Annual Summer Conference
July 21, 2017 – Grand Traverse Resort

General Session—The Future of Medicaid

Panelist: **Chris Priest, (Michigan Medicaid Director)**

Jeff Myers, (CEO, Medicaid Health Plans of America)

Moderated by Rick Murdock, President of R.B. Murdock Consulting and MAHP Consultant

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- **Session Outline**

1. Panelist broad overview of changes that may be taking place in Medicaid
2. Two Scenarios (there is no status quo)
   - Congress does enact legislation---from what we know, what can we expect—when can we expect changes—and what is likely impact to Medicaid and how can/must we act.
   - Congress does NOT enact legislation —therefore rely more on regulatory changes to be handled by CMS (Seema Verma/Dr. Price)—what would that mean for Michigan and what would that mean overall for Medicaid—this also assumes MegaRule continues
3. Likely Future Impact on:
   - Medicaid Expansion (Healthy Michigan)
   - Benefit adjustments?
   - Innovations (SIM), Integration (Behavioral) Additional Expansion of Managed Care (LTSS)
   - Future Financing of Medicaid (current reliance of Provider taxes, special financing arrangements may change?
   - "Maintenance of Effort" Requirements (Impact for Per capital approach or block grant)
   - Path Forward for Waiver (1332?)

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According to Michigan Senate Fiscal Agency, in total, the BRCA, ***if enacted, would lead to significant GF/GP cost increases for the State, ones that would trigger, barring statutory changes, the termination of the Healthy Michigan Plan. If one leaves aside the trigger issue, the SFA estimates that, in FY 2023-24, the State would spend about $800.0 million more GF/GP to continue the same level of Medicaid services.***

- **Key Medicaid Related Services in The BRCA,**
  - Reduction of Retroactive Eligibility (Also in AHCA)
  - Provide 50.0% Federal match funding for Medicaid covered services provided to people between the ages of 21 and 64 who are in institutions for mental disease (IMD). (This provision was not included in the AHCA)
  - **Reduces cap on Medicaid provider taxes** from 6.0% in FY 2019-20 down to 5.0% in FY 2024-25, with a decrease of 0.2% per year in the cap. (This provision was not included in the AHCA.)

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- **Key Medicaid Provisions of BCRA:**
  - Allows states to implement a **work requirement** for certain Medicaid recipients, basically non-disabled, non-elderly, non-pregnant adults who are not caretakers of children under 6 or disabled children (Similar provision in AHCA)
  - The bill would, effectively, **eliminate funding for Planned Parenthood** for one year following enactment. (A similar provision was in the AHCA.)
  - **No changes to the reductions in disproportionate share hospital** (DSH) payments (The original version of the AHCA restored these reductions for all states.)
  - **Changes the Federal match rate for expansion Medicaid**, reducing it down to the traditional Medicaid match rate over a period of four years. (AHCA took a different approach, maintaining the enhanced 90.0% Federal match rate for expansion Medicaid for ongoing cases beyond January 1, 2020, but reimbursing new expansion Medicaid cases at the state's regular match rate)
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- **Implement expenditure caps** on various Medicaid eligibility categories (elderly, blind or disabled, children, expansion Medicaid, and all other eligibles). The base period for the cap would be a state-chosen eight consecutive calendar quarters between January 1, 2014 and September 30, 2017. The spending for each category in that base period would be inflated by various consumer price index (CPI) measures to create a cap in each fiscal year starting in FY 2019-20 (Medicaid CPI +1.0% for elderly, blind, and disabled and medical CPI for other categories up until FY 2024-25, when the inflation measure would be urban CPI).

  If a state exceeded its cap its Federal Medicaid match funding would be reduced by ¼ of the excess in each quarter of the next fiscal year. A similar provision, with differences in the inflation measures used and the base period, was included in the AHCA.

