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State Health Reform Assistance Network

Charting the Road to Coverage

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Digging into the ACHA Provisions on Medicaid Expansion and Capped Funding

State Health Reform Assistance Network

Manatt Health
March 22, 2017

Today's Agenda

- **Review American Health Care Act (AHCA) provisions and related proposals as of March 22nd related to Medicaid expansion authority and funding**
- **Analyze AHCA capped funding formula and implications for states**

On tomorrow's webinar, we'll focus on the AHCA's individual market provisions and their implications for states

Overview of American Health Care Act (AHCA)

Today's focus

Medicaid Expansion	• Maintains Medicaid expansion but largely eliminates availability of enhanced match
Medicaid Financing	• New per capita cap on federal Medicaid spending starting in FY 2020, or • State option to choose block grant for children and certain adults, or adults only
Safety Net Funding	• Repeals ACA DSH cuts for non-expansion states beginning in FY2018 and all other states beginning in FY 2020; provides new safety net funding to non-expansion states
Work Requirements	• Creates new state option for work requirements for most able-bodied adults
Federal Funding to States	• Allots $100 billion in State Innovation Grants for CY 2018-2026 with distribution formula based on enrollment, insurer participation, claims, and poverty
Tax Credits & HSAs	• Provides age-adjusted advanceable premium tax credits in place of income-adjusted tax credits
Marketplaces	• Makes premium tax credits available for plans purchased both on and off Marketplace plans
Individual & Employer Mandate	• Eliminates individual and employer mandate tax penalties, effective 12/31/15
Insurance Reforms	• Allows penalty for individuals with gaps in coverage and age rating; repeals ACA metal-level requirements (but preserves EHBs)

Overview of House Bill's Provisions to Alter Medicaid Expansion

American Health Care Act: Medicaid Expansion

- Maintains authority for Medicaid expansion up to 133% of the FPL
- Eliminates access to enhanced funding for non-expansion states; 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" 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 above 133% FPL

Sources: Manatt Summary, "House Repeal and Replace Bill: American Health Care Act;" (2) House Ways and Means Committee Markup of Bill: https://waysandmeans.house.gov/wp-content/uploads/2017/03/03.06.17-Section-by-Section.pdf; (3) House Energy and Commerce Committee Markup of Bill: http://www.cnn.com/2017/03/06/politics/house-republicans-obamacare-repeal-replace-text/index.html

AHCA Provisions for Non-Expansion States

- $2 billion annually from FY 2018 through 2022 for states that have not expanded Medicaid to increase payments to Medicaid providers (all types, not only hospitals)
  - Linked to expansion status as of July 1 in preceding year
- Each non-expansion state's share is based on its share of individuals with income below 138% FPL in 2015 relative to other non-expansion states
- The federal government will provide an enhanced match rate for payments made out of the allotment at 100% for FYs 2018-2021 and 95% for FY 2022
- Provides relief from ACA DSH cuts in FY 2018 and FY 2019 (delayed until FY 2020 for expansion states)

Sources: Manatt Summary, "House Repeal and Replace Bill: American Health Care Act;" (2) House Ways and Means Committee Markup of Bill: https://waysandmeans.house.gov/wp-content/uploads/2017/03/03.06.17-Section-by-Section.pdf; (3) House Energy and Commerce Committee Markup of Bill: http://www.cnn.com/2017/03/06/politics/house-republicans-obamacare-repeal-replace-text/index.html

Estimates of Federal Funds Available under Safety Net Adjustment Pool

Non-Expansion State	Population Under 138% of Poverty Line (in thousands)	Share of Non-Expansion Population Under 138% of Poverty Line	Federal Supplemental Payment Amount By Year (in millions)					
			2018	2019	2020	2021	Total for 2018 Through 2021 (100% Federal Funding)	Supplemental Payment Amount for 2022 (Amount Shown is Net of 5% State Share)
Alabama	1,258	4.5%	$90.3	$90.3	$90.3	$90.3	$361.2	$85.8
Florida	4,731	17.0%	$339.7	$339.7	$339.7	$339.7	$1,359.0	$322.8
Georgia	2,464	8.8%	$176.9	$176.9	$176.9	$176.9	$707.6	$168.1
Idaho	368	1.3%	$26.4	$26.4	$26.4	$26.4	$105.7	$25.1
Kansas	557	2.0%	$40.0	$40.0	$40.0	$40.0	$159.9	$38.0
Maine	267	1.0%	$19.2	$19.2	$19.2	$19.2	$76.7	$18.2
Mississippi	915	3.3%	$65.7	$65.7	$65.7	$65.7	$262.9	$62.4
Missouri	1,279	4.6%	$91.9	$91.9	$91.9	$91.9	$367.4	$87.3
Nebraska	343	1.2%	$24.6	$24.6	$24.6	$24.6	$98.5	$23.4
North Carolina	2,403	8.6%	$172.6	$172.6	$172.6	$172.6	$690.4	$164.0
Oklahoma	926	3.3%	$66.5	$66.5	$66.5	$66.5	$266.1	$63.2
South Carolina	1,158	4.2%	$83.1	$83.1	$83.1	$83.1	$332.5	$79.0
South Dakota	169	0.6%	$12.2	$12.2	$12.2	$12.2	$48.7	$11.6
Tennessee	1,600	5.7%	$114.9	$114.9	$114.9	$114.9	$459.6	$109.2
Texas	6,447	23.1%	$462.9	$462.9	$462.9	$462.9	$1,851.7	$439.8
Utah	512	1.8%	$36.8	$36.8	$36.8	$36.8	$147.1	$34.9
Virginia	1,342	4.8%	$96.4	$96.4	$96.4	$96.4	$385.6	$91.6
Wisconsin	1,016	3.6%	$73.0	$73.0	$73.0	$73.0	$292.0	$69.3
Wyoming	96	0.3%	$6.9	$6.9	$6.9	$6.9	$27.5	$6.5
Total	27,852	100%	$2,000.0	$2,000.0	$2,000.0	$2,000.0	$8,000.0	$1,900.0

