Medicaid Reform, Controlling Costs, Improving Quality

LFC Hearing

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Charles Milligan

Commissioner, MACPAC

CEO, UnitedHealthcare Community Plan of New Mexico

MACPAC

Background on MACPAC

- "Medicaid and CHIP Payment and Access Commission"
- Created by Congress in the 2009 Reauthorization of CHIP
- 17 Commissioners appointed by the Comptroller General of the US (head of GAO) to three-year rolling terms
- Full-time Executive Director and staff
- Typically convenes for 6-7 public meetings during the year
- For more information: macpac.gov

Purpose of MACPAC, per 42 USC Section 1396

- "Review policies of the Medicaid program . . . and the State Children's Health Insurance Program established under title XXI (in this section referred to as "CHIP")"
- "Make recommendations to Congress, the Secretary [of HHS], and States concerning such . . . policies"
- "By not later than March 15 of each year . . . submit a report to Congress containing . . . MACPAC's recommendations concerning such policies
- "By not later than June 15 of each year . . . submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs
- "Submit an annual report to Congress on disproportionate share hospital payments"
- Otherwise make recommendations to Congress and the Secretary of HHS on access, quality, payment policies, dual eligibles, eligibility, proposed regulations, and other policies

Alternative Financing Models: Basic Approaches

1. Block grants

- Lump sum grants to states based on a predetermined formula
- States spend funds on a specified range of activities
- States typically do not provide matching funds, but could be subject to a maintenance-of-effort requirement on existing spending

2. Capped allotments

- Overall cap on total federal contribution with state-specific grants
- Federal funds are provided as matching payments to the states up to the cap
- States are required to contribute state share to draw down federal allotment
- Financing approach used in the State Children's Health Insurance Program (CHIP)

3. Per capita caps

- Per enrollee limits on federal payments to the states
- Federal spending increases based on the number of enrollees and legislated growth factor
- States responsible for any spending above the fixed per capita payment with no federal matching funds

Medicaid Provisions of American Health Care Act (H.R. 1628)

Status

- House bill to repeal and replace the Affordable Care Act and restructure Medicaid
- Congressional Budget Office (CBO) estimates:
  - **Reduces federal outlays for Medicaid by $834 billion over the 2017-2026 period**
  - **Lower Medicaid enrollment by 14 million (17 percent) by 2026**
  - **In New Mexico, the CBO's estimated effect would be a loss of $11.7 billion in federal funding over ten years**
- Passed in the House on May 4, 2017

AHCA: Medicaid Expansion

- Codifies the expansion to the new adult group as optional and eliminates state option to expand above 133 percent federal poverty level (FPL)
- Prohibits non-expansion states from expanding
- Reduces enhanced matching rates:
  - **Eliminates enhanced matching rate for new adult group and for pre-ACA expansion states as of January 1, 2020**
  - **Enhanced match only continues for existing enrollees who do not have more than a 30-day break in eligibility**

AHCA: Selected Additional Medicaid Provisions

- Directs states to count qualified lottery winnings or lump sum incomes in determining eligibility
- Eliminates retroactive eligibility requirement
- Ends hospital presumptive eligibility (PE) and PE for adults
- Ends requirement to cover 10 essential health benefits in Medicaid
- Requires six-month eligibility redeterminations for new adult group and individuals with incomes above 133 percent FPL (under ACA-established pathway)
- Provides state option to establish a work requirement for non-disabled, non-elderly, non-pregnant adults
- Maintains scheduled DSH allotment cuts for expansion states for FY 2018 and 2019
- Eliminates DSH allotment reductions for all states beginning in FY 2020

AHCA: State Flexibility

- States must choose between block grant approach and per capita cap approach
- No changes to state flexibility or requirements under the per capita cap approach
- Block grant provision would substantially change requirements for states, yet there would still be mandatory populations, and mandatory services, for example:
  - **Health care for children under 18 years of age**
  - **Hospital care**
  - **Surgical care and treatment**
  - **Medical care and treatment**
  - **Obstetrical and prenatal care and treatment**
  - **Prescribed drugs, medicines, and prosthetic devices**
  - **Other medical supplies and services**