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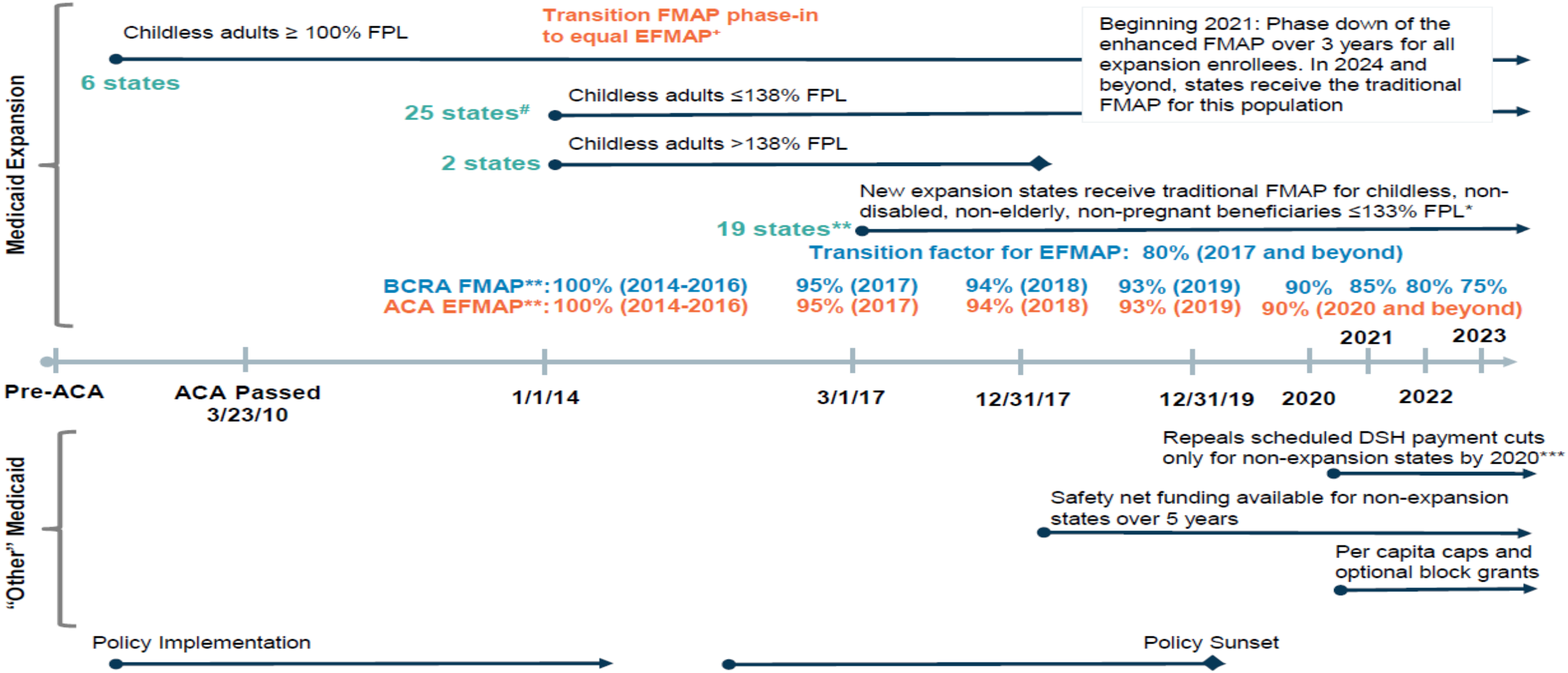
- The bill would give the State the **option of receiving its Medicaid funding as a block grant**. The block grant would be based on the base period expenditure cap trended forward based on the urban CPI (not the medical CPI) and statewide population growth.

  States would still be required to cover most basic medical services and the actuarial value of the coverage would have to be at least 95.0% of the aggregate benchmark coverage set under the ACA. States would have to meet maintenance of effort requirements as well. Cost sharing could not exceed 5.0% of family income. A similar provision was included in the AHCA.

Timeline of Medicaid Coverage and Funding Changes Under BCRA



+The ACA provided for a transition matching rate between 2014-2019 to equal ACA EFMAP in states that expanded eligibility above 100% FPL pre-ACA
*BCRA eliminates option to extend coverage to adults above 133% FPL after 12/31/2017
#Wisconsin covers childless adults at 100% FPL as of January 2014, but is not an expansion state
**States have not expanded Medicaid to date
***Non-expansion states may be eligible for increase in DSH payments if their per capita Medicaid DSH allotment amount is below the national average per capita Medicaid DSH allotment amount
Orange denotes policy under the ACA; Blue denotes proposed policy under BCRA
ACA: Affordable Care Act; BCRA: Better Care Reconciliation Act of 2017; EFMAP: Enhanced Federal Medical Assistance Percentages; FPL: Federal Poverty Level

Medicaid Health Plans of America