THE SYCAMORE INSTITUTE

MEDICAID REFORM 101: MORE THAN JUST BLOCK GRANTS

PART 2 OF 5 – A SUMMARY OF RECENT FEDERAL PROPOSALS

BOTTOM LINE

This paper summarizes the key features of recent federal proposals in order to better understand how reforms might impact Tennessee's ability to control its own spending on TennCare and how state policymakers approach their own reforms.

Recent Congressional proposals provide broad outlines of what federal reforms may look like but lack legislative language and at least some key details. **These recent federal proposals largely rely on a per capita cap structure that would cap federal funding for all enrollees but would allow federal contributions to vary with enrollment. They also offer states significant new program design flexibilities but retain mandatory eligibility and benefits for vulnerable elderly and disabled populations.** This means that federal contributions for the protected populations would be constrained without the federal flexibilities states could use to reduce the costs associated with these populations. To prevent additional state spending that would result from the loss of federal dollars, states could (1) use their flexibilities with other populations to limit benefits to free up federal dollars or (2) limit enrollment to free up their own dollars for the costs of these protected populations. Our other briefs in this series explore how Tennessee might approach its own reforms and the potential impact on the state.

THE SYCAMORE INSTITUTE'S "MEDICAID REFORM 101" SERIES:

PART 1: Key federal Medicaid reform design elements

PART 2: Summary of recent federal proposals

PART 3: Key state TennCare reform design elements

PART 4: Summary of recent TennCare proposals

PART 5: Analysis of the potential impact on Tennessee

INTRODUCTION

The previous brief in this series summarizes the key design elements that federal lawmakers are likely to discuss when considering Medicaid reform. Within the framework of these design elements, this brief summarizes specific recent federal proposals. Our follow-up briefs summarize state reform efforts and potential impact to Tennessee. This 5-part series provides a framework and context for changes to Medicaid and TennCare that may be adopted by state and federal policymakers in the coming months and years.

See our first brief for background on the Medicaid program.

KEY FEATURES OF FEDERAL MEDICAID REFORM PROPOSALS

- Proposals predominantly rely on a capped federal contribution to state Medicaid costs through **categorical per capita caps** to replace the current unlimited FMAP; one provides a state option for a **capped block grant**.
- **Growth in federal contributions would be limited** to a pre-determined growth factor that is less than current anticipated growth in Medicaid costs.
- Particularly **vulnerable populations may retain federally-mandated eligibility and benefit coverage** – including populations that are elderly or have a disability.
- Proposals allow states to **cross-subsidize the costs for aged and disabled** eligibility groups using any savings achieved with program design flexibilities for adult and child eligibility groups.
- In many cases, states would be provided with the ability to exercise flexibility without going through a long waiver-approval process. **Some or all federally-mandated benefit and eligibility requirements for some populations may be repealed.**
- States may also be allowed to impose **cost-sharing**, **work requirements**, **limited benefits**, and **enrollment caps** for some or all eligibility populations.

RECENT FEDERAL MEDICAID REFORM PROPOSALS

Our first brief in this series summarizes the key design elements that federal lawmakers must address in tackling Medicaid reform. The tables that are displayed on the following pages summarize 2 recent proposals within the context of these design options. Although fairly comprehensive, these proposals do not include legislative language, so our summaries include the details as they are presented in each plan.

In addition to these 2 proposals, other proposals have been included in the federal FY 2015 and 2016 budget resolutions passed in the U.S. House of Representatives, which lay out federal budgetary goals for the year and at least 4 additional years. Budget resolutions are not legally binding, and they do not include specific legislation. However, both the FY 2015 and 2016 House resolutions included broad assumptions about Medicaid reform underlying each resolution's desired budgetary goals. Both resolutions assumed that the Medicaid program would be reformed into an allotment or block grant accompanied by state "freedom and flexibility" and a repeal of the ACA's eligibility expansion. [1] [2] [3] [4]