Numbers and percents may not add to totals because of rounding.

Source: Manatt analysis of the 2015 table titled "Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months by Age" from the American Community Survey 1-Year Estimates, produced by the Bureau of the Census.

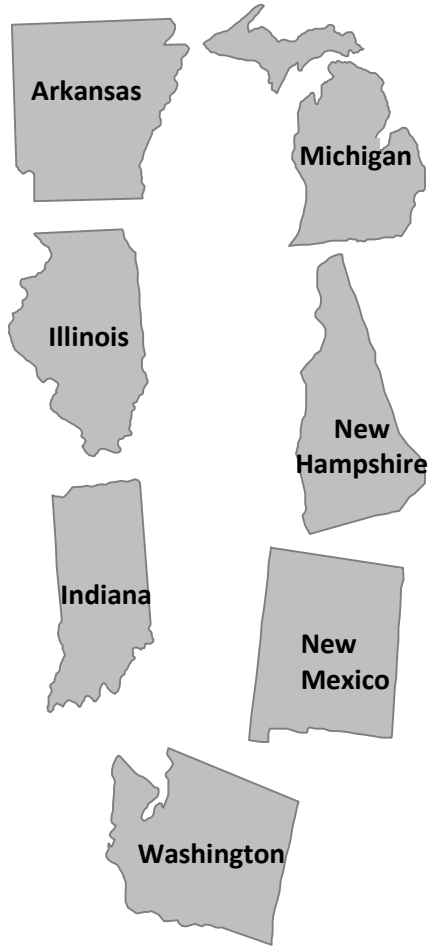
Implications for Trigger States under AHCA

Key Implications

Trigger States: At least seven expansion states have legislative provisions that require the state to reduce or eliminate Medicaid eligibility and/or benefits for the expansion population if enhanced funding is reduced

- **Arkansas:** Expansion will be terminated within 120 days after FMAP reduction
- **Illinois**: If FMAP is reduced below 90%, the expansion will be terminated no later than the end of the third month following the month in which the reduction in FMAP takes effect
- **Indiana**: Requires the state to terminate the expansion program if FMAP rates are reduced
- **Michigan**: Expansion will be terminated if the FMAP is reduced and annual state savings and other nonfederal net savings associated with the implementation of the expansion are not sufficient to cover the reduction
- **New Hampshire:** Expansion will be terminated within 180 days if the FMAP rate falls below 95 percent in 2017 and 94 percent in 2018
- **New Mexico:** The state will "reduce or rescind eligibility" for the new adult category if FMAP rates are reduced
- **Washington:** If FMAP is reduced, the WA Healthcare Authority must take steps to ensure that the state does not incur any additional costs beyond what would have been incurred had the enhanced FMAP remained in effect

Trigger States



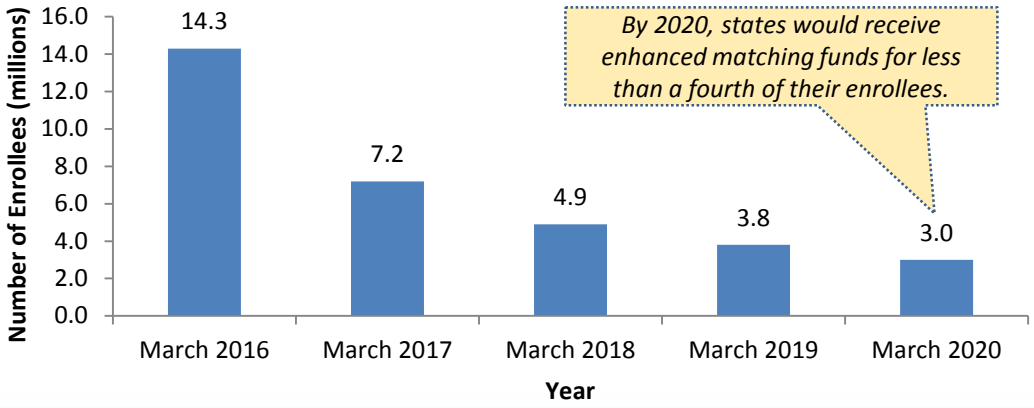
Sources: Arkansas HB 1143; Illinois SB 26; Indiana SB 165; Michigan HB 4714; New Hampshire HB 1696; New Mexico HB 2; Washington SB 5034

