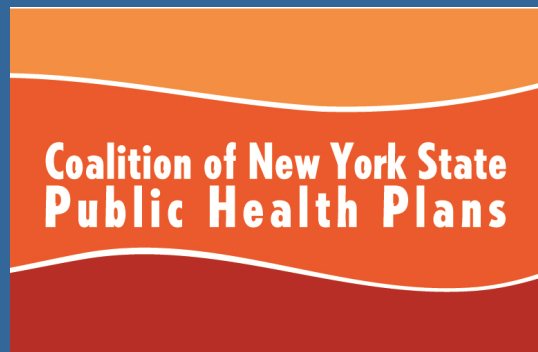


BCRA Medicaid Provisions: Analysis of Impact on New York July 2017

Prepared by Manatt Health for:



manatt

- **Overview of Findings**
- **Role of Medicaid in New York**
- **Major Medicaid Provisions in the Senate’s July 20 Better Care Reconciliation Act (BCRA)**
- **Estimated Impact of Selected Provisions**
 - Key assumptions
 - Expansion-related changes
 - Per capita cap
 - Medicaid disproportionate share hospital (DSH) payments
 - Essential Plan
- **Key Implications**

Overview of Findings

The Stakes for New York

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- Medicaid covers nearly one in three people in New York—more than 6 million individuals
- BCRA imposes substantial cuts on New York that grow over time: The state is expected to lose \$40 billion in federal Medicaid funds through FY* 2026, with the reduction in federal funding exceeding 12% during FYs 2020-2026 when both expansion and per capita cap changes are in effect
 - \$24 billion due to loss of enhanced funding for expansion—including \$1.7 billion over the next three years, before cuts grow substantially starting in FY 2021
 - \$16 billion due to the new cap on federal Medicaid funding
- Offsetting federal cuts would be difficult: New York would need to increase its own Medicaid spending by \$40 billion to maintain its current program
- “Collins-Faso” provision in BCRA also requires New York to find an alternative state funding source for \$2.3 billion annually in county contributions, or face a further federal per capita cap reduction
- BCRA’s continuation of Medicaid DSH cuts under current law for expansion states results in an additional \$250.4 million federal funding cut to New York in FY 2018, which will increase over time
- Loss of federal funds for the Essential Plan that covers an additional 650,000 low-income New Yorkers also results in substantial state costs, estimated at over \$1.5 billion in SFYs 2020 and 2021 alone**

* References to FY throughout this document are federal fiscal years unless noted otherwise.

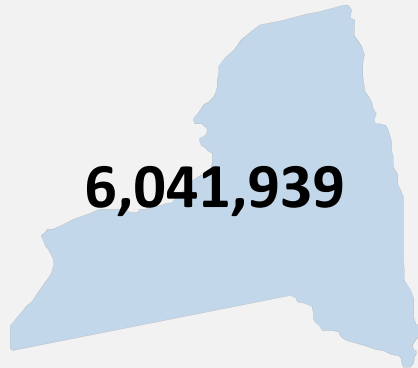
** https://www.health.ny.gov/press/releases/2017/docs/aca_repeal_analysis.pdf