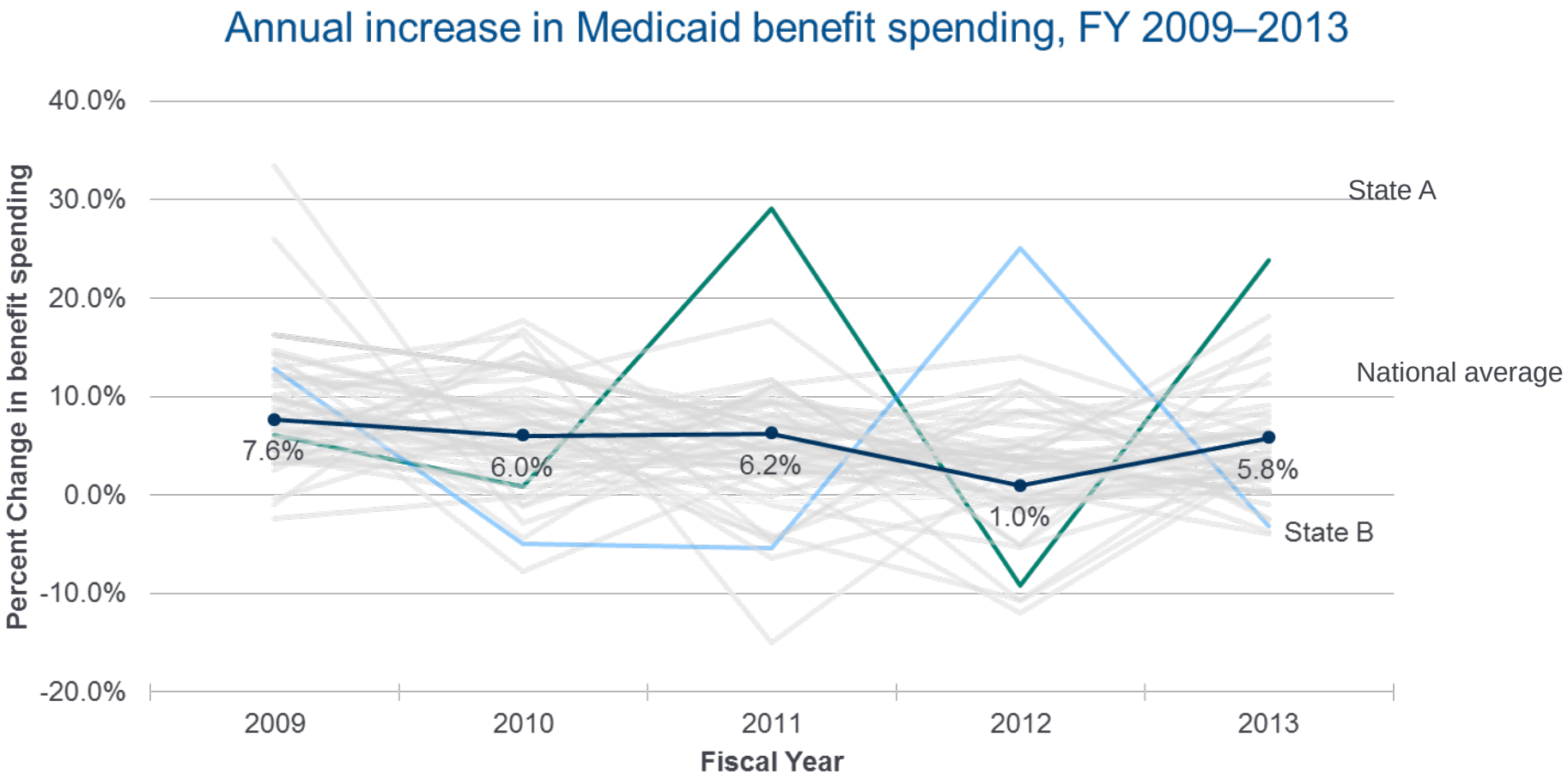
Financing Alternatives: Key Design Elements

