Insight

Medicaid Reforms in the Better Care Reconciliation Act

TARA O'NEILL HAYES | JUNE 28, 2017

Last week, the Senate released the Better Care Reconciliation Act (BCRA), its version of legislation to repeal and replace the Affordable Care Act (ACA). Nearly 60 percent of the legislative text is dedicated to provisions affecting Medicaid. Among the most significant of these provisions are the changes to the way in which the Federal government will finance its share of the program's costs. If passed, this legislation will provide some of the most significant entitlement reforms in decades. Such reforms are long overdue, as the Medicaid program has become unsustainable for both the Federal and state governments.

Medicaid Expansion

Under the ACA, states were provided the option, beginning in 2014, of expanding eligibility for Medicaid to childless adults earning up to 133 percent of the federal poverty level (FPL); these individuals are referred to as the expansion population. To date, 31 states, including the District of Columbia, have chosen to expand their Medicaid program in such a way. The federal government covered all costs for these individuals in the first 3 years; beginning in 2017, the percentage of costs covered by the federal government is gradually reduced until eventually leveling off at 90 percent in 2020, where it would remain indefinitely under the ACA.

The BCRA would instead continue the reduction in the federal financing of these costs by an additional five percentage points in each year from 2021 to 2023, when the Federal share would be 75 percent. In 2024 and subsequent years, the share of costs for the expansion population covered by the federal government would be the same as it is for all other Medicaid enrollees in each state, ending the preferential treatment for such individuals. States would still be allowed to cover this population under their Medicaid program, but they would no longer receive additional funding relative to what is provided for the lowest-income beneficiaries—children, non-expansion population adults, the elderly, and disabled individuals.

Financing Reform

The current financing structure of the Medicaid program makes it an open-ended entitlement program with a limitless draw on Federal revenues. Consequently, total Medicaid expenditures increased 11.6 percent between 2014 and 2015, but Federal taxpayers shouldered an outsized portion of that burden—the federal share of Medicaid expenditures grew 16 percent that year, after growing 13.6 percent the year before.[1] Following passage of the ACA, the federal government's share of the program's overall cost has grown from 57 percent to 63 percent.[2] This cost growth is unsustainable. The reforms presented in this legislation offer the chance to save the program so that our country's most vulnerable citizens will continue to have access to the care they need. Without such reforms, other spending reductions would have to be made, likely in the form of reduced provider reimbursement rates.

Medicaid provider participation is already so low in many parts of the country because of the program's low payment rates that it impedes beneficiaries' ability to see doctors in a timely manner. Physicians are much less likely to accept new Medicaid patients (69 percent) than Medicare patients (84 percent) or privately-insured individuals (85 percent) [3], and that likelihood is correlated with each state's Medicaid provider reimbursement rates.[4] As a result, many Medicaid recipients still seek primary care in the emergency room, rather than a doctor's office.[5]

Per Capita Caps

Under the BCRA, beginning in 2020, the Medicaid program would no longer be an open-ended entitlement program but rather one primarily financed through per capita allotments—fixed amounts of funding per person enrolled.[6] This financing reform would not change who is eligible for the program, and the states would continue to receive federal funding for every enrolled individual. Federal funding for each group of enrollees covered by this change would be based on historical averages, and would grow over time by a pre-determined amount. Any excess costs would have to be covered by the state.

For most individuals, states would receive a fixed amount of federal funding for each enrollee, depending on the enrollee's category of eligibility and historical expenditures for that group.[7] Providing different funding amounts for each individual based on the category by which they are eligible for the program ensures that an appropriate and proportionally consistent amount of funding is provided regardless of any change in a state's enrollment mix across eligibility categories. These allotments would maintain the federal government's current share of Medicaid financing, based on each state's existing federal matching assistance percentage (FMAP) (except for the current enhanced FMAP for expansion population enrollees, which would be reduced to match that of each state's other enrollees, as discussed above).[8]

