Medicaid/CHIP: Moving Forward

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Chair, Government Relations & Public Policy
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Agenda

• Medicaid Origins
• Population Served
• Budget/Federal/State Share
• ACA Vision
• Who is in the Gap
• Waiver Strategies
Medicaid plays a central role in our health care system.
Medicaid’s Origins

- Enacted in 1965 as title XIX of the Social Security Act
- Means-tested; originally focused on the public assistance population

**Entitlement**

- Eligible Individuals are entitled to a defined set of benefits
- States are entitled to federal matching funds

**Federal**

- Sets core requirements on eligibility and benefits

**State**

- Flexibility to administer the program within federal guidelines

**Partnership**
Medicaid has evolved over time to meet changing needs.

Millions of Medicaid Beneficiaries

- Medicaid eligibility for women and children is expanded
- "Katie Beckett" option
- Medicaid eligibility for women and children is expanded
- Medicaid is de-linked from welfare
- Implementation of the ACA Medicaid expansion
- SCHIP enacted
- ACA enacted
- Medicaid enacted
- SSI enacted

NOTE: *Projection based on CBO March 2015 baseline.
SOURCE: KCMU analysis of data from the Health Care Financing Administration and Centers for Medicare and Medicaid Services, 2011, as well as March 2015 CBO baseline ever-enrolled counts.
Medicaid is the major source of health coverage for 20% of people in the US.

Medicaid’s 74.4 million beneficiaries include:
- 1 in 2 low-income individuals
- 2 in 5 children
- 3 in 5 nursing home residents
- 2 in 5 people with disabilities
- 1 in 5 Medicare beneficiaries

Total Population: 318.9 million

SOURCE: Health insurance coverage: KCMU analysis of 2015 data from the 2016 ASEC Supplement to the CPS.
Medicaid plays a key role for selected populations.

### Percent with Medicaid Coverage

#### Families
- **Nonelderly Below 100% FPL**: 55%
- **Nonelderly Between 100% and 199% FPL**: 40%
- **All Children**: 38%
- **Children Below 100% FPL**: 76%
- **Parents**: 17%
- **Births (Pregnant Women)**: 49%

#### Elderly and People with Disabilities
- **Medicare Beneficiaries**: 20%
- **Nonelderly Adults with a Disability**: 45%
- **Nonelderly Adults with HIV in Regular Care**: 42%
- **Nursing Home Residents**: 62%

**NOTE:** FPL--Federal Poverty Level. The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $19,318 in 2016.

Medicaid spending growth per enrollee has been slower than growth in private health spending

Average Annual Medicaid Spending on Medical Services Growth versus Growth in Various Benchmarks, 2007-2013:

<table>
<thead>
<tr>
<th>Category</th>
<th>Percent Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid services per enrollee</td>
<td>1.7%</td>
</tr>
<tr>
<td>Medicaid acute care per enrollee</td>
<td>3.1%</td>
</tr>
<tr>
<td>Medicaid Long-term care per enrollee</td>
<td>3.1%</td>
</tr>
<tr>
<td>National health expenditures per capita</td>
<td>3.2%</td>
</tr>
<tr>
<td>Medical care consumer price index</td>
<td>4.6%</td>
</tr>
<tr>
<td>Private health insurance per enrollee</td>
<td>1.7%</td>
</tr>
<tr>
<td>GDP per capita</td>
<td>-0.8%</td>
</tr>
</tbody>
</table>

NOTE: Acute Care includes payments to managed care plans.

