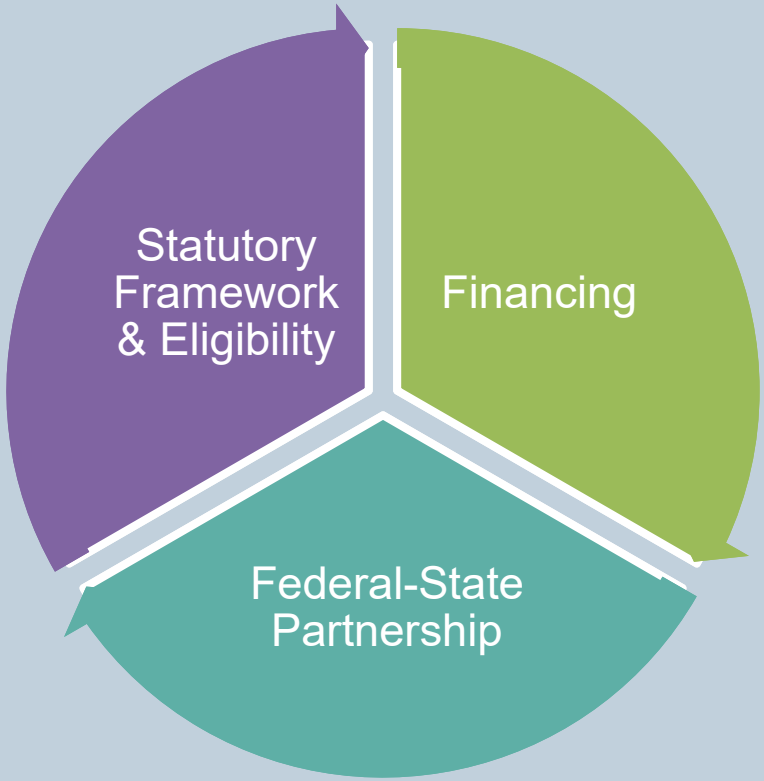
National Association of Medicaid Directors (NAMD): Who are we?

- Created in 2011 to support the 56 state and territorial Medicaid Directors
- Standalone, bipartisan, & nonprofit
- Core functions include:
  - Developing consensus on critical issues and leverage Directors' influence with respect to national policy debates;
  - Facilitating dialogue and peer to peer learning amongst the members; and
  - Providing effective practices and technical assistance tailored to individual members and the challenges they face.

Key Considerations in Medicaid Structural Reform Proposals

NAMD has requested that the Trump Administration and congressional leaders form an **expert workgroup** of Medicaid Directors to provide technical expertise on any Medicaid proposals.

It has also requested that **lawmakers consider three main issues** in the development of any proposals that would change the structure of Medicaid:



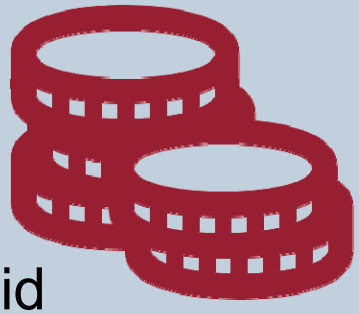
Statutory Framework and Eligibility: Questions

- 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

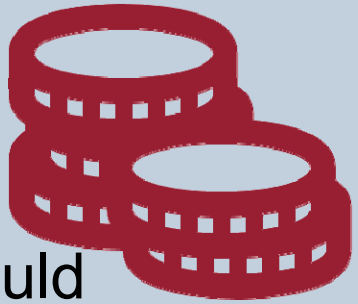
- Long-term care
  - Medicaid is currently the default long-term care program in the United States, and as demographics change, more Americans are expected to need long-term services and supports.
- Dually Eligibles
  - Approximately 40% of Medicaid spending is for low-income *Medicare* beneficiaries.
- 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?

Today's Web Briefing Will Be Recorded

The archived web briefing will be available later today.

Slides are available for download.

kff.org/medicaid/event/web-briefing-for-journalists-medicaids-future-understanding-block-grants-and-per-capita-caps/

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Q&A – Ask Questions Via Chat

- Click the chat icon  to open up the chat dialogue.
- Submit questions via chat at any time.
- We will answer questions after the presentations.

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Kaiser Family Foundation Resources

5 Key Questions: Medicaid Block Grants & Per Capita Caps

http://kff.org/medicaid/issue-brief/5-key-questions-medicaid-block-grants-per-capita-caps/

Current Flexibility in Medicaid: An Overview of Federal Standards and State Options

http://kff.org/medicaid/issue-brief/current-flexibility-in-medicaid-an-overview-of-federal-standards-and-state-options/

Medicaid State Fact Sheets

http://kff.org/interactive/medicaid-state-fact-sheets/

Medicaid's Future

kff.org/tag/medicaids-future/

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