Design Elements
Establishing Spending Limits

- Base year
- Growth factors (inflation factors)
- Carve-outs, e.g:
  - DSH
  - Medicare cost sharing
  - IHS and Native Americans
  - Administrative Costs
  - Vaccines for Children
- State-specific impacts
- Enrollee-specific impacts

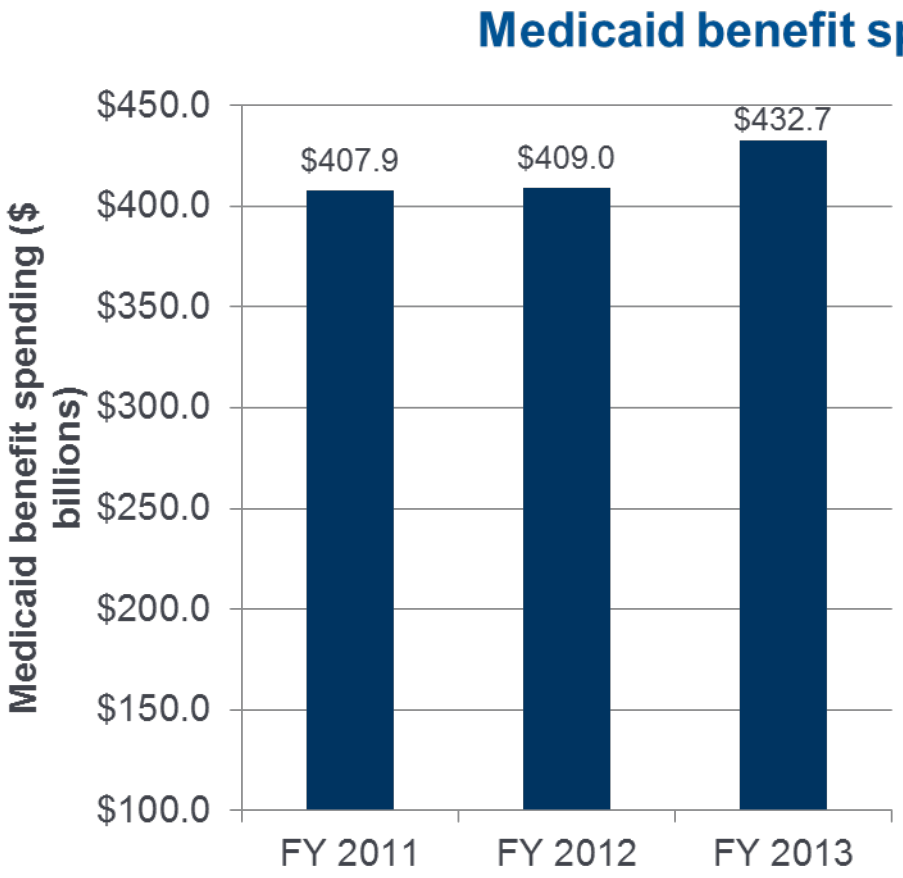
Choice of Base Year

Analysis: State spending can fluctuate substantially from year to year



Source: MACPAC analysis of FY 2008–2013 CMS-64 net financial management report.

Analysis: Later base year with higher spending does not always lead to a higher future federal spending



- Total spending increased each year from FY 2011–2013
- However, using FY 2012 or FY 2013 as the base year will not necessarily lead to a higher block grant or per capita cap
- Depends on how the growth factor used for the cap compares to actual trend between base year choices

Source: MACPAC analysis of CMS Office of the Actuary, 2016, 2015 Actuarial report of the financial outlook for Medicaid.