Implications for States of Limiting Enhanced Funding for Medicaid Expansion to Grandfathered Individuals

Based on states' experiences with enrollment freezes, the number of beneficiaries for whom a state receives enhanced matching funds can be expected to dwindle rapidly

- **States will face three choices:**
  1. Provide substantial new state funding to maintain expansion
  2. Limit expansion to grandfathered individuals and accept that there will be rising numbers of uninsured people
  3. Terminate the expansion entirely

Estimated Decrease Over Time in Continuous Enrollment of Grandfathered Individuals



Impact of State's Experiences with Past Enrollment Freezes

Arizona: Froze Medicaid enrollment of childless adults effective July 2011. One year after the freeze was implemented, enrollment dropped by 49%; after 24 months, enrollment was down 66%

Maine: Froze enrollment in March 2005 for childless adults below 100% FPL covered by MaineCare, a Medicaid 1115 waiver, causing enrollment to drop by 40%

Wisconsin: Created a limited benefit plan demonstration for adults below 200% FPL in 2009 and froze enrollment in January 2010, resulting in a 32% decrease in enrollment after 12 months and a 57% decrease after 24 months

Source: Internal Manatt analysis of enrollment data.

Estimated Decrease Over Time in Continuous Enrollment of Grandfathered Individuals

State	March 2016 Enrollment	Number of Individuals Remaining Continuously Enrolled			
		After 1 Year (51% remaining)	After 2 Years (34% remaining)	After 3 Years (27% remaining)	After 4 Years (21% remaining)
Total	**14,266,410**	**7,217,473**	**4,882,221**	**3,831,161**	**3,006,376**
Alaska	14,428	7,299	4,938	3,875	3,040
Arizona	416,349	210,634	142,482	111,808	87,738
Arkansas	303,944	153,767	104,015	81,622	64,050
California	3,535,354	1,788,559	1,209,861	949,399	745,009
Colorado	425,513	215,270	145,618	114,269	89,669
Connecticut	207,625	105,039	71,053	55,756	43,753
Delaware	66,730	33,759	22,836	17,920	14,062
DC	61,993	31,363	21,215	16,648	13,064
Hawaii	108,072	54,674	36,984	29,022	22,774
Illinois	664,124	335,985	227,275	178,347	139,952
Indiana	381,631	193,070	130,601	102,485	80,422
Iowa	148,896	75,327	50,955	39,985	31,377
Kentucky	443,200	224,218	151,671	119,019	93,396
Maryland	248,237	125,585	84,951	66,663	52,311
Massachusetts	394,943	199,804	135,157	106,060	83,227
Michigan	633,013	320,246	216,628	169,992	133,396

Note: Excludes Louisiana, which expanded in July 2016; enrollment for North Dakota reflects December 2015. Percentage decreases are based on Arizona experience with an adult enrollment freeze, and an assumption that an approximately two percent average monthly decline observed between months 24 and 30 continues through year four.

Source: Manatt analysis of Centers for Medicare & Medicaid Services, January-March 2016 MBES Medicaid Enrollment Report, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/sdis/index.html.

Estimated Decrease Over Time in Continuous Enrollment of Grandfathered Individuals, cont.

State	March 2016 Enrollment	Number of Individuals Remaining Continuously Enrolled			
		After 1 Year (51% remaining)	After 2 Years (34% remaining)	After 3 Years (27% remaining)	After 4 Years (21% remaining)
Minnesota	187,060	94,635	64,015	50,234	39,419
Montana	46,688	23,620	15,977	12,538	9,839
Nevada	203,929	103,169	69,788	54,764	42,974
New Hampshire	52,892	26,758	18,101	14,204	11,146
New Jersey	536,741	271,541	183,682	144,139	113,108
New Mexico	243,110	122,991	83,197	65,286	51,231
New York	2,094,895	1,059,821	716,911	562,572	441,459
North Dakota	19,517	9,874	6,679	5,241	4,113
Ohio	677,540	342,772	231,866	181,949	142,779
Oregon	550,610	278,557	188,429	147,863	116,031
Pennsylvania	702,758	355,530	240,496	188,722	148,093
Rhode Island	60,455	30,585	20,689	16,235	12,740
Vermont	63,281	32,014	21,656	16,994	13,335
Washington	592,910	299,957	202,904	159,222	124,945
West Virginia	179,972	91,049	61,590	48,330	37,926

Note: Excludes Louisiana, which expanded in July 2016; enrollment for North Dakota reflects December 2015. Percentage decreases are based on Arizona experience with an adult enrollment freeze, and an assumption that an approximately two percent average monthly decline observed between months 24 and 30 continues through year four.
Source: Manatt analysis of Centers for Medicare & Medicaid Services, January-March 2016 MBES Medicaid Enrollment Report, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/sdis/index.html.

