GOVERNORS' ACA REPLACE AND REFORM WORKING PAPER 1: MEDICAID

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.

OVERVIEW

Obamacare has destabilized the private health insurance market and set Medicaid on an increasingly unsustainable path for states and the federal government alike. While stabilizing and strengthening the insurance market should be the first priority, Congress and the Administration must recognize the interconnectivity between the private market, including the ACA Marketplace, and Medicaid. Access to affordable coverage outside of Medicaid for low-income individuals is critical to the effort to reduce reliance on Medicaid. As the primary regulators of private insurance and significant funders of Medicaid, states need to be equity partners with the federal government in developing and implementing reforms.

Each state must be permitted to pursue Medicaid transformation in its own way. Governors agree that Washington should not dictate a "one size fits all" solution to Medicaid. We believe that each state should support the ability of another to find a solution that fits their state from among a variety of options. Moreover, after decades of experience operating Medicaid through waivers, it is time to change the law itself.

We believe the following components, the details of which are below, must be included in any structural reform to Medicaid.

1. **States should be given a choice between converting their Medicaid financing to a per capita cap or block grant model for one or more population groups *[or a default option with reduced federal financial participation]*.** Regardless of which reform option a state elects, reform must allow states an appropriate transition period and the opportunity to use a partial and/or multi-phase approach to implementation. [*See attached policy questions for consideration*.]

2. **The nature of the current federal-state relationship needs to fundamentally change.** Significant new state flexibility and control will be required to effectively manage the financial risk associated with structural reform. Enhanced state authority will also enable states to design move innovative programs focused on achievement of state priorities and outcomes, rather than compliance with processes.

These components are interrelated. States cannot successfully administer a quality Medicaid program that grants significant flexibility in lieu of adequate funding. But a new financing structure that limits federal participation in Medicaid will transfer risk from the federal government to the states, so states must be granted meaningful relief from federal regulatory constraints that exist today in order to effectively manage that risk.

As we embark on this complex effort, we must ensure that individuals are not left without access to care, especially during any transition period. State-specific, innovative approaches have been developed by states to extend access to quality care and address the unique health needs of their citizens. Medicaid reform must allow states to maintain individualized aspects of their programs to foster stability, as well as the sharing of best practices among states.

STRUCTURAL CHANGES TO FINANCING

Equity across states should be a key guiding principle for Congress. All states, regardless of expansion status, should have equal access to federal resources to meet state-specific coverage and population health goals. States are pragmatic stewards of taxpayer dollars and must balance their budgets, which

will provide states appropriate time to address issues and differences that are inherent with each eligibility category across states.

Before applying the new financing mechanism to children and more complex populations, additional consideration is needed of the specific coverage needs for these populations. While states must include any adult populations for whom they are receiving enhanced match, a state could choose to implement per capita caps for any of the below populations. For states that choose to do so, we recommend the following prioritization for phasing in:

1. Childless adults;
2. Parents and caretaker relatives;
3. Children;
4. Pregnant women; and
5. Disabled and elderly.*

*States that choose to move this population under the per capita system would be allowed to discontinue Medicare cost-sharing for dual eligibles and the state contribution for the Medicare Part D "clawback." Thus, Medicare would become responsible for providing the Medicare cost-sharing for Medicare-eligible low-income seniors and people with disabilities in these states.

Per Capita Cap Base Year and Growth Rate

There are several options for consideration in establishing per capita cap amounts and growth rates. To inform the decision-making process and devise an equitable, transparent methodology, we recommend that the Congressional Budget Office (CBO) model each of the options below and provide estimated impact on a state-by-state and national level.

Base Per Capita Cap Amounts	Growth Rates
● State-specific per capita expenditures in the current base year for each eligibility group; OR ● National average per capita expenditures by eligibility group; OR ● State-specific per capita expenditures for existing population and national average for any new members.	● National average trend; OR ● Variable trend rate based on current spending relative to the national average to move states toward the mean over time – states below average would be trended at a higher rate and those above at a lower rate.

Adjustments to the Growth Rate

The per capita growth rate should account for the lack of control that states currently have of certain underlying costs (e.g. pharmacy, RHCs, FQHC PPS, Medicare Parts B & D). There should be an annual adjustment of medical CPI plus an additional percentage adjustment to address those underlying costs. However, reductions to this additional adjustment over medical CPI should be discussed as states receive additional flexibilities to adequately address underlying costs.

While per capita caps recognize the countercyclical nature of Medicaid, states would still be at significant risk in the event of a significant economic downturn. There should be consideration of an adjustment factor that would be triggered by specific national economic events. The Government Accountability Office (GAO) has done extensive work in this area, which should be evaluated in the

- *Dual Eligibles.* Medicare's inflexibility has greatly limited states' full potential to manage this population. By strengthening the duals office within CMS and allowing states more flexibility to manage this complex population, states can be strong partners in improving outcomes for these individuals. In addition, state responsibility for the rate of growth on Medicare Parts B & D should be capped at Medical CPI.

- *U.S. Citizens and Nationals in Territories.* Medicaid reform must include an equitable solution for individuals who are U.S. citizens or nationals who live in the territories. Territorial governments should not be expected to bear the cost for individuals who are not U.S. citizens or nationals.

REDEFINING THE FEDERAL-STATE PARTNERSHIP

Over the past eight years, states have not been treated as equity partners in the development and implementation of Medicaid regulation. Recent examples of rules implemented under this federal regulatory overreach include the new Medicaid managed care regulations, access requirements, mental health parity requirements, and the home and community-based services (HCBS) settings rule. While we support many of the objectives behind these rules, we strongly recommend that Congress suspend these rules and bring states to the table to best determine how to modify and operationalize the requirements being imposed upon states. Going forward, the federal rule-making and promulgation process should be reworked to incorporate the following two steps:

1. Engage states during the pre-conceptual phase of work.
2. 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.

Given that both of the options described above would transfer significant risk to the states, it is imperative that the federal-state partnership around Medicaid is transformed to ensure that states can efficiently and effectively manage their programs. A key part of this transformation must be a shift from the focus on process to a focus on outcomes. States and the federal government should agree to a set of performance standards and the federal government should only intervene when those standards are not being met.

NECESSARY STATE AUTHORITY TO ENABLE REFORM

The 1115 waiver process is not sufficient to enable effective state management of the Medicaid program. Under the financing reform options outlined above, the need for a waiver of any kind for the populations covered under a per capita cap or block grant model would be virtually eliminated. The state plan amendment process would be overhauled to focus on outcome improvement, rather than the lengthy procedural requirements that show no regard for improvements in population health.

Additionally, it is important to note that the ACA made some changes that were requested by states to improve Medicaid program performance, including Modified Adjusted Gross Income (MAGI) methodology for determining eligibility, home and community-based services (HCBS) state plan option, and extending federal drug rebates to pharmacy benefits administered by managed care organizations pharmacy rebate agreements. These flexibilities should be retained given that most states have already adopted one or more of these options and repealing these provisions would be disruptive to state operations.

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