Session 32 PD, Medicaid Block Grants and Their Potential Impact on the Various Medicaid Programs

Moderator:
Jessica Grado

Presenters:
Zachary Christian Aters, ASA, MAAA
Sabrina H. Gibson, FSA, MAAA
Steve Schramm
Agenda

Block Grants/Per Capita Caps as Alternative Funding Mechanisms for Medicaid

- Overview (Steve Schramm)
- Impacts on States (Steve Schramm)
- Implications for Actuarial Soundness (Zach Aters)
- Impacts on MCOs (Sabrina Gibson)
Steve Schramm, MScE

- Founder/Managing Director of Optumas – Strategy and Actuarial Consultancy
- Time...Medicaid consultant = 30 yrs
- Time...Wanted to be Actuary = 30 yrs
- Time...Realize wasn’t happening = 30 secs
Zachary Aters, ASA, MAAA

- A Senior Actuary for Optumas
- Medicaid consulting actuary for 10+ years
- Active member of the American Academy of Actuaries (AAA) Medicaid
- Active with the Medicaid SOA committee as a presenter of current Medicaid topics at Society of Actuaries meetings and webinars.
Sabrina Gibson, FSA, MAAA

- Vice President and Chief Medicaid Actuary for WellCare Health Plans
- Health care actuary for more than 20 years
- Medicaid actuary for 11 years mostly with a health plan but also as a consulting actuary
- Experience with 26 Medicaid and CHIP programs in 16 states
- Active member of the American Academy of Actuaries (AAA) Medicaid workgroup and on the committee that developed the Actuarial Standard of Practice on Medicaid Managed Care Rate Setting – ASOP 49
- Active with the Medicaid SOA committee as a presenter of current Medicaid topics at Society of Actuaries meetings and webinars
- Chaired the SOA Project Oversight Committee for the recently released Medicaid Managed Care Margin study
Overview and Impacts on States
WHY ????

- Historically, Medicaid funded as an Entitlement Program:
  - If a State spent money on eligible individuals and eligible services, Fed’s paid approx. 50–75% (known as FMAP*)

- In 2017, Congress introduced AHCA to dramatically change Medicaid funding:
  - Per Capita Caps – OR – Block Grants

* Federal Medical Assistance Percentage
WHY ???? (cont’d)

- Goal = Limit federal exposure to Medicaid spending
- Increased programmatic flexibility in exchange for funding constraints:
  - **Per Capita Cap (PCC)** = State is at risk for $ rate of growth, but not population growth*
  - **Block Grant (BG)** = Fixed total budget w/ State @ risk for per capita $ AND population growth

* Sort of…Still at Risk within Sub–Categories
Basic Calculations

- Per Capita Caps and Block Grants
  - Base year (Federal Fiscal Year 2016?)
  - Annual increase (CPI–M or +?)
  - 5 sub-categories for PCC only
    - Elderly (CPI–M+1%)
    - Aged/Disabled (CPI–M+1%)
    - Children (CPI–M)
    - Non Expansion Adults (CPI–M)
    - Expansion Adults (CPI–M)
US is THEM?!?! – Role Reversal

- States are now in the position with CMS that they have placed MCOs
  - State is to CMS what MCO is to State...

- Prior to Rules Being Finalized, States will need to make their case to Congress:
  - What additional flexibility to manage costs are you granting States?
  - How do States make investments in their programs?
  - What protections are you granting States?
Practical Considerations

- What Should States be Thinking About?
  - Funding – Who Pays for Program Now?
  - Interventions – How Sophisticated?
  - Network – How Effective is My Network?
  - Reimbursement – What % is my Fee Schedule?
  - Population – Who Am I Covering?
Let’s Make a Deal!!!

- **Program Design:**
  - Multi-Year Growth Target Calc?

- **Target Population:**
  - Exclude High-Cost/Growth Rate Pops?

- **Benefits:**
  - Reduce Drug Coverage Requirements?

- **Service Delivery Network**
  - High-Performing Networks?
Implications for Actuarial Soundness
Actuarial Soundness for Medicaid

- Definition and oversight recently revamped by Medicaid Final Rule
- Each payment rate within a rating cohort must be considered actuarially sound for each participating Managed Care Entity
- Increased oversight facilitates better transparency within the rate development process
Actuarial Soundness under Block Grant?