MAKING MEDICAID WORK is a proposal for Medicaid reform put forward by the Republican-led U.S. House Energy & Commerce and Senate Finance Committees in May of 2013. [5]

<table>
<tr><th colspan="8">MAKING MEDICAID WORK
(May 2013)</th></tr>
<tr><th colspan="8">FEDERAL FINANCING</th></tr>
<tr><th>Basic Structure</th><th>Spending Categories</th><th>Eligibility Criteria</th><th>Base Year</th><th>Cap Growth</th><th>State Differences</th><th>State Contribution</th><th>ACA Expansions</th></tr>
<tr><td rowspan="4">State-specific per capita caps</td><td rowspan="2">Caps would apply to all medical assistance and non-benefit expenditures.

Separate payments would be made for GME, DSH, Medicare-Medicaid dual eligible enrollees, partial Medicaid enrollees, and "other appropriate exclusions."</td><td rowspan="2">Each state would have four different caps based on four broad Medicaid eligibility categories: aged, blind and disabled, children, and adults.

If a state were able to constrain its costs for one eligibility category below the federal cap, they could use any difference to offset costs in another eligibility category where costs may exceed the cap. This “risk corridor” would allow states to “determine how to protect vulnerable populations such as the disabled from unpredictable spending.”</td><td rowspan="4">Caps would be based on costs for each state in "the most recent year."</td><td rowspan="4">The caps would grow by “a realistic exogenous” growth factor. If a state’s costs were slower than the growth factor, the cap would be rebased every five years.</td><td rowspan="4">Caps for states with costs in the top 25% of all states would grow slower than the growth factor; while caps for states with costs in the lowest 25% of all states would grow faster.</td><td rowspan="4">States would be required to continue investing at least as much as would be required under the FMAP towards Medicaid costs (e.g. 35% in Tennessee). The proposal, however, would reduce states’ ability to use taxes on Medicaid providers to fund the state’s share.</td><td rowspan="4">The proposal does not explicitly address the ACA expansion beyond allowing states to cap enrollment for “high income” populations if states’ costs exceed a “state-determined budget target.”</td></tr>
<tr></tr>
<tr><td colspan="2">The Secretary would establish special provisions for waiver programs. Although no details are provided, this could conceivably take the form of an overarching block grant, capped allotment, or consolidated per capita cap for all enrollees under a waiver.</td></tr>
<tr><td colspan="2">The proposal would also allow states to receive a defined federal allotment (i.e. a block grant or capped allotment) for long-term care services and supports.</td></tr>
<tr><td colspan="6">States could also be eligible for bonus payments for performance on measures related to cost reduction, access, and quality which could be used for public health initiatives.</td></tr>
<tr><th colspan="8">STATE BENEFIT DESIGN</th></tr>
<tr><th colspan="7">State Flexibility</th><th>Federal Accountability</th></tr>
<tr><td colspan="7">The plan appears to include near maximum flexibility in tailoring eligibility and benefit design for all populations except those with disabilities, who would be guaranteed all current law benefits. Some of the explicit allowable flexibilities outlined in the plan for states’ use include:
• Caps on enrollment for “high income” recipients;
• Reform of the waiver process to set time limits on CMS approval and to allow for programmatic innovations that have been approved in one state to be automatically approved for other states;
• Value-based insurance that structures beneficiaries’ out-of-pocket costs to create incentives for certain kinds of care or providers;
• Premium support for the purchase of a private health insurance plan offered in the individual market or by an employer;
• Limited benefit and primary care-only plans;
• “Unique care coordination and benefit design approaches” for high-cost, complex enrollees;
• Accounts that reward enrollees for healthy behaviors;
• Enforceable cost-sharing requirements for any services and for enrollees at any income level;
• Premiums for “certain Medicaid populations;”
• High deductible plans with pre-funded accounts; and
• Greater flexibility for states to implement payment reform.</td><td>The proposal would require that Medicaid providers transparently publish price information and that states provide more data on provider quality. States would also be required to report to the federal government on measures related to access, costs, and care quality.</td></tr>
</table>

A BETTER WAY TO FIX HEALTH CARE is an outline of reforms across the health care sector – including Medicaid – proposed by the U.S. House Republican Caucus under the leadership of Speaker Paul Ryan in June of 2016. [6]

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<tr><td>Federal Medicaid allotment based on state-specific per capita caps</td><td>Caps would apply to medical assistance costs and non-benefit expenditures.