Choice of Growth Factors

Growth factors

- After choosing a base year, block grants and per capita caps inflate permissible spending for future years by a specific growth factor
- The growth factor could benchmarked to:
  - **Experience of other payers (e.g., Medicare, private insurance)**
  - **Price inflation (e.g., consumer price index for all urban consumers (CPI-U))**
  - **Medical price inflation (e.g., medical care component of consumer price index (CPI-M))**
  - **Economic output (e.g., gross domestic product (GDP))**

Average annual growth in Medicaid spending per enrollee compared to various benchmarks, by calendar year

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Average annual percent growth in spending per enrollee by source of coverage																
Medicaid[1]	-1.0	3.0	-3.6	4.1	-0.3	3.8	1.1	1.6	4.5	4.5	4.6	4.6	4.7	4.8	5.1	5.2
Medicare	1.7	2.6	0.3	0.0	1.9	2.2	1.4	3.2	4.7	5.2	5.2	4.7	4.8	5.0	4.7	4.0
Private health insurance[2]	5.9	4.1	1.8	2.3	3.3	4.5	5.0	5.9	5.2	5.1	4.2	4.6	4.7	4.7	4.7	4.6
Average annual percent growth in prices and economic output																
CPI-U	1.6	3.2	2.1	1.5	1.6	0.1	1.2	2.4	2.3	2.3	2.4	2.4	2.4	2.4	2.4	2.4
CPI-M[3]	3.4	3.0	3.7	2.5	2.4	2.6	3.8	3.8	4.3	4.2	4.2	4.2	4.2	4.2	4.2	4.2
GDP	3.8	3.7	4.1	3.3	4.2	3.7	2.9	4.2	3.9	3.6	3.5	3.8	3.9	4.0	4.0	4.0

Notes: CPI-U is consumer price index for all urban consumers. CPI-M is the medical care component of the CPI-U. GDP is gross domestic product.
[1]Medicaid per person spending growth includes federal and state spending on Medicaid benefits and administration.
[2]Private health insurance includes employer-sponsored coverage and direct purchase coverage and medical spending and corresponding net costs of property and casualty insurance. Direct purchase coverage includes Medicare supplemental and individually-purchased plans, including plans purchased on the exchanges.
[3] CPI-M from the Office of the Actuary of the Centers for Medicare & Medicaid Services (OACT). In their scoring of the American Health Care Act, the Congressional Budget Office (CBO) projected that CPI-U medical care would grow at an average annual rate of 3.7 percent from 2017–2026.
Sources: MACPAC compilation of CPI data from the Bureau of Labor Statistics; CBO, 2017, Budget and economic data, https://www.cbo.gov/about/products/budget-economic-data#3; and OACT, 2017, national health expenditure amounts by type of service and source of funds, CY 1960-2015 and national health expenditure amounts by type of expenditure and source of funds: CY 1960-2025 in projections format, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html.