Medicaid Expenditures by Service, with DSH Payments and Payments to Medicare, FY 2014

- **Long-Term Care**: 24.9%
- **Payments to Medicare**: 3.2%
- **Payments to MCOs**: 37.0%
- **Other Acute**: 9.2%
- **Outpatient/Clinic**: 5.5%
- **Drugs**: 1.7%
- **Mental Health**: 0.5%
- **ICF/MR**: 2.2%
- **Mental Health**: 0.5%
- **Home Health and Personal Care**: 11.7%
- **Nursing Facilities**: 10.5%
- **Inpatient**: 11.4%
- **Physician, Lab & X-ray**: 3.3%
- **DSH**: 3.8%

**Total = $475.91 billion**

**NOTE**: Excludes administrative spending, adjustments and payments to the territories.

**SOURCE**: Urban Institute estimates based on FY 2014 data from CMS (Form 64), prepared for the Kaiser Commission on Medicaid and the Uninsured.
Medicaid LTSS Spending is increasingly devoted to HCBS as opposed to institutional care.

NOTE: Home and community-based care includes state plan home health, state plan personal care services and § 1915(c) HCBS waivers. Institutional care includes intermediate care facilities for individuals with intellectual/developmental disabilities, nursing facilities, and mental health facilities.

Nearly two-thirds of Medicaid spending is for the elderly and people with disabilities, FY 2014.

Enrollees
Total = 80.7 Million

Expenditures
Total = $462.8 Billion

NOTE: Totals may not sum to 100% due to rounding.
SOURCE: KFF estimates based on analysis of data from the FFY2014 Medicaid Statistical Information System (MSIS) and CMS-64 reports. Because FFY2014 data was missing some or all quarters for some states, we adjusted the data using secondary data to represent a full fiscal year of enrollment.
State Take-Up of Key Medicaid Eligibility Pathways for Seniors and People with Disabilities, 2015

- **SSI Beneficiaries**: 51 states
- **Medicare Savings Programs**: 51 states
- **Seniors and People with Disabilities >75-100% FPL**: 21 states
- **Medically Needy**: 33 states
- **Children with Significant Disabilities**: 50 states
- **Working People with Disabilities**: 44 states
- **Long-Term Care Special Income Rule**: 44 states
- **Section 1915(i) HCBS**: 17 states

NOTES: Section 209(b) allows states to apply Medicaid financial and functional eligibility rules to SSI beneficiaries that are more restrictive than the federal SSI rules. Children with disabilities includes Katie Beckett state plan option, comparable HCBS waivers, and Family Opportunity Act buy-in. All states may not use § 1915(i) as an independent eligibility pathway; instead states can use § 1915(i) to provide HCBS to those who are eligible for Medicaid through another existing pathway.

Medicaid Eligibility for Aged, Blind, Disabled Pathway by State, 2015

NOTES: Eligibility limits are for an individual. States generally must cover SSI beneficiaries (75% FPL) and have the option to extend the income limit for this pathway up to 100% FPL. *Two states use Section 209(b) to apply more restrictive income limits than the federal SSI rules: CT’s limit is equivalent to 63% FPL, and OH’s limit is 64% FPL. SOURCE: KCMU Medicaid Financial Eligibility Survey for Seniors and People with Disabilities (2015).
Medicaid is a budget item and a revenue item in state budgets.

<table>
<thead>
<tr>
<th>Category</th>
<th>Medicaid</th>
<th>Elementary &amp; Secondary Education</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>51.7%</td>
<td>19.6%</td>
<td>28.7%</td>
</tr>
<tr>
<td>Elementary &amp; Secondary Education</td>
<td>15.6%</td>
<td>25.3%</td>
<td>57.7%</td>
</tr>
<tr>
<td>Other</td>
<td>33.7%</td>
<td>8.6%</td>
<td>57.7%</td>
</tr>
</tbody>
</table>

**Total State Spending**
- **State & Federal Funds**
  - $1.98 Trillion
  - Medicaid: 28.7%
  - Elementary & Secondary Education: 15.6%
  - Other: 51.7%

**State Funds**
- **General & Other Funds**
  - $1.25 Trillion
  - Medicaid: 19.6%
  - Elementary & Secondary Education: 25.3%
  - Other: 59.1%

**Federal Funds**
- $600.4 Billion

SOURCE: Kaiser Family Foundation estimates based on the NASBO’s November 2017 State Expenditure Report (data for Actual FY 2016.)
NOTE: The June 2012 Supreme Court decision in National Federation of Independent Business v. Sebelius maintained the Medicaid expansion, but limited the Secretary's authority to enforce it, effectively making the expansion optional for states. 138% FPL = $16,242 for an individual and $27,724 for a family of three in 2015.
34 states including DC have adopted the Medicaid expansion.

