

# PRINCIPLES AND POLICES TO SUPPORT REPEAL AND REPLACE

## 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.
- Complex reform must incentivize incremental progress that has a positive impact on individual access and health outcomes.

## 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 the following options:**
  - a. Enacting structural Medicaid reform by converting financing to a per capita cap or block grant model for one or more population groups.** 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.
  - b. Defaulting to the current structure, with reduced federal financial participation.** Under this option, Medicaid expansion enrollees would be funded under the traditional match rate for that population.

**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 more 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. 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 requires managing Medicaid to be sustainable over time, bringing both federal budget predictability and better health outcomes.

Under both reform options presented below, enrollment would be optional and could be capped for some populations. However, certain populations would be mandatory and excluded from any enrollment caps. These include aged, blind, and disabled individuals, as well as children and pregnant women up to pre-ACA federal mandatory minimum eligibility standards. In reverting to these minimums, certain changes will be necessary to resolve historic inequities between states.

Current expansion states would have the option to select any income level at or below *138% FPL* and retain enhanced federal financial participation. For a state that has expanded eligibility to childless adults with incomes less than *138% FPL*, but has not received the enhanced match, federal funding would be adjusted to be equitable with expansion states. Non-expansion states may choose to expand eligibility for adults at any income level at or below *138% FPL*, with enhanced federal participation to create funding equity.

#### ***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). The model must be built upon a financing base that takes the most current data/expenditures into account when building base funding levels (see below), including all federal funding earned through, or supported by, state contributions, provider taxes, and other local arrangements.

## 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.

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
<ul style="list-style-type: none"><li>• State-specific per capita expenditures in the current base year for each eligibility group; OR</li><li>• National average per capita expenditures by eligibility group; OR</li><li>• State-specific per capita expenditures for existing population and national average for any new members.</li></ul>	<ul style="list-style-type: none"><li>• National average trend; OR</li><li>• 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.</li></ul>

## 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 formulation of a trigger. Incorporating adjustments that would protect states against undue risk for economic fluctuations provides a sustainable approach to funding the Medicaid program and strengthens the federal-state partnership, as well as budget predictability.

## ***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.

Additionally, a state that chooses one or more block grant option will switch from the current federal matching arrangement to a financial maintenance-of-effort (MOE) for the populations covered by the block grant(s), based on state expenditures in a designated base year. States will be able to access stable and predictable federal allotments by meeting a financial MOE based on a level of state spending. States that meet their financial MOE would be permitted to draw 100% of their available federal allotment. Therefore, as states become more efficient in the management of their Medicaid programs, they will be able to continue using federal dollars without committing additional state dollars. This also provides protection for states in periods of budget distress, as states would be able to control their spending without forfeiting federal funds.

Under this option, a new section would be added to Title XIX of the Social Security Act, breaking Medicaid into several parts, most of which would be block grant-eligible. States would have full control over the service delivery system and would be permitted to impose conditions of participation on the adult populations.

- Under a new Part A of Medicaid, the adult enhanced match populations, as well as other non-elderly, non-disabled populations a state chooses to include, would be served through a Children's Health Insurance Program (CHIP)-like model. Allotments to states would be capped and indexed. The funding formula would consist of several variables, including a national federal minimum per capita amount for adults and children to promote equity among the states, a state-specific per capita amount that reflects variations among states, and adjustments based on population growth and relative state poverty levels, regardless of whether a state had previously expanded Medicaid under the ACA or through a Section 1115 Demonstration Project. All covered populations would be enrolled into comprehensive benchmark plans, which were first established in CHIP, then for adults under the Deficit Reduction Act of 2005 (DRA).
- Under Part B, Long Term Services and Supports (LTSS) would be delivered through a separate program that would level the playing field between HCBS and institutional care. Funding would be indexed for elderly population growth, low-income population growth, and inflation. States would be assured of stable and predictable levels of funding as they transition to new service delivery models and accelerate towards person-centered planning and supports. States that choose this option 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.

- Under a new Part C, medical services for individuals with disabilities and low-income seniors, as well as any other populations whom a state does not include in Part A, would continue as under current law, regardless of which other block grants a state chooses to take. Federal funding would remain an open-ended match with no change in benefits for individuals with disabilities and low-income seniors, including the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit for children with disabilities. States would still be able to adopt benchmark plans for non-disabled, non-elderly populations.

### **OPTION 3 – DEFAULT TO THE CURRENT STRUCTURE WITH REDUCED FEDERAL FINANCIAL PARTICIPATION**

Structural reforms to Medicaid by converting financing to a per capita cap or block grant model, and providing states necessary control of the program, need to occur to ensure predictability and sustainability over time for federal and state governments. However, states should have the opportunity to remain in the current structure. Under this option, Medicaid expansion enrollment at the enhanced federal match rate would be frozen, grandfathering all current enrollees at the enhanced rate for a period of time. All new enrollees would be funded under the traditional match rate for that population.

### ***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.

### ***SUPPLEMENTAL PAYMENTS***

Governors will work with the Trump Administration and Congress to achieve improved efficiency and transparency and reduce the rate of growth of supplemental payments.

### ***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.* The federal government should continue to honor its commitment to American Indians and Alaska Natives. Congress has full constitutional authority to legislate with regard to health care for these populations and should therefore fully fund their care, relieving states from this financial obligation. However, delivery of benefits could still be provided through state Medicaid systems. The federal government also has an obligation to improve the health status of these individuals, and the current system does not provide them adequate access to high-quality health care services. Additionally, the federal government lacks a solution to address the LTSS needs of the elderly tribal population. These

issues should be addressed at the federal level as a key part of any reform and in consultation with the Tribes.