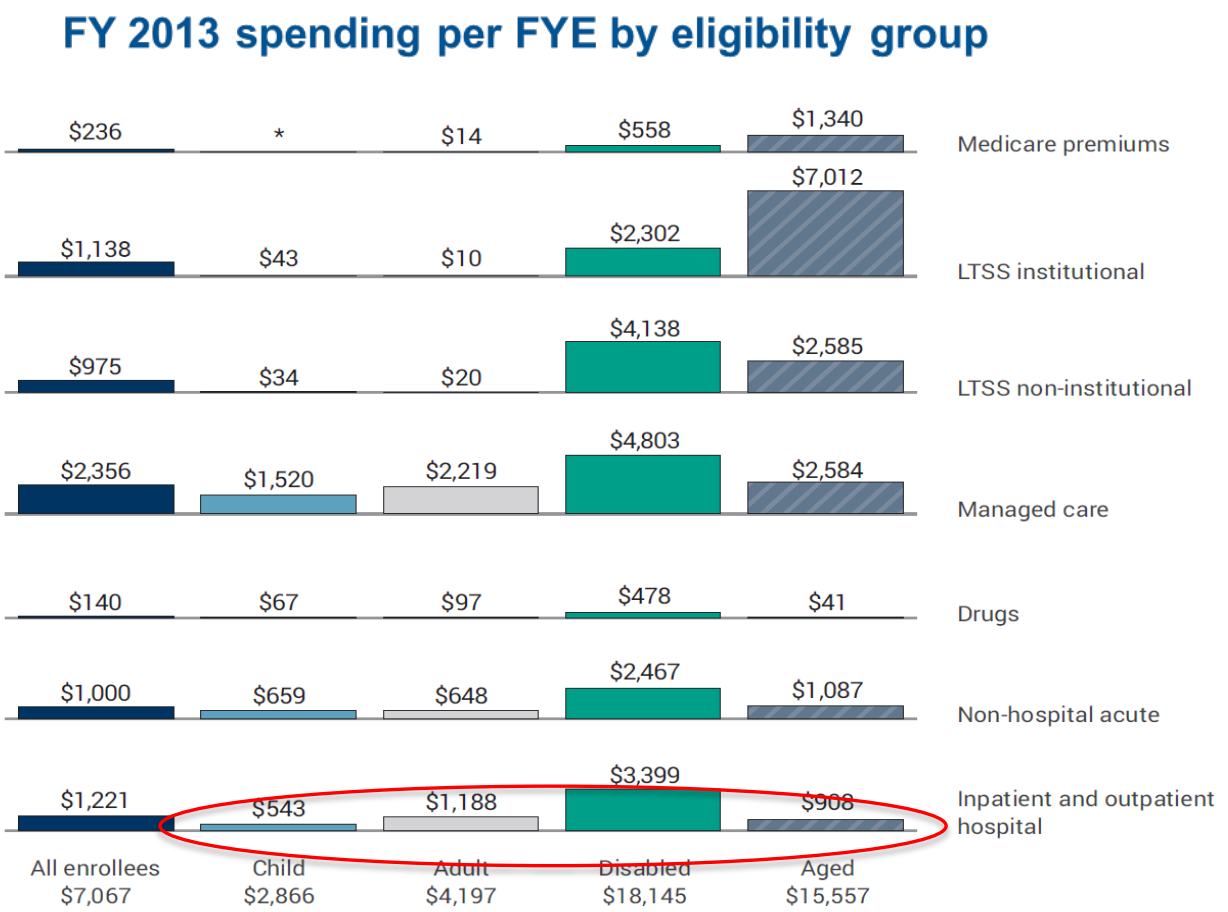
Analysis: Spending for children and non-expansion adults is projected to grow much faster than CPI-U

Fiscal Year	AHCA trend (CPI-U)	Projected growth for children			Projected growth for non-disabled, non-elderly, non-expansion adults		
		Total spending	Enrollees	Spending per enrollee	Total spending	Enrollees	Spending per enrollee
2021	2.6%	6.2%	1.4%	4.8%	6.4%	1.2%	5.1%
2022	2.6%	6.3%	1.3%	4.9%	5.8%	0.6%	5.2%
2023	2.6%	6.0%	1.0%	4.9%	5.9%	0.6%	5.2%
2024	2.6%	6.0%	1.0%	5.0%	5.9%	0.6%	5.3%
2025	2.6%	5.7%	0.6%	5.0%	5.9%	0.6%	5.3%

Notes: AHCA is American Health Care Act. CPI-U is the consumer price index – all urban consumers.
Source: MACPAC analysis of CMS Office of the Actuary (OACT), 2017, 2016 Actuarial report on the financial outlook for Medicaid.

Impact of Changes in Enrollment Mix

Analysis: Average spending per enrollee varies by major eligibility group



Notes: FYE is full-year equivalent. FY is fiscal year. LTSS is long-term services and supports. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Excludes Idaho, Louisiana, and Rhode Island due to data reliability concerns regarding completeness of monthly claims and enrollment data. * Values less than $1 are not shown.

Source: MACPAC, 2016, *MACStats*, Exhibit 19, December 2016.