Role of Medicaid in New York

New York: Medicaid Enrollment

Medicaid covers nearly *one in three* New Yorkers

Average Monthly Medicaid Enrollment, SFY 2017

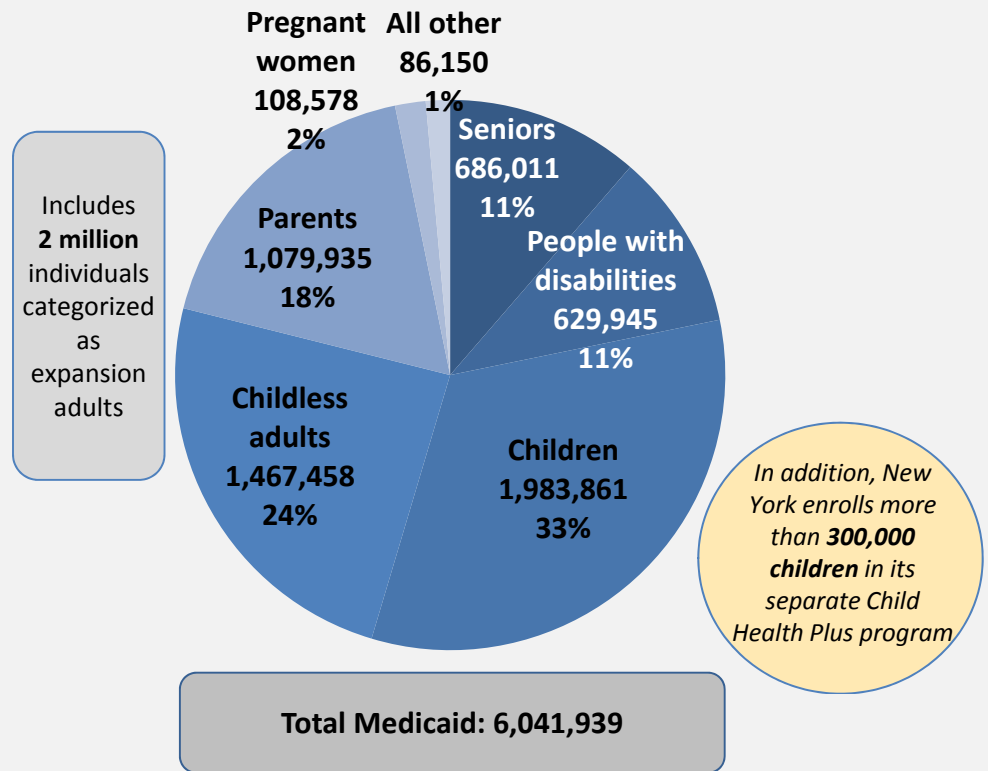


Share of New York Medicaid Enrollees in Working Households, 2015



Nearly Eight in Ten

Medicaid Enrollment by Eligibility Category, SFY 2017

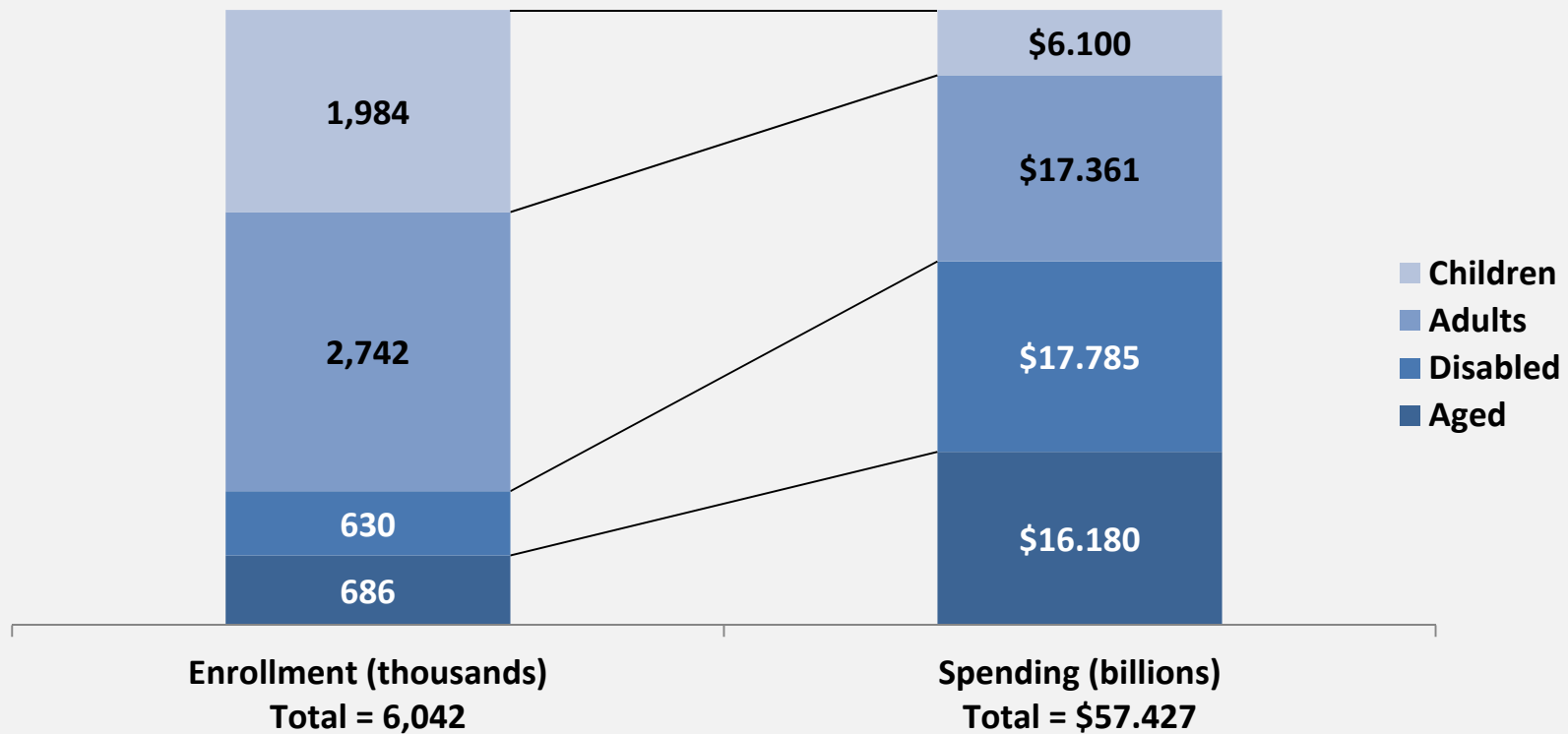


Note: Medicaid child group includes CHIP-funded children.
 Sources New York State Department of Health; <https://health.data.ny.gov/Health/Child-Health-Plus-Program-Enrollment-by-Month-and-/cucz-jjkg>;
<http://kff.org/medicaid/state-indicator/distribution-by-employment-status-4/?currentTimeframe=0&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D>

Expenditures by Eligibility Group

Most of New York's enrollees are children and non-disabled adults, but most program spending is on seniors and people with disabilities

New York Medicaid Enrollment and Spending by Eligibility Group, SFY 2017



Note: Includes CHIP-funded Medicaid children. Excludes supplemental payments.
Source: New York State Department of Health.

New York Medicaid Coverage and Financing

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- More than 2 million New Yorkers are covered through the Medicaid expansion adult group
- Expansion brought billions in additional federal funding to the state, and helped to decrease the state's uninsured rate by nearly 35%
- Additional federal funds made Essential Plan coverage possible, and resulted in Medicaid savings for the state

New York receives federal funding for all allowable Medicaid costs:

- Federal dollars are guaranteed as match to state spending so long as state complies with federal Medicaid law, rules and the terms and conditions of any state waivers
- New York claims federal dollars for medical and administrative services, supplemental payments to providers, and other payments under waiver authority
- Federal Medicaid funding (more than \$30 billion in 2015) makes up nearly two-thirds (64%) of all federal funding in New York's budget
- The state receives enhanced federal funding for low-income adults who were:
 - “Newly eligible” under the Affordable Care Act (ACA) expansion
 - Eligible under pre-ACA rules because New York was a “leader state” that expanded coverage

Major Medicaid Provisions in the BCRA

Major Medicaid Provisions in BCRA

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Phases out, before entirely eliminating, “newly eligible” enhanced federal match for Medicaid expansion

- 2021: 85% FMAP
- 2022: 80% FMAP
- 2023: 75% FMAP
- 2024+: State’s regular FMAP
- In addition, “leader state” enhanced match reduced starting with 2018

Converts federal Medicaid funding to a per capita cap

Block grant option for certain adults

Maintains ACA DSH cuts for New York and other Medicaid expansion states

Congressional Budget Office (CBO) projects that coverage provisions in the July 20 BCRA draft would cut federal Medicaid spending by \$756 billion over 10 years (2017-2026) and reduce Medicaid coverage by 15 million in 2026*

* <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52941-hr1628bcra.pdf>

Congress is considering enacting a per capita cap funding structure for Medicaid

This represents a fundamental change in Medicaid financing

- Eliminates the federal government’s guarantee that it will fully share fiscal responsibility with states for the cost of Medicaid
- Instead, states would be allocated a set amount per beneficiary. These amounts would be added together to establish an overall limit on expenditures that the federal government will match
- Applies to nearly all beneficiaries and service