Capped Federal Medicaid Funding Formula

State Option 1: AHCA Capped Funding Model

Focus for Today's Presentation

- 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
- After FY 2019, 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
- State match still required, with federal match provided for state expenditures up to cap
- To the extent state's total Medicaid expenditures are higher than the cap, state would be required to repay the federal amount in the following year

State Option 2: AHCA Block Grant Model

- 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 non-expansion, non-disabled adults and children, or only adults
- Based on state's per capita spending target for each applicable eligibility group in the initial year the state opts for the block grant, multiplied by the state's FY 2019 enrollment in the eligibility group and FY 2019 average FMAP
- Block grant amount trended forward at CPI-U – a lower trend rate than under the per capita cap
- Enhanced CHIP FMAP is applied to block grant amount and federal share is paid to state on quarterly basis; not clear whether states have matching requirement
- State subject to limited guard-rails on Medicaid coverage, but generally have significant latitude regarding eligibility, benefits, cost-sharing and delivery system (but must comply with mandatory minimum eligibility levels for pregnant women and children)

Spending Included and Excluded from Per Capita Cap

Cap applies to spending on medical services, under state plan or waiver, for most Medicaid beneficiaries

	Included	Excluded
Eligibility Group	• Aged (65+) • Blind and Disabled • Children • Expansion Adults • Other Adults (e.g., Pregnant Women & Low Income Parents)	*Generally "partial benefit" categories:* • Qualified Medicare Beneficiaries • Emergency services • Family Planning • Tuberculosis • Breast and Cervical Cancer • Premium Assistance through ESI • Indian Health Service • CHIP-financed Children
Spending	• Medical Expenditures under State Plan • Medical Expenditures under Waiver • Non-DSH Supplemental Payments	• Administration • DSH • Medicare Cost-Sharing • Vaccines for Children • New Funding Pool for Non-Expansion States

Calculating the Aggregate Cap is a 3 Step Process

1

Calculate "Adjustment Factor"

FY 2016 average per capita spending is trended forward by growth in medical CPI to create a benchmark for FY 2019 spending; the ratio of the benchmark to actual FY 2019 spending is an "adjustment factor."

2

Calculate Per Capita "Provisional Targets"

The "adjustment factor" is applied to actual FY 2019 per capita spending for each eligibility group to calculate a "provisional target" per eligibility group

3

Calculate Aggregate Cap

The per capita "provisional target" is multiplied by actual FY 2019 enrollment to establish a cap per eligibility group. The 5 eligibility group caps are then summed together to an aggregate cap.

Impact of Adjustment Factor:

- Actual FY 2019 spending > trended FY 2016 amount → adjustment factor < 100%
- Actual FY 2019 spending < trended FY 2016 amount → adjustment factor > 100%

Step 1: Calculate Adjustment Factor (One Time, FY 2019)

FY 2016 per capita spending is trended forward and then applied to FY 2019 enrollment to project a total spending target in FY 2019. Target is compared to actual FY 2019 spending to calculate an "adjustment factor"

Trended forward at Medical CPI growth

FY 2016 Average Per Capita Spending

FY 2019 Projected Average Per Capita Spending

X

FY 2019 Medicaid Enrollment for included eligibility groups

=

Adjustment Factor

FY 2019 Projected Total Spending Target

FY 2019 Total Medical Assistance Spending attributable to included eligibility groups

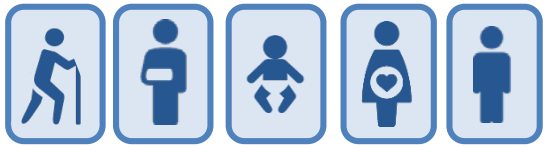
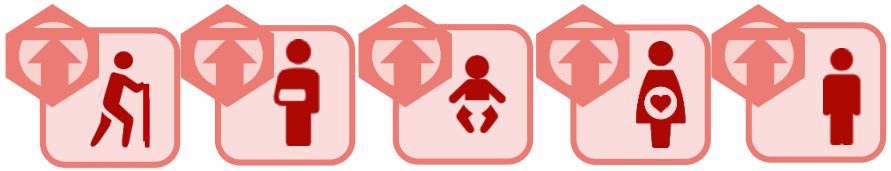
=

FY 2019 Actual Total Spending

Step 2: Calculate Per Capita Provisional Targets (One Time, FY 2019)

The adjustment factor is applied to FY 2019 per capita spending, to calculate per capita "FY 2019 provisional targets" for each eligibility group