NOTES: Current status for each state is based on KFF tracking and analysis of state activity. *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 expansion waivers. KY's traditional expansion continues while its expansion waiver is pending with CMS after having been invalidated by a court in June, 2018. UT passed a law directing the state to seek CMS approval to partially expand Medicaid to 100% FPL using the ACA enhanced match, and UT also has a measure on the ballot in November to fully expand to 138% FPL. ID and NE have Medicaid expansion measures on their November 2018 ballots. Expansion is adopted but not yet implemented in VA and ME. (See the link below for more detailed state-specific notes.)

Some states are moving forward under an 1115 Waiver.

- Section 1115 Demonstration waivers allow states to make changes to their Medicaid programs outside of what is otherwise allowed under Federal regulation.
- 1115 waivers must be proposed by a state and approved by CMS.
- Waivers vary significantly in scope:
  - Arkansas and Iowa have used 1115 waivers to implement premium assistance models.
Most current state waiver activity relates to behavioral health, followed by work requirements and other eligibility restrictions, as of August 29, 2018.

NOTES: Some states have multiple approved and/or pending waivers, and many waivers cover different areas. Therefore, the total number of pending or approved waivers across states cannot be calculated by summing counts of waivers in each category. Pending waivers are not included until officially accepted by CMS and posted on Medicaid.gov. “MLTSS” = Managed long-term services and supports.

Medicaid Policy Issues Going Forward

- **Coverage (Eligibility, Outreach and Enrollment)**
  - Will additional states decide to implement the Medicaid expansion change?
  - Introduction of work requirements

- **Financing and Fiscal Issues**
  - Continued debate on capitation block grants to replace current program. What are goals/risks?

- **Access to and Delivery of Services**
  - What new innovations will be successful in integrating care for complex populations (duals demonstrations)
  - Public charge rule concerns

- **Ballot Measure in Idaho, Montana, and Nebraska in fall**
A block grant or per capita cap would be a fundamental change to Medicaid financing.

<table>
<thead>
<tr>
<th></th>
<th>Current Medicaid Program</th>
<th>Block Grant</th>
<th>Per Capita Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage</td>
<td>Guaranteed coverage, no waiting list or caps</td>
<td>No guarantee (can use wait lists or caps)</td>
<td>May be guaranteed for certain groups</td>
</tr>
<tr>
<td>Federal Funding</td>
<td>Guaranteed, no cap</td>
<td>Capped</td>
<td>Capped per enrollee</td>
</tr>
<tr>
<td></td>
<td>Responds to program needs (enrollment and health care costs)</td>
<td>Not based on enrollment, costs or program needs</td>
<td>Not based on health care costs and needs</td>
</tr>
<tr>
<td></td>
<td>Can fluctuate</td>
<td>Fixed with pre-set growth</td>
<td>Fixed with pre-set growth per enrollee</td>
</tr>
<tr>
<td>State Matching Payments</td>
<td>Required to draw down federal dollars</td>
<td>Unclear</td>
<td>Unclear</td>
</tr>
<tr>
<td></td>
<td>Federal spending tied to state spending</td>
<td>Federal spending not tied to state spending beyond cap</td>
<td>Federal spending not tied to state spending beyond per enrollee cap</td>
</tr>
<tr>
<td>Core Federal Standards</td>
<td>Set in law with state flexibility to expand</td>
<td>Uncertain what the requirements would be to obtain federal funds</td>
<td></td>
</tr>
</tbody>
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