There is no benefit to states – they face “downside only” risk under a per capita cap

- States face federal cuts if their spending exceeds the cap, but no additional federal funds if they keeping spending below the cap
- Further, states cannot use any room that they have under the cap from a “good” year to offset federal cuts in a future year

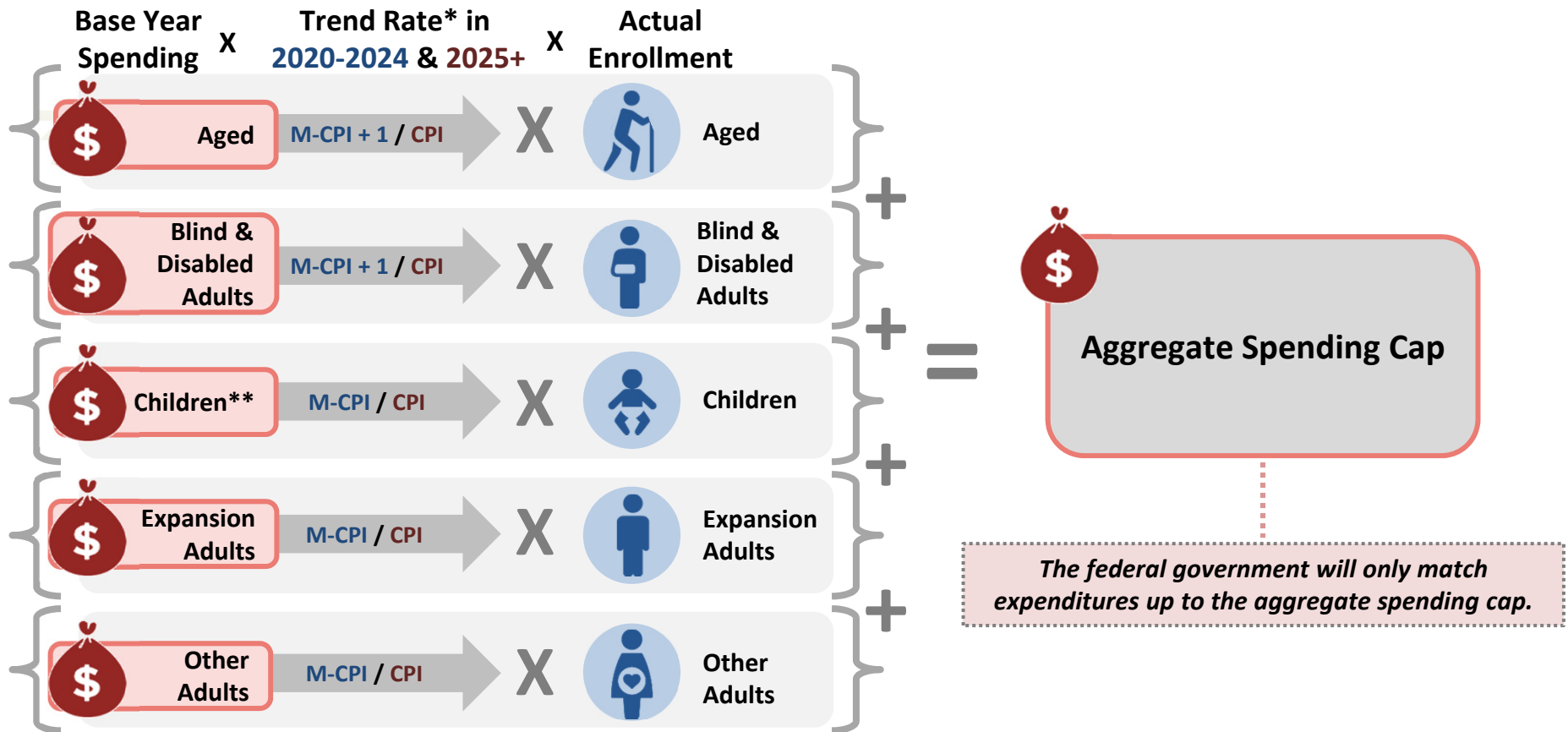
The Per Capita Cap in BCRA

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- BCRA cap for each state's Medicaid spending is “built up” from per capita limits on five different eligibility groups
 - Children, seniors, adults with disabilities, expansion adults and other adults
 - Each group's limit is based on historic per capita spending increased by a national trend rate
 - Through 2024: Medical component of the Consumer Price Index (CPI) for children and adults; medical CPI + 1 percentage point for seniors and people with disabilities
 - Starting in 2025: CPI for all groups
- If a state spends in excess of cap, the federal government will “claw back” any federal matching funds that it provided for these expenditures the next year
- Under a “redistribution” provision, states with particularly high or particularly low spending in a given year will receive an adjustment in the following year to their cap
- Only New York is subject to the Collins-Faso provision that would reduce the state's federal cap if it continues to finance Medicaid with certain county contributions
- As discussed later, per capita cap cuts in New York depend on a variety of factors (e.g., interaction with global cap under the state's Section 1115 waiver), but could be substantial

Formula for the Per Capita Cap in BCRA

The **aggregate cap** on Medicaid funding is built up from **per capita caps** for five different eligibility groups



* To calculate states' starting caps in FY 2020, base year spending is trended by M-CPI; starting in 2020, M-CPI+1 is used to trend and calculate the aged and disabled spending caps, while M-CPI continues to apply to children, expansion adults, and other adults; beginning in FY 2025, CPI is used for all eligibility groups.