FY 2019 Actual Per Capita Spending **FY 2019 Per Capita "Provisional Targets"**

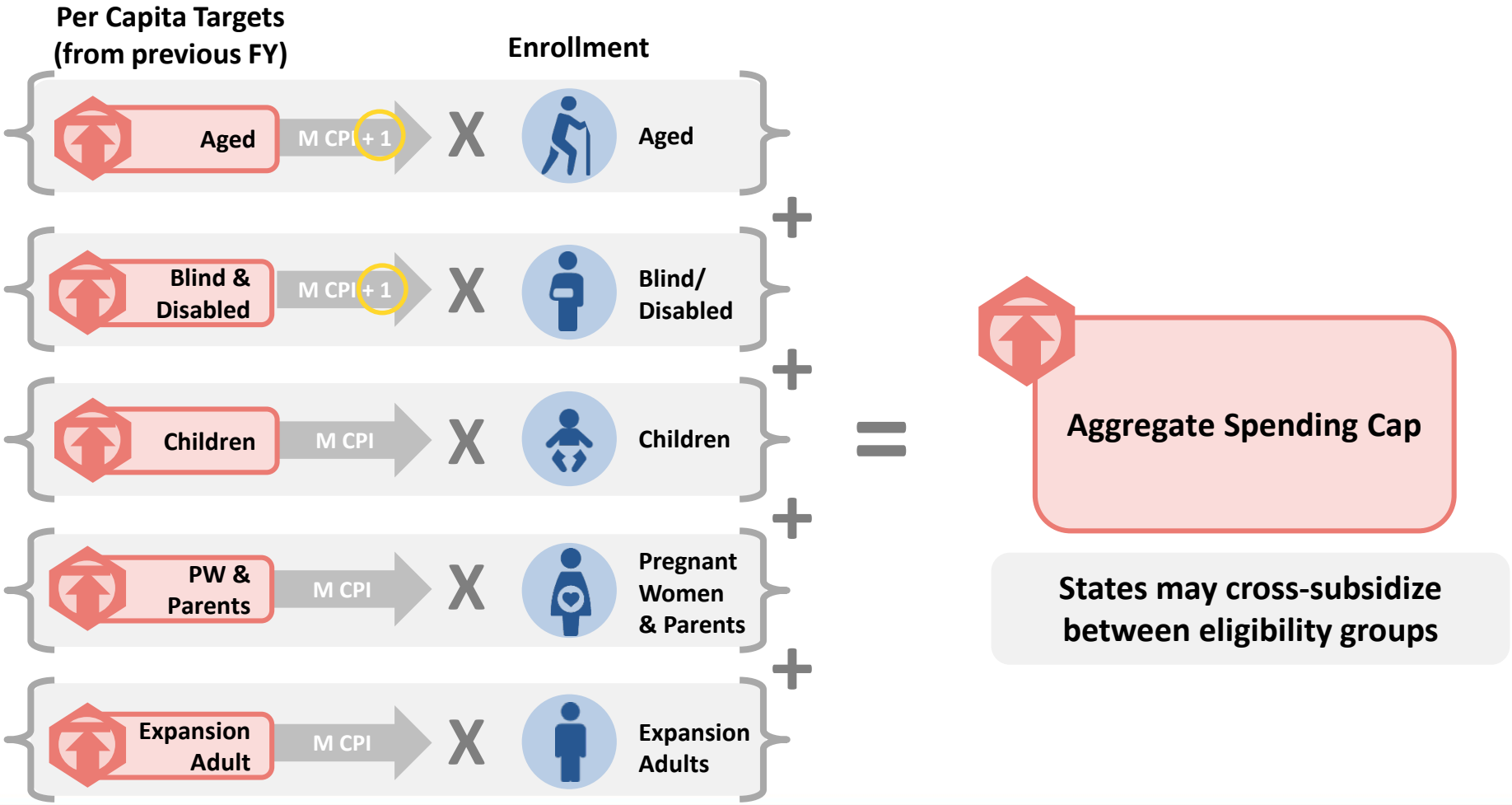
Adjustment Factor x  = 

Impact of Adjustment

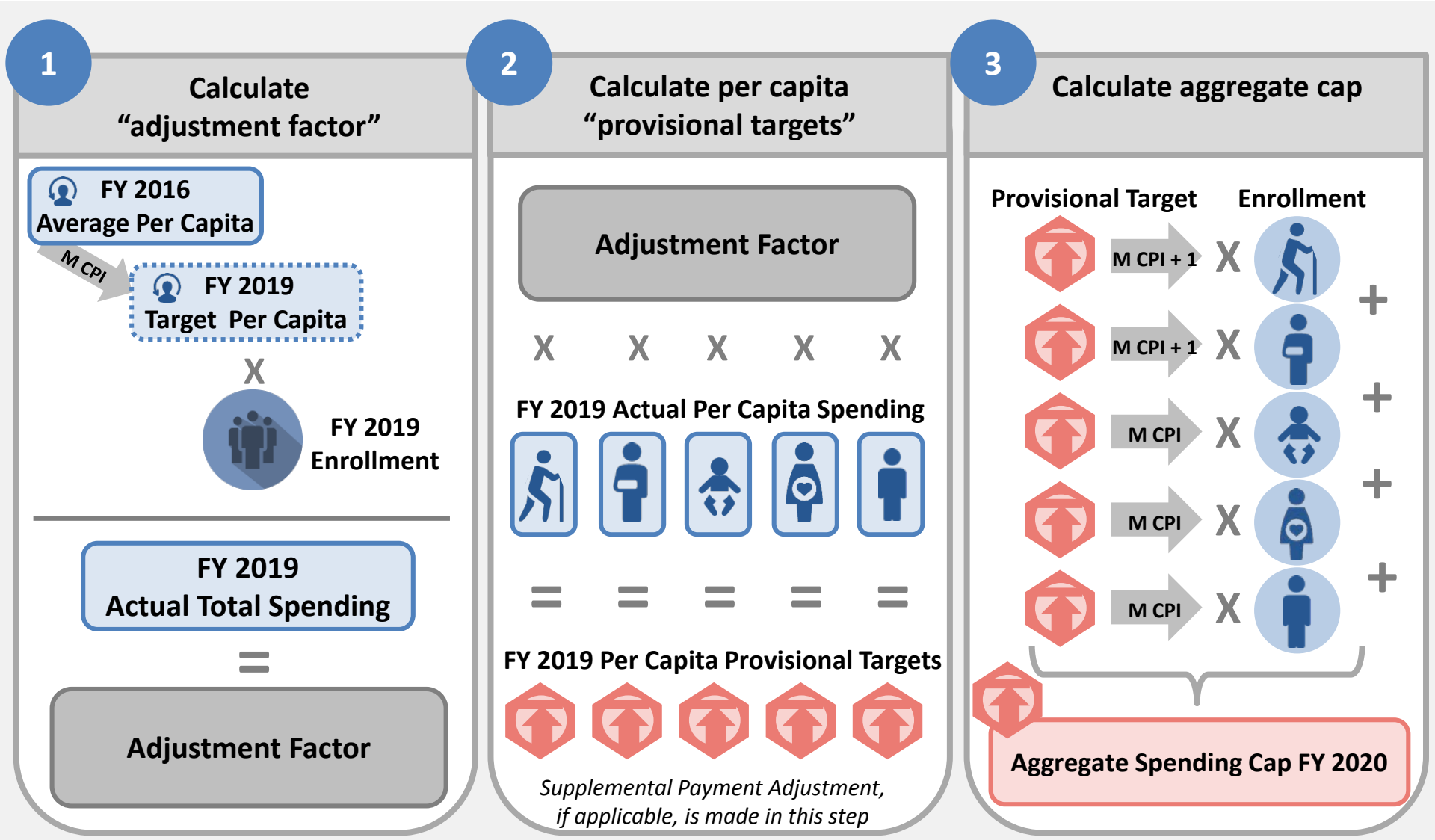
- Adjustment could raise or lower the provisional targets for each eligibility group relative to actual FY 2019 per capita spending for each group
- Effect of adjustment factor depends on how each state's growth in actual spending compares to the growth in trend rate between FY 2016 and FY 2019
  - States growing slower than trend rate = adjust target upwards
  - States growing faster than trend rate = adjust target downwards

Step 3: Calculate Aggregate Cap (Each Year, FY 2020+)

Each year, a single annual cap is set by trending forward the previous year's per capita target, multiplying by enrollment in the year in question, and adding these eligibility group caps together