Separate payments would be made for GME, DSH, and "other appropriate exclusions."</td><td>Each state would have four different caps based on four broad Medicaid eligibility categories: aged, blind and disabled, children, and adults.

Although not explicitly stated, the alltoment approach driven by underlying per capita caps would imply that federal dollars could be spread across the different eligiblity groups at state discretion regardless of the eligibility group-specific cap.</td><td>Caps would be based on costs in 2016, updated for inflation.</td><td rowspan="2">The caps would grow at "a rate slower than current law."

The proposal does not address any future rebasing.</td><td rowspan="2">The proposal does not explicitly address any specific approach to state differences.</td><td rowspan="2">The proposal does not explicitly address a state's obligation to contribute towards Medicaid costs.</td><td>States that expanded Medicaid eligibility under that ACA would receive an allotment based on current levels of spending for these enrollees, but over time, the enhanced FMAP associated with these costs would be phased down to the normal FMAP. States would also be allowed to spend these dollars on other, more vulnerable populations with the goal of "transitioning many of the able-bodied adults from Medicaid into commercial coverage."</td></tr>
<tr><td>Includes a state option for a block grant</td><td>A block grant would include all spending categories.</td><td>A block grant would provide a lump-sum for all eligible enrollees.</td><td>A block grant would be based on "current" spending.</td><td>Under a block grant, for states that have expanded Medicaid eligibility, some portion of the allotment would be phased out under the assumption that the expansion population would be transitioned into other non-Medicaid coverage.</td></tr>
<tr><th colspan="7">STATE BENEFIT DESIGN</th></tr>
<tr><th colspan="6">State Flexibility</th><th>Federal Accountability</th></tr>
<tr><td colspan="6">Although not explicitly stated for the per capita cap option, the plan appears to limit flexibility around both eligibility and benefit design for both elderly and disabled enrollees under both financing options. Some of the design flexibilities outlined below could be used by states to generate savings in expenses for adults and children in order to offset any costs above the category-specific cap for aged and disabled enrollees. Some of the explicit allowable flexibilities outlined in the plan for states' use include:
• Work or job training requirements for able-bodied adults;
• Premium assistance or limited benefit plans for "work-capable" adults;
• "Reasonable, enforceable" premiums for most non-disabled adult enrollees;
• Cost-sharing subsidies for eligible adults enrolled in an employer plan;
• Incentives for wellness and healthy behaviors;
• Broad new flexibilities for populations and benefits that are currently optional under federal law, including premiums, limited benefit packages, waiting lists, and enrollment caps;
• Automatic renewals of waivers that have been renewed twice by CMS in the past; and
• Reform of the waiver process to set time limits on CMS approval.</td><td rowspan="2">States would be required to report to the federal government on measures related to access, costs, and care quality.</td></tr>
<tr><td colspan="6">Under the block grant option, states would receive "maximum flexibility" around eligibility and program design for non-disabled, non-elderly enrollees. The plan would preserve current benefit requirements for all elderly and disabled enrollees.</td></tr>
</table>

PARTING WORDS

The years of work ahead to reform Medicaid at both the federal level and in Tennessee are sure to be full of trade-offs. Accomplishing the goals of reducing federal spending while increasing state flexibility comes with a number of choices that federal policymakers will have to address. These choices, of course, will drive the choices that our own state's lawmakers will then have to make using their own goals to guide their action. And at all levels, these choices will have to be weighed with other goals – like preserving access to care for the most vulnerable.

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