GOVERNORS' ACA REPLACE AND REFORM WORKING PAPER 1: MEDICAID
DRAFT EXECUTIVE SUMMARY

GUIDING PRINCIPLES

- ➔ Obamacare is unsustainable.
- ➔ Replace and reform must be simultaneous with repeal.
- ➔ It is better to get it right than go too fast – avoid the mistakes of Obamacare.
- ➔ Stabilizing the private insurance market should be the first priority.
- ➔ States support fundamental reform to the Medicaid entitlement.
- ➔ There is no one-size-fits-all solution for states – Medicaid reform must include options regarding funding structure and affected populations.
- ➔ Significant state flexibility and control must accompany structural financial changes.
- ➔ Equity across states must be established – states must have equal access to federal resources to achieve their coverage and access to care goals.
- ➔ State-federal relationship must be fundamentally rebalanced, both from an administrative and financial perspective.

KEY ELEMENTS

- Medicaid will be structurally reformed.
  - States would have choices between per capita caps and block grants to cover their expansion populations, and with equitable access to federal resources for non-expansion states willing to enact reform
  - States would be able to phase-in other populations at their discretion
- States must be granted significant additional authorities to manage increased risk associated with structural reform.

OPTION 1—PER CAPITA CAPS

Under this option, states would assume the increased risk associated with capped funding for benefits per Medicaid enrollee, but would continue to share risk with the federal government for population growth. This option would be based on federal match of expenditures by the state up to the amount(s) determined by the per capita cap(s).

Eligibility Categories - Each eligibility category would have its own per capita cap. A transition to this model would start with the childless adult and parent populations for whom a state is receiving enhanced match, and could be followed by additional populations at the state's discretion. Phasing in the per capita cap by population will provide states appropriate time to address issues and differences that are inherent with each eligibility category across states.

Per Capita Cap Base Year and Growth Rate - There are several options for consideration in establishing per capita cap amounts and growth rates that need to be modeled for coverage and cost.

Adjustments to the Growth Rate –There should be an annual adjustment of medical CPI plus an additional percentage adjustment to address underlying costs. However, reductions to this additional adjustment over medical CPI should be discussed as states receive additional flexibilities to adequately address underlying costs. There should be consideration of an adjustment factor that would be triggered by specific national economic events.

OPTION 2—BLOCK GRANTS FOR NON-ELDERLY, NON-DISABLED POPULATIONS

Under this option, similar to the per capita cap model, a state would be required to convert financing for the adult expansion population into a block grant and could choose to phase in other populations. Potential block grant populations are the same as those listed under the per capita cap model, except for the disabled and elderly eligibility groups.

State funding for the block grant would switch from matching to a maintenance-of-effort (MOE) and Medicaid would be broken into the following parts under a new section of Title XIX:

- Under a new Part A, the adult expansion population and other non-disabled, non-elderly populations of a state's choosing would be served through a Children's Health Insurance Program (CHIP)-like model. Allotments to states would be capped and indexed.
- Under a new Part B, Long Term Services and Supports (LTSS) would be delivered through a separate program that would level the playing field between home and community based services (HCBS) and institutional care.
- Under a new Part C, medical services for individuals with disabilities and low-income seniors would continue as under current law, regardless of which other block grants a state chooses to take.

FUNDING FLEXIBILITY AND CARRYOVER

Savings achieved through better program management could be used across all populations covered under a per capita cap or block grant. Additionally, similar to the CHIP program, states would have two years to spend any savings generated under these caps, but all savings must be spent within the Medicaid program.

SPECIAL POPULATIONS

As part of reform, financial responsibility for special populations should be borne by the federal government, and thus would not be included under either of the financing reform models described above. These include: American Indians and Alaska Natives; undocumented immigrants; refugees; and disaster victims not eligible for Medicaid. Additionally, the following populations must be addressed in reform: dual eligibles; and U.S. citizens and nationals in territories.

REDEFINING THE STATE-FEDERAL PARTNERSHIP

- Engage states during the pre-conceptual phase of work.
- Establish a distinct process for state Medicaid leaders to review federal regulation and guidance prior to finalization to ensure the policies proposed are operationally sound.

NECESSARY STATE AUTHORITY TO ENABLE REFORM

Authorities that should be extended to states to manage the increased risk associated with transitioning to a per capita cap or block grant model, without requiring a waiver from the federal government, should include changes to:

- Eligibility (Temporary eligibility, Modified Adjusted Gross Income (MAGI), enrollment limits, work requirements, etc.)
- Benefits (Cost-sharing, pharmacy, benefit redesign, benchmarks, comparability, etc.)
- Service Delivery (managed care, network adequacy, premium assistance, etc.)
- Payment (Change provider payment rate and structures, including FQHCs, etc.)

POLICY QUESTIONS FOR GOVERNORS

- **Policy Question 1** – Should states have an option to remain under the current structure with federal financial participation reduced to regular FMAP for the expansion population, rather than adopt a per capita cap or block grant model for this population?
- **Policy Question 2** – Should states propose reducing the upper limit for the enhanced match for adults from 138% FPL to 100% FPL and, if so, what are the conditions that need to be in place before making a change?

NEXT STEPS

- Circulate sign-on letter to demonstrate gubernatorial support for proposal.
- Charge current working group of Medicaid directors and advisors to engage with Administration and Congress to develop details of proposal, including OMB, Office of the Actuary, and CBO to ensure accurate analysis of fiscal impact and coverage.
- Establish working groups of advisors to develop additional ACA replace and reform proposals on the private insurance market and public health funding.