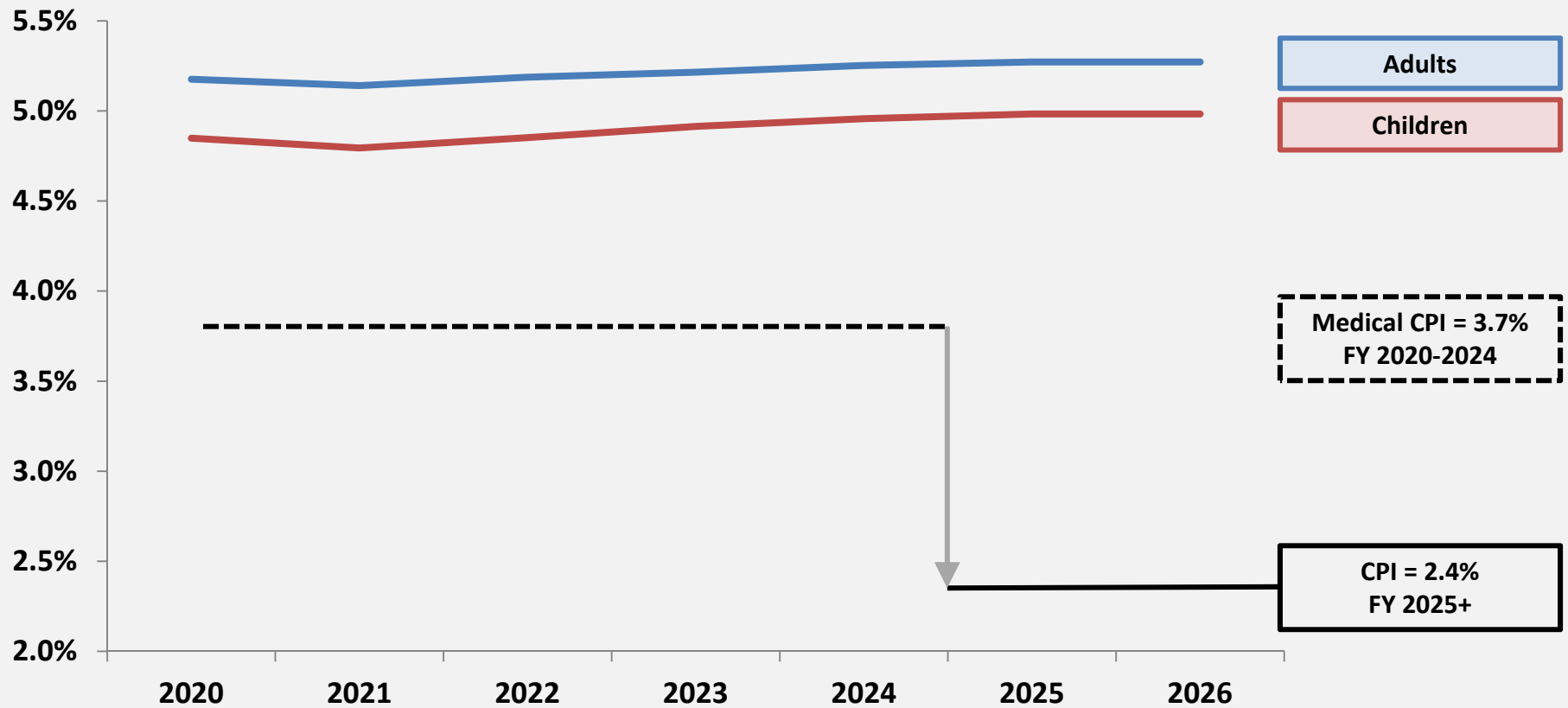
** BCRA per capita cap carves out children enrolled based on a disability determination.

Most Populations and Services Subject to Per Capita Cap in BCRA

	Included	Excluded
Eligibility Group	<p><i>Most full-benefit enrollees, including dual eligibles:</i></p> <ul style="list-style-type: none"> • Aged (65+) • Blind and disabled adults • Children • Expansion adults • Other adults (e.g., pregnant women and low-income parents) 	<p><i>“Partial-benefit” enrollees with coverage limited to:</i></p> <ul style="list-style-type: none"> • Medicare premiums and cost sharing • Emergency services • Family planning • Premium assistance for employer coverage <p><i>Others:</i></p> <ul style="list-style-type: none"> • Children who qualify for Medicaid based on disability • CHIP-financed children • Individuals receiving any Medicaid-funded services through an Indian Health Service or tribal facility • Breast and cervical cancer eligibility pathway • Tuberculosis pathway
Spending	<ul style="list-style-type: none"> • Medical expenditures under state plan • Medical expenditures under waivers • Supplemental payments, other than DSH 	<ul style="list-style-type: none"> • Administration • DSH • Medicare premiums and cost sharing • Vaccines for Children program • New funding pool for non-expansion states

Spending for Children and Adults Growing Faster than the Allowable Trend Rates in BCRA

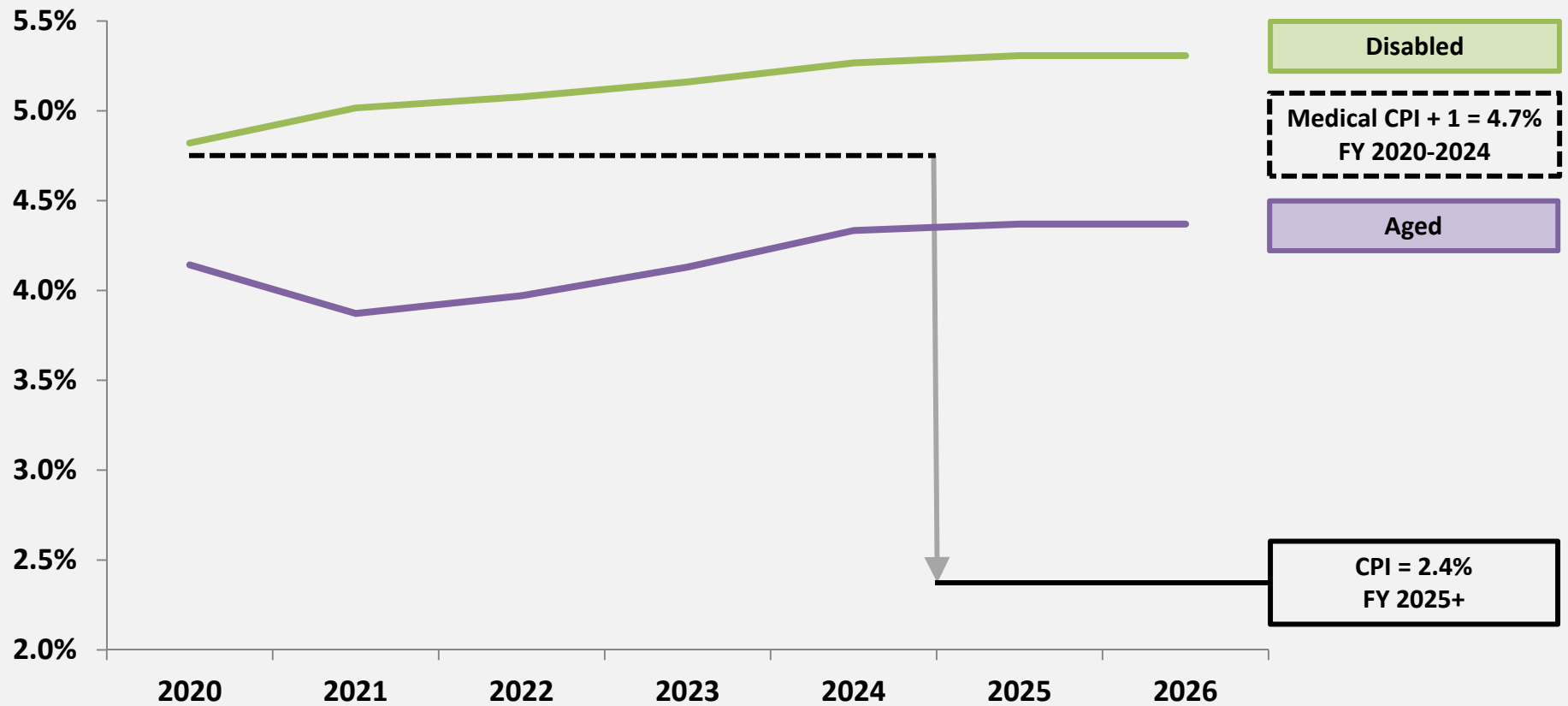
Estimated Annual Per Enrollee Spending Growth, FY 2020-2026