Enrollee groups as defined for per capita caps

- Covered eligibility groups
  - **aged**
  - **disabled**
  - **children**
  - **non-expansion adults**
  - **new adult group**
- Number of enrollees for a year is defined as average monthly enrollees or FYE

Analysis: Spending for newborns is about four times that of other children, which per capita cap would not address

Average benefit spending per FYE for children by eligibility and age group, FY 2013

Age group	Eligible on basis other than disability	Eligible on basis of disability
Less than 1 year	$9,172	$95,428
1-5 years	$2,709	$24,622
6-14 years	$2,232	$15,223
15-20 years	$3,143	$17,307
Total	$2,863	$17,950

Note: FYE is full year equivalent. Includes federal and state funds. Excludes spending for administration. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Excludes Idaho, Louisiana, and Rhode Island due to data reliability concerns regarding the completeness of monthly claims and enrollment data.
Sources: MACPAC analysis of Medicaid Statistical Information System data as of December 2015 and analysis of CMS-64 financial management report net expenditure data from the Centers for Medicare & Medicaid Services as of June 2016.

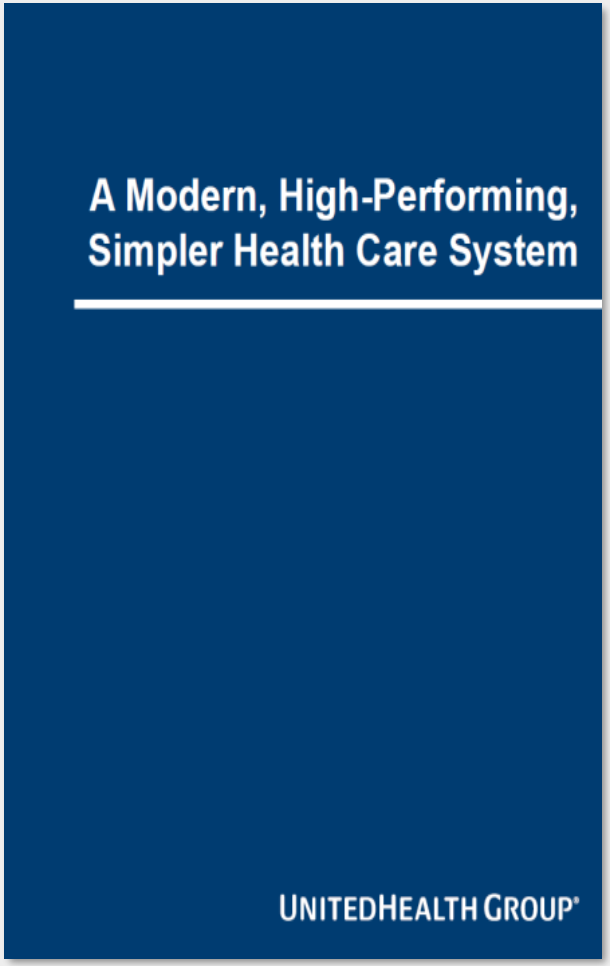
Federal Activities at HHS

Letter from Secretary Price to Governors

- Invitation to pursue 1115 waivers
- Invitation to include in those waivers, with respect the Medicaid expansion population especially:
  - **Features that look like commercial insurance**
    - **No retroactive coverage**
    - **More commercial-like benefit package**
    - **Cost sharing, including premiums and copays**
  - **Features that look like welfare reform**
    - **Work requirements**
    - **Drug testing**