The five categories of enrollees (collectively referred to as Section 1903A enrollees) affected by this financing reform are children, adults, expansion population adults, elderly, and disabled. Individuals specifically excluded, who will continue to receive federal financing as they do now, include children enrolled in the Children's Health Insurance Program (CHIP), blind and disabled children under age 19, individuals eligible for coverage of breast and cervical cancer treatment, individuals receiving assistance through an Indian Health Service facility, and certain partial-benefit enrollees. Furthermore, certain types of Medicaid payments and expenditures would be excluded from the calculation of total medical assistance expenditures, such as Medicaid disproportionate share hospital (DSH) payments, Medicare cost-sharing payments, and safety-net provider payment adjustments in non-expansion states[9]; other non-DSH supplemental payments would be included in the capped allotment.

The amount provided for each eligible enrollee would be based on average medical assistance expenditures per person during the base period and increased each year by a specific rate of growth, discussed further below. States would be allowed to choose the base period upon which initial payment rates and targets will be set from any consecutive two-year period between October 2013 and June 2017—notably, this period includes the years with the highest rates of cost growth. Average per capita annual expenditures for each of the specified five eligibility categories during this base period would be increased by the rate of growth in the medical care component of the consumer price index (CPI-M) from the end of the base period to September 2019 to determine each group's provisional target for FY2019. Going forward through 2024, the growth rate to determine the target expenditure amounts for children, adults, and expansion population adults each year will continue to be CPI-M. For the elderly and disabled, the targets will grow each year by CPI-M plus one percentage point. In 2025 and subsequent years, the target growth rate for all enrollee categories will be the general rate of inflation (CPI-U) from September of the prior fiscal year to the current year.

If a state's total medical assistance expenditures for all of its Section 1903A enrollees exceeds the aggregate target amount for all such enrollees in a given year, then the federal expenditures provided to the state in the following year will be reduced by the federal government's share of the excess (based on the state's FMAP). Because expenditures will ultimately be considered on an aggregate basis for all enrollee categories, states will not be penalized if expenditures for a single enrollee group exceed their target, so long as equal savings can be achieved across the remaining categories.

In order to reward states that keep costs down, states would receive a slight increase (between 0.5 and 2 percent, to be determined by the Secretary of Health and Human Services) in their target per capita amount in the following year for any enrollee category in which state's per capita expenditures for a year are less than 25 percent of the national average per capita expenditures for that enrollee category. Similarly, states with expenditures exceeding the national average by 25 percent or more would be penalized by having an equal reduction in their target for any such enrollee category in the following year.

Block Grant

For a select group of Medicaid enrollees, states may instead choose to receive a block grant instead of per capita allotments to finance their Medicaid program. The block grant would provide states additional flexibility regarding program requirements pertaining to eligibility and services covered, but—unlike the per capita allotment provision—would not provide guaranteed funding for each enrolled individual, and overall funding would grow at a slower rate than that allowed under the per capita allotment.

The block grant option would only be available for non-elderly, non-disabled, non-expansion adults. States choosing this option would be required to submit an application for participation in the Medicaid Flexibility Program, and each program period would be for five consecutive years. States must provide details regarding the conditions for eligibility under the program; the types, amount, duration, and scope of services which will be available; and a plan for notifying current enrollees of the proposed changes. Further, the state must agree to submit regular enrollment reports and statistical information, as well as annual reports pertaining to the quality of care provided to program enrollees. Public notice and comment periods would be required as part of the application process.

Funding under the block grant in the first years would be similar to the amount that would otherwise be provided for such individuals if they were being covered under the per capita allotment option. Funding would be equal to the Federal government's share of the target expenditures that would otherwise be applied to the state (based on the state's FMAP) multiplied by the number of people covered under the block grant two years

prior to implementation, with an adjustment made for any increase in the state's population plus three percentage points. In subsequent years, the block grant amount will be increased by the rate of growth in CPI-U from April to April each year. Any excess funds in a given year may be kept by the state and rolled over for use in the following year, so long as the state uses a certain percentage of such funds (ranging from 65 to 85 percent) to provide health assistance to program enrollees.[10] Upon satisfying this maintenance of effort requirement, the state may also choose to use any remaining block grant funds for non-health care related programs, including infrastructure, if such uses are otherwise consistent with the quality standards established by the Secretary for the program. States failing to meet their targeted funding obligations will subsequently have their funding reduced by an equal amount in the following year.