Source : Manatt Medicaid Financing Model. | Note: Per enrollee growth rates projected by CMS Office of the Actuary; M-CPI projected by CBO. Spending growth for the aged and disabled groups is capped at medical CPI +1 in FY 2020-2024; the 2019 baseline amount from which 2020 caps are calculated is trended forward from 2016 by M-CPI.

Spending for Disabled Group Outpacing Allowable Trend Rates, Aged to Exceed Trend Rate in FY 2025

Estimated Annual Per Enrollee Spending Growth, FY 2020-2026



Source : Manatt Medicaid Financing Model. | Note: Per enrollee growth rates projected by CMS Office of the Actuary; M-CPI projected by CBO. Spending growth for the aged and disabled groups is capped at medical CPI +1 in FY 2020-2024; the 2019 baseline amount from which 2020 caps are calculated is trended forward from 2016 by M-CPI.

The “High/Low” Provision in BCRA

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The provision is designed to give more resources to low-spending states and less to high-spending states, but may not work as intended

- BCRA adjusts a state’s cap if its spending is significantly above or below the national mean
 - States **above** by 25% or more (“high spending”) may see a downward adjustment of 0.5% to 2% in their subsequent year’s cap; states **below** by 25% or more (“low spending”) may see an increase of 0.5% to 2%
 - In FY 2020 and FY 2021, the adjustment is based on whether a state’s average per capita spending across all eligibility groups is “high” or “low”
 - In FY 2022 and beyond, states are judged separately for spending on each of the five eligibility groups; they can receive a downward adjustment for one eligibility group and an upward adjustment for another
- The provision cannot result in a net cost to the federal government; increases in the caps of low spending states must be “paid for” by high spending states
- States will not know in advance of a fiscal year whether they qualify for an adjustment; they must wait until all states have finalized their expenditure and enrollment data for the preceding year
- The provision may have unintended consequences; for example, states that have low spending for each group—but have older and sicker populations that drive up the average across groups—would be at risk for reductions in FYs 2020 and 2021

Since it is unclear how the redistribution provision will be implemented and whether it will affect New York, it is not taken into account in the cap estimates

Key Data and Assumptions for Estimating Impacts

Overview of Manatt Medicaid Financing Model

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- **Designed to assess state-by-state impact of Medicaid financing changes**
 - Per capita cap
 - Block grant
 - Reductions in federal funding for expansion
- **Uses publicly-available data to establish baseline for each state, for example:**
 - CMS-64 data on total Medicaid expenditures and expansion adult and total enrollment
 - MSIS/MAX data on expenditures by eligibility group
 - State-specific population growth projections from the Census Bureau
 - Centers for Medicare & Medicaid Services (CMS) and CBO national growth projections by eligibility group
 - CMS and CBO projections of medical CPI and CPI
- **Allows for sensitivity analysis**
 - Alternative inputs
 - Diversion from projections
 - State behavioral response

Assumptions and Data Used in New York Modeling

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- **New York will maintain expansion coverage** by using state funds to replace lost federal dollars
- **Baseline (current law) spending per enrollee** will increase at rates consistent with CMS Office of the Actuary national projections; actual experience in New York will depend in part on future waiver negotiations
- **Medical CPI** will grow at 3.7% a year and overall CPI at 2.4% in accordance with CBO projections
- **For the “high/low” per capita cap provision, New York’s spending relative to national average may change** and estimates do not take this into account
- **Estimates were developed from publicly available data**, which may differ from the state’s internal data and estimates