UnitedHealthgroup

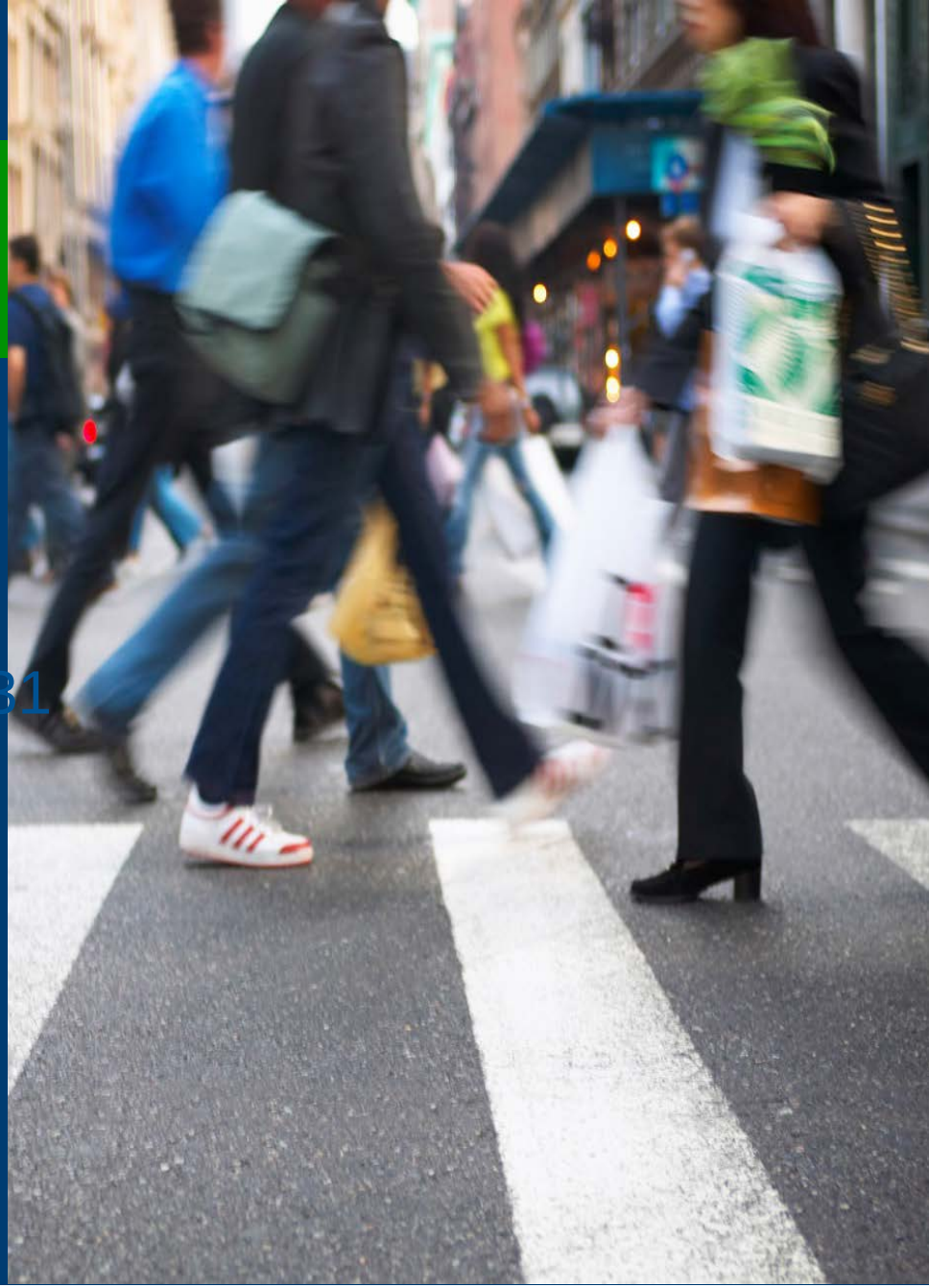
UHG's Thought Leadership Platform



A comprehensive set of health care modernization solutions released by UHG in the summer of 2016.

Improve Access to Care

- State-Based Health Care Market Solutions
- Immediate Actions to Stabilize Coverage



Make Health Care More Affordable

- Repeal Health Care Taxes
- Pay for Value
- Empower Consumers

Make Prescription Drugs More Affordable

- Value-Based Pricing
- Leverage Pharmacy Care Services in Government Programs
- Priority-Based FDA Reviews
- Timely Generic Market Entry

Strengthen and Modernize Medicare

- Support Medicare Advantage
- Modernize Original Medicare

Reinvest in Health

- Create a 21st Century Health Workforce
- Invest in Medical Research
- Accelerate Interoperability
- Prioritize Prevention

Conclusion