- *Undocumented Immigrants.* Emergency health care for undocumented immigrants is covered by Medicaid; and the definition of what constitutes an emergency continues to expand. Immigration policy and enforcement is the responsibility of federal government, and these costs should not be shifted to the states.
- *Refugees.* The cost of health care for refugees is the responsibility of the federal government and should not be shifted to states.
- *Disaster Victims Not Eligible for Medicaid.* States have been forced to rely on Section 1115 Demonstration Project authority to provide care for victims of disasters who are not otherwise eligible for Medicaid. The federal government should design and adequately fund a program outside of Medicaid that can be used to provide support for the victims of disasters.

Additionally, the following populations must be addressed in reform:

- *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.

Listed below are some examples of authorities that should be extended to states to manage the increased risk associated with transitioning to a per capita cap or block grant model.

### ***Eligibility***

- ***Enrollment Limits:*** As populations transition into per capita caps, states should be given additional authority to freeze or reduce enrollment, with exceptions for certain population groups (aged, blind, and disabled individuals, as well as children and pregnant women up to mandatory minimums described above).
- ***Conditions of Eligibility:*** States should have the authority to impose conditions of eligibility to prevent the “crowd-out” effect. Examples include:
  - ***Work Requirements:*** States should have the option to design eligibility policies and tools that promote self-sufficiency and accelerate pathways out of poverty, including job training, leveraging other programs, and work requirements, for able-bodied adults. The design of such requirements, as well as the definition of “able-bodied,” should be left to states, given their unique economies.
  - ***Offer of Employer-Sponsored Insurance:*** States should be permitted to render individuals with access to employer-sponsored insurance ineligible for Medicaid, without a requirement to provide “wrap-around” services.
- ***Elimination of Temporary Eligibility:*** Certain eligibility groups, including retrospective eligibility, presumptive eligibility, and transitional medical assistance, would no longer be federal requirements. States will also not be required to provide coverage prior to final determination of eligibility.
- ***Modified Adjusted Gross Income (MAGI):*** States should be given the option to continue to use the MAGI standard for eligibility in order to align eligibility across federally-funded programs.
- ***Asset Tests:*** States would have the option to impose asset tests on the MAGI population.
- ***Additional Flexibilities:*** States should be provided latitude to establish eligibility requirements that promote state-specific policy goals.

### ***Benefits***

- ***Cost-Sharing:*** States should have the authority to implement enforceable financial participation of enrollees. We would recommend higher limits be established for the adult groups versus children, pregnant women, ABD, and duals, as well as tiered cost-sharing to discourage inappropriate use of higher cost services and settings.

- **Pharmacy:** Financing changes must be accompanied by changes in pharmacy requirements. This includes ending the requirement that states cover every FDA-approved drug to create better alignment with Medicare and commercial insurance policy. The option to exclude a drug from the formulary will be critical to the ability of states to successfully negotiate pharmaceutical prices under any new funding model.
- **Benefit Redesign:** States should be given the authority to design outcomes-based benefit packages, including:
  - Choosing from among benchmark plans as they may under CHIP;
  - Opting out of mandatory benefits and moving to a prioritization and funding-based coverage policy;
  - Optional coverage of “essential health benefits;”
  - Flexibility around LTSS services;
  - Statutorily excluded services, such as Institutions for Mental Diseases (IMD);
  - Optional coverage of EPSDT, except for children with disabilities and children in custody; and
  - Non-emergency medical transportation (NEMT), so that it is not a mandated service for all Medicaid members. In addition, NEMT should be eliminated as an administrative requirement if not offered as a service.
- **Statewideness and Comparability:** The requirement for statewideness and comparability should be restructured or eliminated to allow states the flexibility to design and test pilot programs or target benefits to a specific population.

### **Service Delivery**

- **Mandatory Managed Care:** States must have the option to mandatorily enroll all populations in managed care, with the exception of American Indians and Alaska Natives
- **Use of Funds:** States must have the authority to run their service delivery systems by:
  - Purchasing coverage through managed care companies, employers, providers, and other markets;
  - Providing direct care;
  - Paying for direct care through a fee-for-service system; or
  - Purchasing coverage through premium assistance.
- **Network Adequacy and Any Willing Provider Requirements:** States should have the authority to determine and enforce their own network adequacy requirements.

### **Payment**

- **Provider Payment:** States should have the authority to change provider payment rates and structures to advance their policy goals, including value-based purchasing.
- **Health Information Technology:** Health information technology incentive programs must be redesigned to ensure effective incentives and foster the expansion of efficient systems that reduce costs to the overall system.
- **Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Cost-based Reimbursement:** The Prospective Payment System (PPS) rate-setting approach for health centers is not sufficiently aligned with the present and future realities in states’ delivery system and payment improvement initiatives. Congress and the Administration must begin to bridge the gaps and disconnects between the Medicaid and FQHC/RHC programs in the area of delivery system and payment improvements. Therefore, statutory changes to the PPS must be part of any serious Medicaid reform. This includes limiting the rate of growth in the PPS and aligning statutory structures so that only benefits covered under an approved state plan are eligible for PPS reimbursement.



### ***Administrative Flexibility Across State Programs***

- ***Streamlined Requirements and Programmatic Consistency:*** Federally-funded, state-administered entitlement programs often have similar requirements, but inconsistent administrative policies. Many beneficiaries of these programs are eligible for benefits under multiple programs. Inconsistencies between programs are confusing to beneficiaries and cumbersome and expensive for states to administer. These requirements should be streamlined, without requiring waivers, and states should have authority to make other policy changes to better align programs, as long as they are consistent with the programs' goals.
- ***Use of Contractors:*** Provided sufficient safeguards, states should also have the option to use contract workers to conduct eligibility, enrollment, and workforce service functions. Currently, some entitlement programs allow this, while others do not, resulting in limited service capabilities for contractor program staff.