Impact of Major Medicaid Provisions

Expansion Funding

New York receives two types of enhanced federal funding for Medicaid expansion

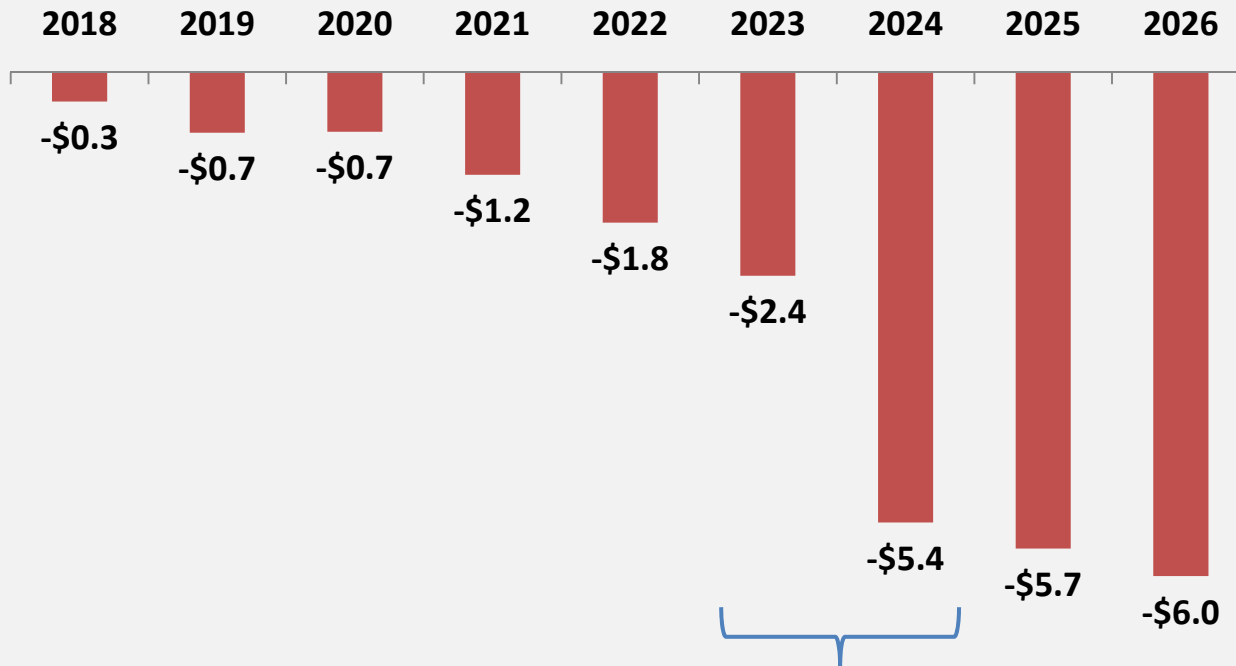
- **Newly eligible FMAP:** For low-income adults with incomes between 100% and 138% FPL who were “newly eligible” under ACA Medicaid expansion
- **“Leader state” FMAP:** For low-income adults with incomes up to 100% FPL who were covered when New York expanded coverage prior to the ACA

Year		2014	2015	2016	2017	2018	2019	2020+
FMAP	Newly eligible	100%	100%	100%	95%	94%	93%	90%
	Leader	75%	80%	85%	86%	90%	93%	90%

BCRA reduces **leader match** starting in 2018; then reduces **newly eligible match** to: 85% in 2021; 80% in 2022; 75% in 2023; and 50% (regular FMAP) in 2024+

Estimated Impact of Expansion Changes

Reduction in Federal Funding Due to Expansion Changes, FY 2018-2026 (billions)



Total federal cut due to expansion changes, FY 2018-2026: **\$24 billion**

To maintain its current Medicaid program, the state will need to offset this cut with an increase in state funding

*Federal match rate for expansion adults will fall from 75% (newly eligible) or 70% (leader state) in 2023 to 50% in FY 2024 causing the size of **federal cuts to more than double** in one year*

Per Capita Cap: Interaction with New York's Global Cap

- Under a global cap included as part of New York's Section 1115 Medicaid waiver, the state share of most of the state's Medicaid spending is limited to the 10-year rolling average of the medical component of the CPI
- The state's SFY 2018 enacted budget reflects continuation of the Medicaid global cap through SFY 2019, and projections assume that statutory authority will be extended*
- Although projected growth is less than CBO's medical CPI projection of 3.7%, New York's spending per enrollee may still exceed BCRA's allowable trend rates due to:
 - Substantial expenditures for items that include an enacted minimum wage increase for home care workers are outside of the global cap
 - The drop in the BCRA's trend rate to CPI as of FY 2025, which is projected at 2.4%
- The State is currently analyzing these issues to determine potential impacts; as noted earlier, estimates here assume per enrollee growth rates in the range of 4 to 5 percent

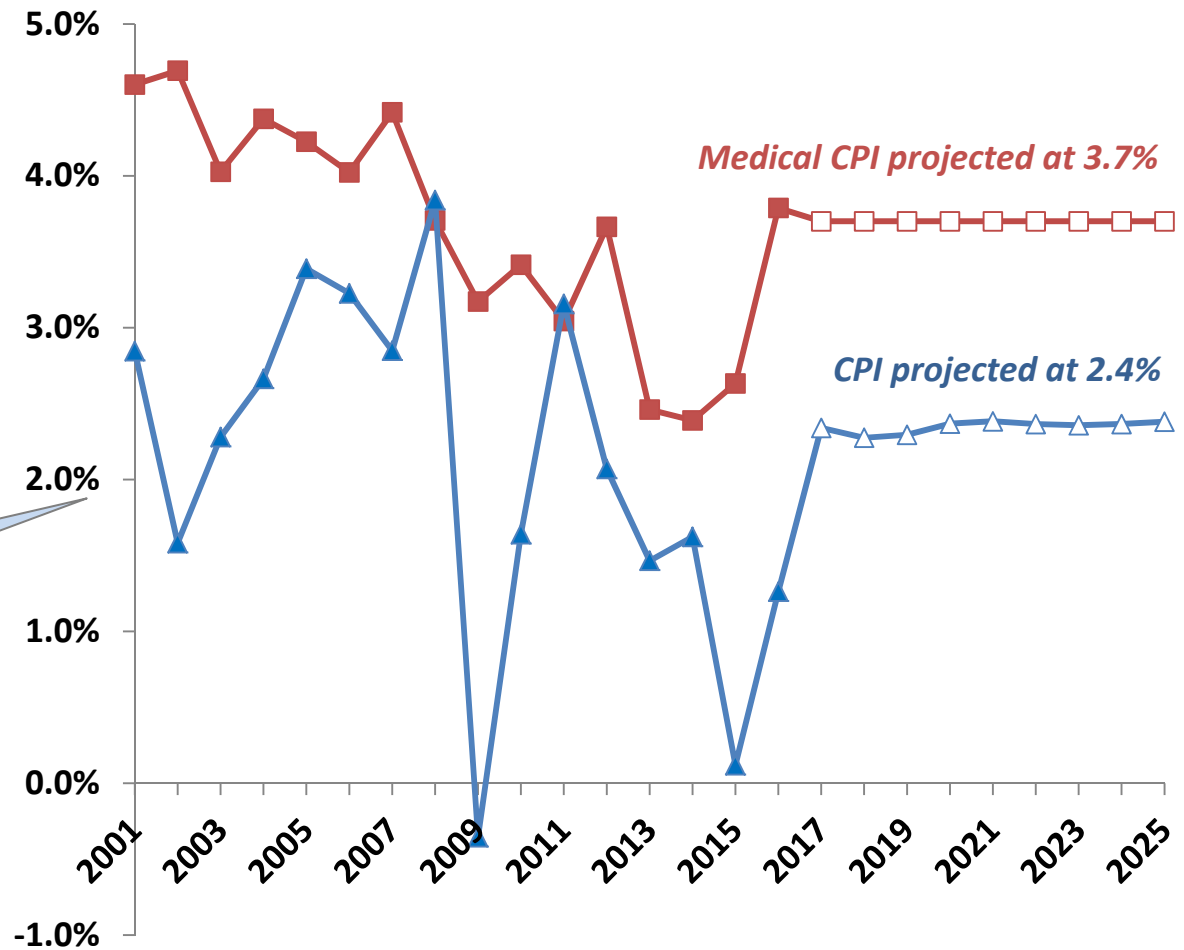
MEDICAID GLOBAL CAP FORECAST (millions of dollars)					
	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Global Medicaid Cap ¹	17,692	18,259	18,825	19,371	19,914
Annual % Change		3.2%	3.1%	2.9%	2.8%