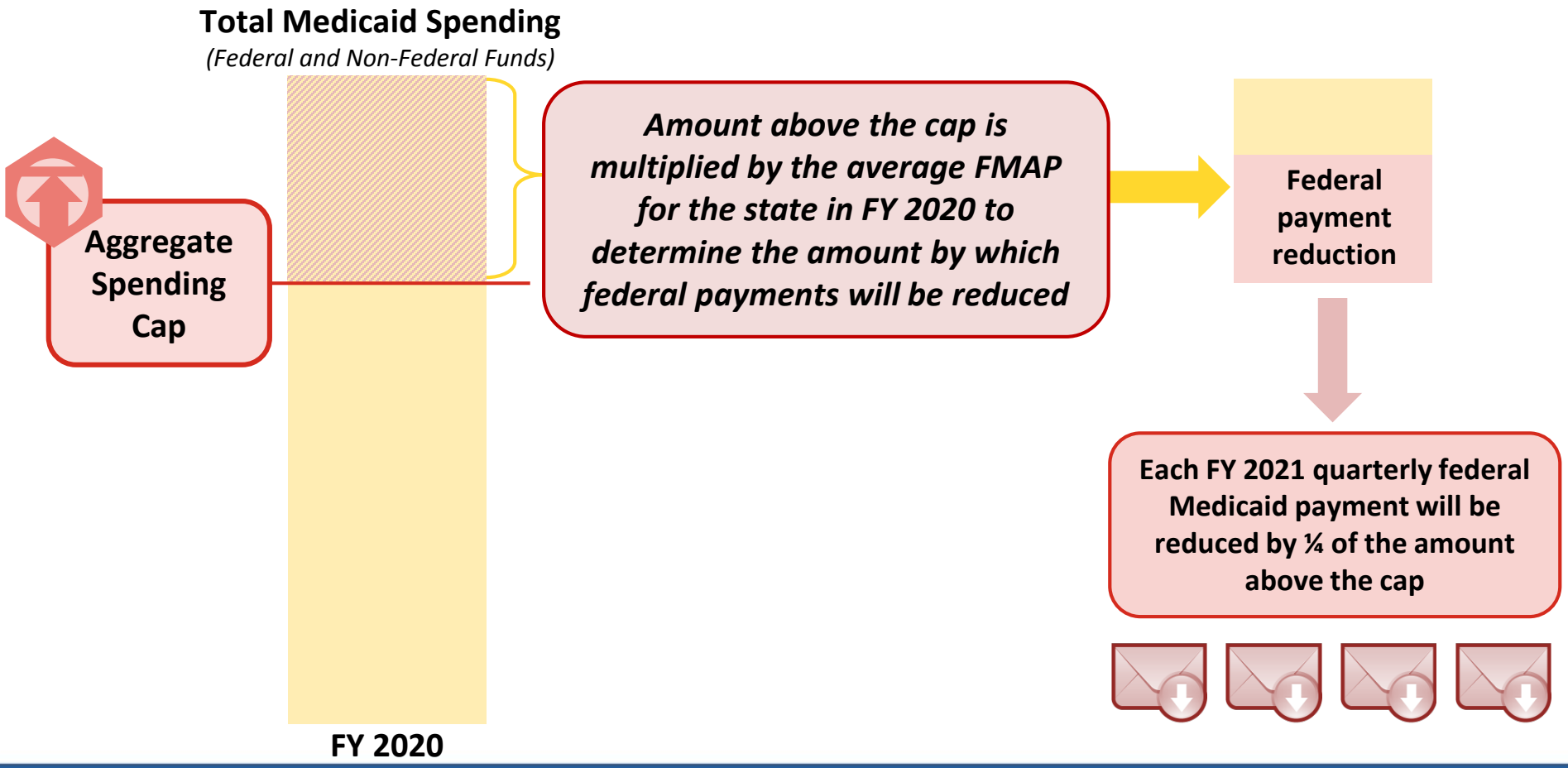


Calculating FY 2020 Spending Cap



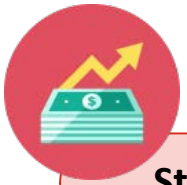
Enforcement of the Cap

If a state's spending is greater than the aggregate spending cap, the state's federal Medicaid payments will be reduced by the amount of federal spending above the spending cap in the following year



State Example: "Average" State

Profile of Average State	
Enrollment, FY 2016*	1.6 million
Total Spending, FY 2016	$11 billion
Per Capita Spending Growth, FY 2016 – FY 2020	4.9% across eligibility groups
Average FMAP, FY 2020	57%



State per capita spending is growing faster than medical CPI (~3.7%) and medical CPI + 1 (~4.7%), so the cap will be lower than actual spending

Aggregate Cap FY 2020 = $14.9 billion

Total Medicaid Spending in State = $15.7 billion

Spending above cap = $840 M

X 57% FMAP

Federal payment reduction= $480 M

FY 2020

Federal payments will be reduced by $480 million in FY 2021, about a 5% cut in federal support

FY 2020

*Assumes composition of enrollment remains constant

State Example: "Average State" with Lower Trend Rate

Profile of Average State	
Enrollment, FY 2016*	1.6 million
Total Spending, FY 2016	$11 billion
Per Capita Spending Growth, FY 2016 – FY 2020	4.9% across eligibility groups
Average FMAP, FY 2020	57%

This example assumes that medical CPI is 3.2% rather than at 3.7%. In this scenario, the cap will be lower than actual spending and the state will face a larger reduction

Aggregate Cap FY 2020 = $14.6 billion

Total Medicaid Spending in State = $15.7 billion

Spending above cap = $1.1 B

X 57% FMAP

Federal payment reduction= $640 M

FY 2020

Federal payments will be reduced by $640 million in FY 2021, about a 7% cut in federal support

FY 2020

*Assumes composition of enrollment remains constant

Treatment of Supplemental Payments

DSH is treated differently than non-DSH supplemental payments and waiver payments

DSH

- Excluded from the cap

Non-DSH Supplemental Payments

- Taken into account in when calculating cap level
- Subject to the cap

1115 Waiver Payments

- Including Uncompensated Care Pools, Delivery System Reform Incentive Programs (DSRIP) and Designated State Health Programs (DSHP) funding pools
- Taken into account in when calculating cap level
- Subject to the cap

AHCA Definition of Non-DSH Supplemental Payments:

- Not DSH payments
- Not made with respect to a specific item or service for an individual
- In addition to any payments made to the provider for any such item or service
- Complies with federal limits (including UPL limits)

Impact of Non-DSH Supplemental Payments in Formula

Non-DSH supplemental payments* are excluded from FY 2019 spending, but then added based on ratio of FY 2016 supplemental payments to FY 2016 total spending to calculate cap.
However, this does not result in a directly proportionate increase in the cap.
States with greater reliance on supplemental payments in FY 2016 will see a greater disparity.