- Will definition be updated?
- Will the review process be modified?
- Predefined funding based on budget considerations may conflict with actuarial soundness.
- Current practice does not allow the actuary to set rates based on budget projections. The actuary must assess the underlying risk of the program.
Impact of Block Grant on Actuary

- More pressure on State Medicaid leadership and actuary
- Limited federal funding may increase the need for state funding, altering the FMAP that the state receives
- Higher state funding may cause changes to program policy and design
- Increased emphasis on efficiency and APMs
- More pressure on actuarial assumptions
Actuary’s Responsibility

- Ensure payment matches risk, and that the payment is not budget driven
- Explore creative approaches surrounding measuring efficiency and quality within a rate methodology
- Work in synergy with participating MCEs in order to implement creative strategies that work for each program
- Monitor access to care and MCEs’ financial profile
Discussion Points

- Does current guidance within Final Rule work alongside Block Grant Approach?
- Does there need to be more emphasis on allocation based on risk assessment, such as health based risk scores?
- Is there additional risk that the certifying actuary is exposed to under a Block Grant Approach?
Impacts on MCOs
MCOs

- Fixed costs leads to pushing programs to MCOs who are experienced at operating under a fixed cost budget.
- Currently most operating on a per capita budget.
- Must be nimble enough to right size costs when the per capita is not enough.
Rainbows and Butterflies

- Block Grant or Per Capita Cap trends outpace medical inflation and population growth
- States have no trouble developing actuarially sound rates within the budget
- No change from today for MCOs
Brimstone and Hell Fire

- Economic crash
- Medicaid population increases 15%
- Block grant increases can’t keep up
- MCO rates must decrease as population increases
- States and MCOs must have flexibility to modify program to reduce costs per member
- Per capita caps would solve this issue
Asteroid Impact

- Cancer Vaccine – every 5 years
- $1,000,000 per treatment
- Cost per member increased $200,000/yr
- Neither block grants or per capita caps can handle this situation
- States and MCOs must have flexibility to modify program to limit treatment
Better Collaboration

- States will need to work more closely with MCOs to analyze changes in:
  - fee schedules,
  - benefits and
  - populations
to ensure costs will not exceed caps in current or future years

- Manipulate funding streams if possible
  - know the levers based on what funding is included or excluded from the block grants or per capita caps
  - Examples: rebates, supplementals, UPL
Currently states are very restrictive and becoming more restrictive as states:

- push for minimum fee schedules,
- require specific providers in the network,
- mandate pass-through payments, and
- take control of the PDLs

MCOs have reduced flexibility in how they control costs

Change is needed if MCOs are expected to operate within the per capita or block grant budgets
What happens in a short year?

- Delay payments to MCOs – one or more months in arrears so MCO carries the float (catch up in fat years?)
- Lower provider fee schedules – MCOs cut fee schedules
- Remove voluntary benefits – MCOs remove benefits
- Allow MCOs to discontinue enhanced benefits
- Arbitrary cuts to MCO administration or margin loads
- Population cuts only work with block grants, since per capita caps would be reduced with reduced populations
  - Potentially the populations cut would be the healthier populations, so costs per member would increase as they are cut
Design to Absorb Fluctuations

- Work with states to design programs that allow for fluctuations in funding depending on whether it is a short or fat year
- Provider bonuses
- MCO bonuses
- Lower MLR guarantees, or extend for the life of the contract
- Expanded benefits that are easily removed (are any??)
Market Impact

- Currently MCOs understand that if a state program is underfunded in one year, the actuarially sound rate setting process will ensure that this changes in future years.
- Block grants or per capita caps formulas define funding trend and will provide MCOs with insight into potential future rate changes.
- If the rates are not projected provide necessary increases, MCOs can exit markets quicker to reduce losses.
- If states have more money than they need to fund the program, MCOs will work hard to enter the market.
- Better strategic planning.
States may be required to negotiate with CMS for changes in block grant or per capita cap amounts.