* <https://www.budget.ny.gov/pubs/archive/fy18archive/enactedfy18/FY2018EnactedFP.pdf>

Use of CPI Trend Rate Likely to Result in Federal Per Capita Cap Cuts

- BCRA Trend Rates**
- FY 2020-2024
 - Children and adults: medical CPI
 - Aged and disabled: medical CPI + 1 percentage point
 - FY 2025+
 - All groups: CPI

Even if New York's global cap keeps growth at or below medical CPI, the state is likely to face a significant federal cut in FY 2025 and beyond when the trend moves to CPI

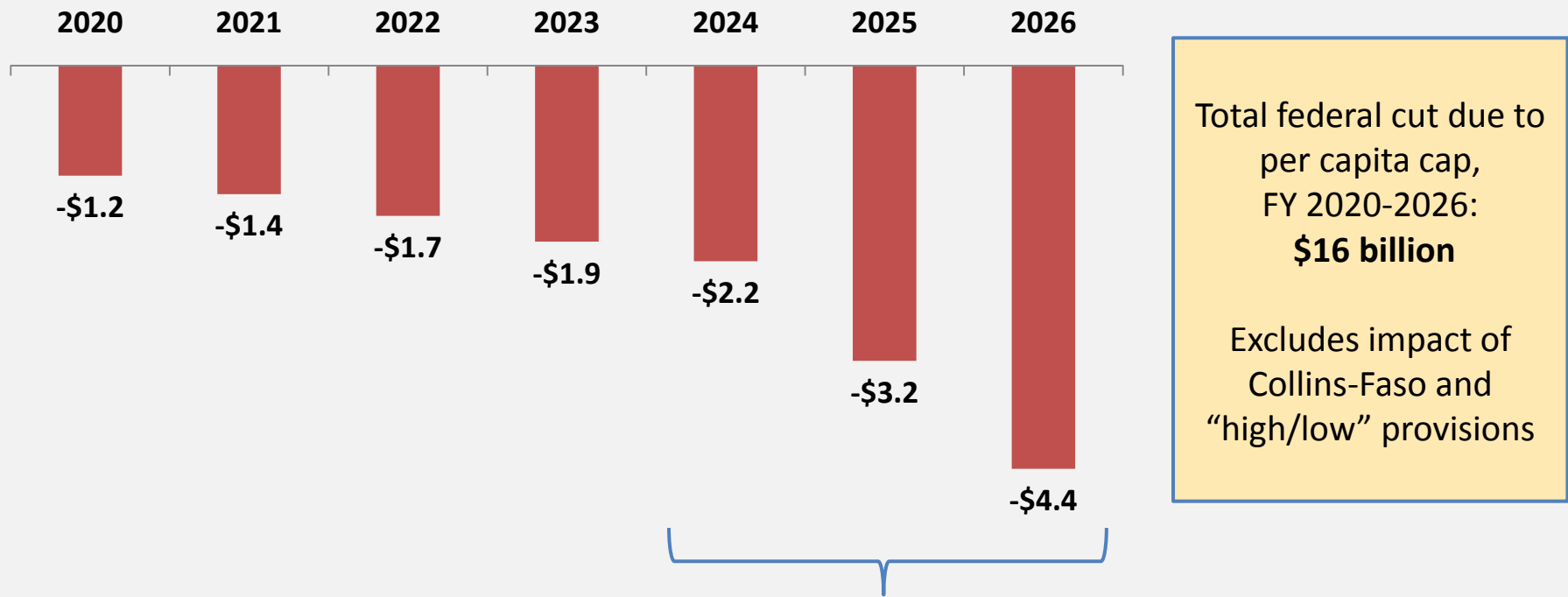


Source: Manatt analysis of Bureau of Labor Statistics, CPI Databases, <https://www.bls.gov/cpi/data.htm>; Congressional Budget Office, <https://www.cbo.gov/publication/52486>; <https://www.cbo.gov/sites/default/files/recurringdata/51135-2017-01-economicprojections.xlsx>

Estimated Impact of Per Capita Cap on New York

New York would have to substantially increase state general fund spending to offset the per capita cap cuts in order to maintain current program spending levels

Reduction in Federal Funding Due to Per Capita Cap, FY 2020-2026 (billions)