States would be able to modify eligibility for the program, but they must continue covering those individuals currently required to be covered.[11] The health assistance provided may differ from the medical assistance provided to Medicaid enrollees covered outside the block grant, but coverage of certain services would still be required, including mental health and substance use disorder services.[12] The actuarial value of services provided must be at least 95 percent, and beneficiaries could be required to contribute no more than five percent of household income. States may not terminate the program unless they have a transition plan approved by the Secretary in place.

New Quality Performance Bonus Payments

The BCRA would establish a new quality performance bonus program for Medicaid and CHIP. Bonus payments would be available to states that meet certain quality metrics and have aggregate expenditures for Section 1903A enrollees (excluding non-expansion population adults) far enough below the state's targeted amount, all of which is to be determined by the Secretary of HHS. Bonuses provided would be equal to $8 billion between FY2023 and 2026.

DSH Payments

Each year, states receive various forms of supplemental funding for their Medicaid programs; these payments are primarily funded by the federal government through Disproportionate Share Hospital (DSH) payments. The ACA imposed reductions to Medicaid's future DSH payments on the grounds that fewer people would be uninsured and therefore the payments would not be as crucial. The BCRA would restore these payment cuts for states that did not expand Medicaid, lessening the blow to hospitals in these states caused by the ACA's payment reductions.

Optional Work Requirements

The BCRA would allow states the option of instituting conditional "work requirements" for select Medicaid enrollees. Any work requirements would only be allowed to apply to non-disabled, non-elderly adults, excluding pregnant women, individuals under age 19, and individuals who are the sole caretaker of a child under age six or with disabilities. The definition of "work" would match that of the Temporary Assistance for Needy Families (TANF) and includes activities relating to on-the-job training and education, as well as participating in job search and readiness programs and community service. Such a provision is intended to help ensure that the Medicaid program is a well-functioning part of the social safety net which helps lift able-bodied individuals out of government dependency and into a life of self-sufficiency.

Conclusion

The BCRA will provide much-needed entitlement reform to the Medicaid program. The ACA's Medicaid expansion of eligibility will continue, but the federal government's share of the funding for such individuals will be reduced beginning in 2021. Additionally, Medicaid will be transformed from an open-ended entitlement program to one financed through federal per capita allotments. Federal financing will vary for each group of eligible enrollees to reflect their historical costs and will grow at a fixed rate over time. States will be required to fund any costs in excess of the federal payments, requiring states to find more cost-efficient means to deliver care.

[1] https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2016.pdf

[2] https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2016.pdf

[3] https://www.cdc.gov/nchs/data/databriefs/db195.pdf,

[4] http://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&selectedDistributions=all-services–primary-care&selectedRows=%7B%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[5] http://www.oshpd.ca.gov/documents/PressReleases/2017/ED-Encounters-by-Expected-Payer-2012-2016.pdf

[6] Certain individuals and certain types of Medicaid expenditures would be excluded from this change.

[7] Certain categories of individuals are excluded from this structural financing reform and states will continue to receive unlimited federal funding for such individuals, as provided under the current Medicaid program based on the state's FMAP.

[8] https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages

[9] Non-expansion states would be allowed to increase provider reimbursement rates to safety-net providers between 2018 and 2021 at full cost to the federal government, and in 2022, with the federal government paying for 95 percent of the increased cost.

[10] States would be required through a "maintenance of effort" provision to provide a percentage of the block grant funding received for targeted health assistance expenditures; this percentage would be equal to the State's CHIP FMAP, as defined by Section 2105(b) of the Social Security Act.

[11] https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

[12] State maintenance of effort provision requires states to spend a given amount on targeted medical assistance expenditures equal to the amount of the block grant multiplied by the state's enhanced FMAP provided under Section 2105(b) of the Social Security Act, which will not exceed 85 percent and will be at least 65 percent.