Supplemental Payment Adjustment

Non-DSH Supplemental Payments = 5% of total Medicaid spending ($1 billion out of $20 billion total)

$$\left(1 + \frac{\text{FY 2016 Supp. Payments = \$1 B}}{\text{FY 2016 Total Spending = \$20 B}}\right) \times \text{FY 2019 Total Spending – Supp. Payments \$20 B - \$1 B = \$19 B}$$

$$=$$

$19.95 B Cap

0.25% less than if adjustment fully accounted for supplemental payments

Supplemental Payment Adjustment

Non-DSH Supplemental Payments = 20% of total Medicaid spending ($4 billion out of $20 billion total)

$$\left(1 + \frac{\text{FY 2016 Supp. Payments = \$4 B}}{\text{FY 2016 Total Spending = \$20 B}}\right) \times \text{FY 2019 Total Spending – Supp. Payments \$20 B - \$4 B = \$16 B}$$

$$=$$

$19.2 B Cap

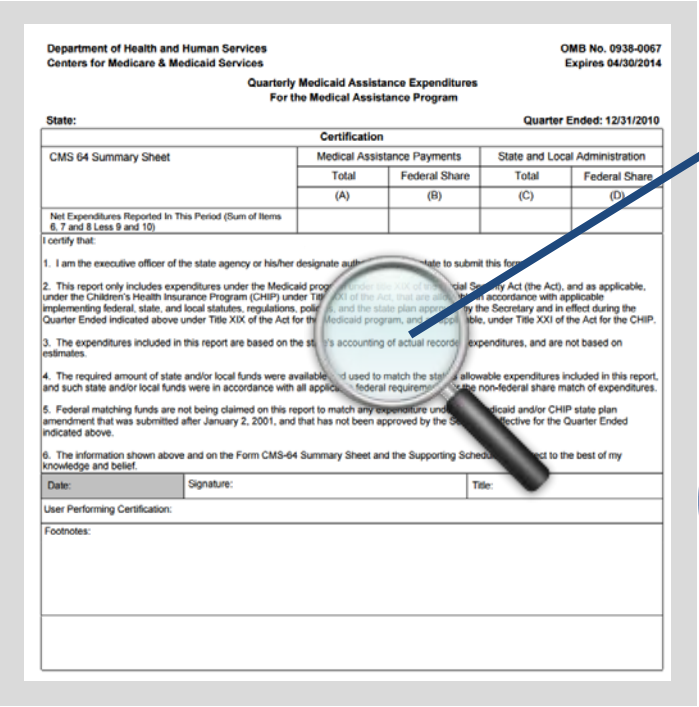
4% less than if adjustment fully accounted for supplemental payments

*Includes UPL and 1115 waiver payments, including Uncompensated Care Pools, DSRIP and DSHP

APPENDIX

Data Reporting to Inform Caps

CMS-64 Expenditure and Enrollment Reports



Department of Health and Human Services
Centers for Medicare & Medicaid Services

OMB No. 0938-0067
Expires 04/30/2014

Quarterly Medicaid Assistance Expenditures
For the Medical Assistance Program

State:

Quarter Ended: 12/31/2010

Certification				
CMS 64 Summary Sheet	Medical Assistance Payments		State and Local Administration	
	Total	Federal Share	Total	Federal Share
	(A)	(B)	(C)	(D)
Net Expenditures Reported In This Period (Sum of Items 6, 7 and 8 Less 9 and 10)				

I certify that:

1. I am the executive officer of the state agency or his/her designate au... state to submit this for...

2. This report only includes expenditures under the Medicaid prog... Social Security Act (the Act), and as applicable, under the Children's Health Insurance Program (CHIP) under Title ... of the Act, that are ... in accordance with applicable implementing federal, state, and local statutes, regulations, poli..., and the state plan appr... by the Secretary and in effect during the Quarter Ended indicated above under Title XIX of the Act for the Medicaid program, and ... under Title XXI of the Act for the CHIP.

3. The expenditures included in this report are based on the st... accounting of actual record... expenditures, and are not based on estimates.

4. The required amount of state and/or local funds were available ... used to match the sta... allowable expenditures included in this report, and such state and/or local funds were in accordance with all applica... federal requirem... the non-federal share match of expenditures.

5. Federal matching funds are not being claimed on this report to match any expenditure und... Medicaid and/or CHIP state plan amendment that was submitted after January 2, 2001, and that has not been approved by the S... effective for the Quarter Ended indicated above.

6. The information shown above and on the Form CMS-64 Summary Sheet and the Supporting Schedu... ect to the best of my knowledge and belief.

Date:	Signature:	Title:
User Performing Certification:		
Footnotes:		

New Data Reporting Requirements in CMS-64

Effective October 1, 2018

- Medical assistance expenditures for each of the 5 enrollee categories and for each excluded category
- Number of enrollees in each included and excluded category
- Other data points as HHS Secretary determines necessary

Temporary Enhanced Funding for Data/Systems Expenditures

Oct. 1, 2017 – Sep. 30, 2019

- 100% FMAP for design, development, implementation and operation of systems
- 60% FMAP for administrative expenditures attributable to data reporting requirements

Thank You!

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