MCOs can assist with that, since they have experience with negotiating rates with states.
Recommended Resources

- AAA Paper – Proposed Approaches to Medicaid Funding 3/17/17
  http://www.actuary.org/files/publications/Medicaid_Funding_031717.pdf

- AAA Paper – Comments on American Health Care Act (AHCA)
Recommended Resources

- Mega-Reg
  http://www.actuary.org/files/publications/Medicaid_Funding_031717.pdf

- Bill Links
Medicaid Block Grants/Per Capita Caps
Session 32
POLLING QUESTIONS
Society of Actuaries Health Meeting
June 2017
Poll: What do you do?

1. State Consulting Actuary
2. MCO Actuary
3. Other Health Actuary
4. Non-health Actuary
Poll: Block Grants are a workable Medicaid funding mechanism

1. Yes, without question
2. Yes, with appropriate design
3. No, this is a ridiculous concept
Poll: Per Capita Caps are a workable Medicaid funding mechanism

1. Yes, without question
2. Yes, with appropriate design
3. No, this is a ridiculous concept
Poll: What do you think medical CPI has been over the last 11 years?

1. 5.1%
2. 3.3%
3. 1.8%
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11 Year Average
3.3

5 Year Average
2.9

**Expected Per Enrollee Medicaid Inflation as a % - Projected 2015-2024**

- Aged Medicaid Enrollees: 4.1
- Disabled Medicaid Enrollees: 4.8
- Adult Medicaid Enrollees: 5.3
- Child Medicaid Enrollees: 5.3

Poll: What was the largest one year increase in Medicaid spending, between 1998 and 2013 (pre-Expansion)?

1. 12.7%
2. 7.3%
3. 5.4%
4. 3.1%
Percent Change in Total Medicaid Spending and Enrollment, FY 1998 – FY 2014

6.6% Trend

5.3% Trend

NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.

SOURCE: Medicaid Enrollment June 2012 Data Snapshot, KCMU, August 2013. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2012 - 2014 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.
Poll: If block grant results in underfunding of the program, what strategies should the State consider?

1. Consider reducing covered benefits
2. Review eligibility requirements
3. Review provider contracting
4. Review State budget allocations
5. All the above
Poll: Which of the voluntary benefits do you think should be the first to be removed when states are over budget?

1. Prescription Drugs
2. Physical Therapy
3. Inpatient Psychiatric Hospital Services for Under Age 21
4. State Plan Home and Community Based Services–1915(i)
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<th>Mandatory Benefits</th>
<th>Optional Benefits</th>
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<td>Inpatient hospital services</td>
<td>Prescription Drugs</td>
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<td>Outpatient hospital services</td>
<td>Clinic services</td>
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<td>Nurse Midwife services</td>
<td>Physical therapy</td>
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<td>Nursing Facility Services</td>
<td>Occupational therapy</td>
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<td>Home health services</td>
<td>Eyeglasses</td>
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<td>Physician services</td>
<td>Respiratory care services</td>
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<td>Rural health clinic services</td>
<td>Podiatry services</td>
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<td>Laboratory and X-ray services</td>
<td>Optometry services</td>
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<td>Federally qualified health center services</td>
<td>Dental Services</td>
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<td>Family planning services</td>
<td>TB Related Services</td>
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<tr>
<td>EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services</td>
<td>Self-Directed Personal Assistance Services- 1915(j)</td>
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<td>Certified Pediatric and Family Nurse Practitioner services</td>
<td>State Plan Home and Community Based Services-1915(i)</td>
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<td>Freestanding Birth Center services (when licensed or otherwise recognized by the state)</td>
<td>Other diagnostic, screening, preventive and rehabilitative services</td>
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<td>Tobacco cessation counseling for pregnant women</td>
<td>Speech, hearing and language disorder services</td>
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<td>Transportation to medical care</td>
<td>Source: <a href="https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html">https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html</a></td>
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Poll: If block grant results in overfunding of the program, what strategies are available to the State?

1. State pays excess back to the federal government (78%)
2. State should be allowed to create reserves (6%)
3. Review provider contracting (4%)
4. Expand covered benefits (13%)
Poll: What should CMS allow in terms of definition of actuarial soundness?

1. Current definition should apply
2. More emphasis on allocation of funds via risk assessment (health based risk score)
3. Less emphasis put on historical base data
4. Actuarial soundness should be waived
END OF PRESENTATION