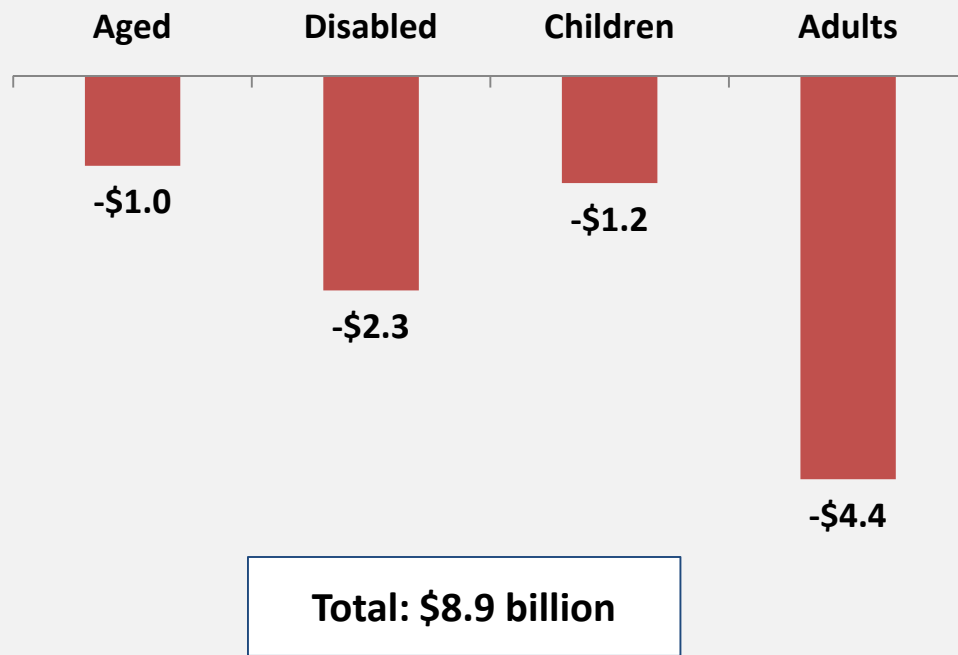


Federal cuts more than double between FY 2024 and 2027 due to switch to CPI as the per capita cap trend rate in FY 2025

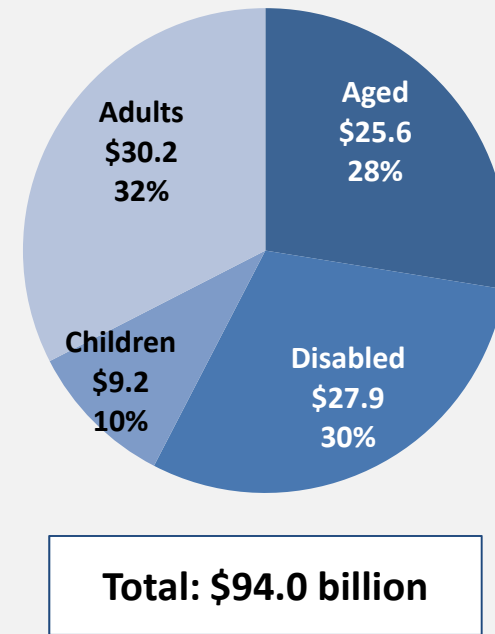
Contribution to Impact of Per Capita Cap Varies by Group, But Cuts Could Be Applied to Any Group

- For example, FY 2026 spending of \$94 billion would leave New York \$8.9 billion over its projected cap
- State would need to cut spending in FY 2026, or face a clawback the following year

Estimated Contribution to Impact of the Cap, FY 2026 (billions)



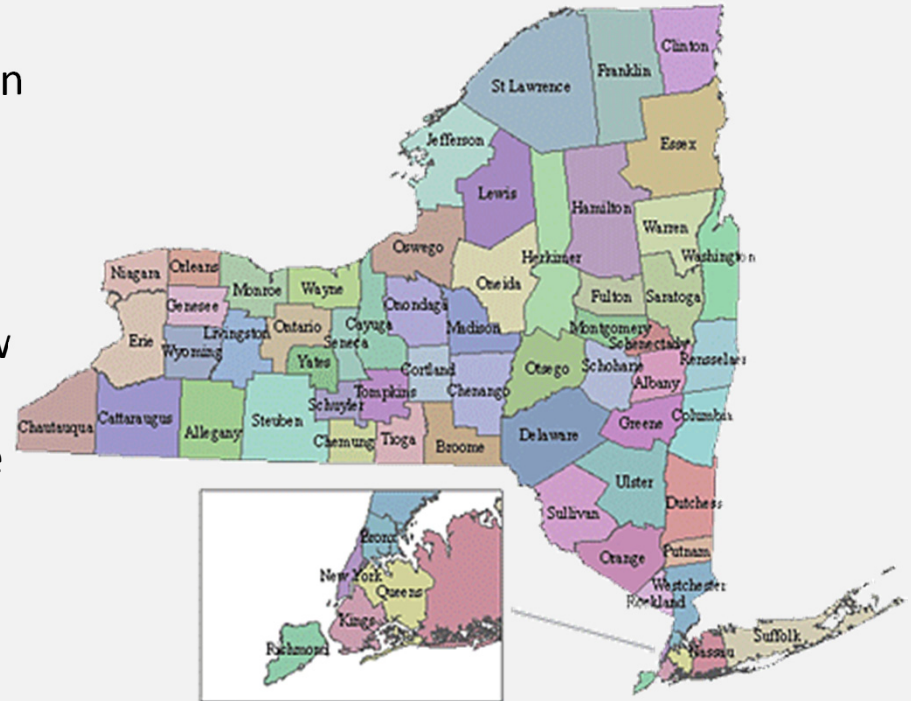
Estimated Spending Prior to Per Capita Cap Cuts, FY 2026 (billions)



Individuals exempt from the cap – e.g., children enrolled based on disability and users of IHS and tribal health facilities – could be affected by the cuts, such as payment rate reductions, necessary to stay below cap

Per Capita Cap: Treatment of County Contributions

- New York counties affected by the Collins-Faso provision in BCRA contribute \$2.3 billion annually to fund part of the non-federal share of Medicaid costs; provision does not affect New York City
- Starting in FY 2020, federal funds under New York's per capita cap would be reduced by this amount if the state continues to finance Medicaid with these county contributions
- To avoid this federal cut, the state must find an alternative financing source
- Governor Cuomo has proposed a new assessment on counties for this purpose*



* <http://www.timesunion.com/allnews/article/Cuomo-proposes-Faso-Collins-federal-tax-11247082.php>

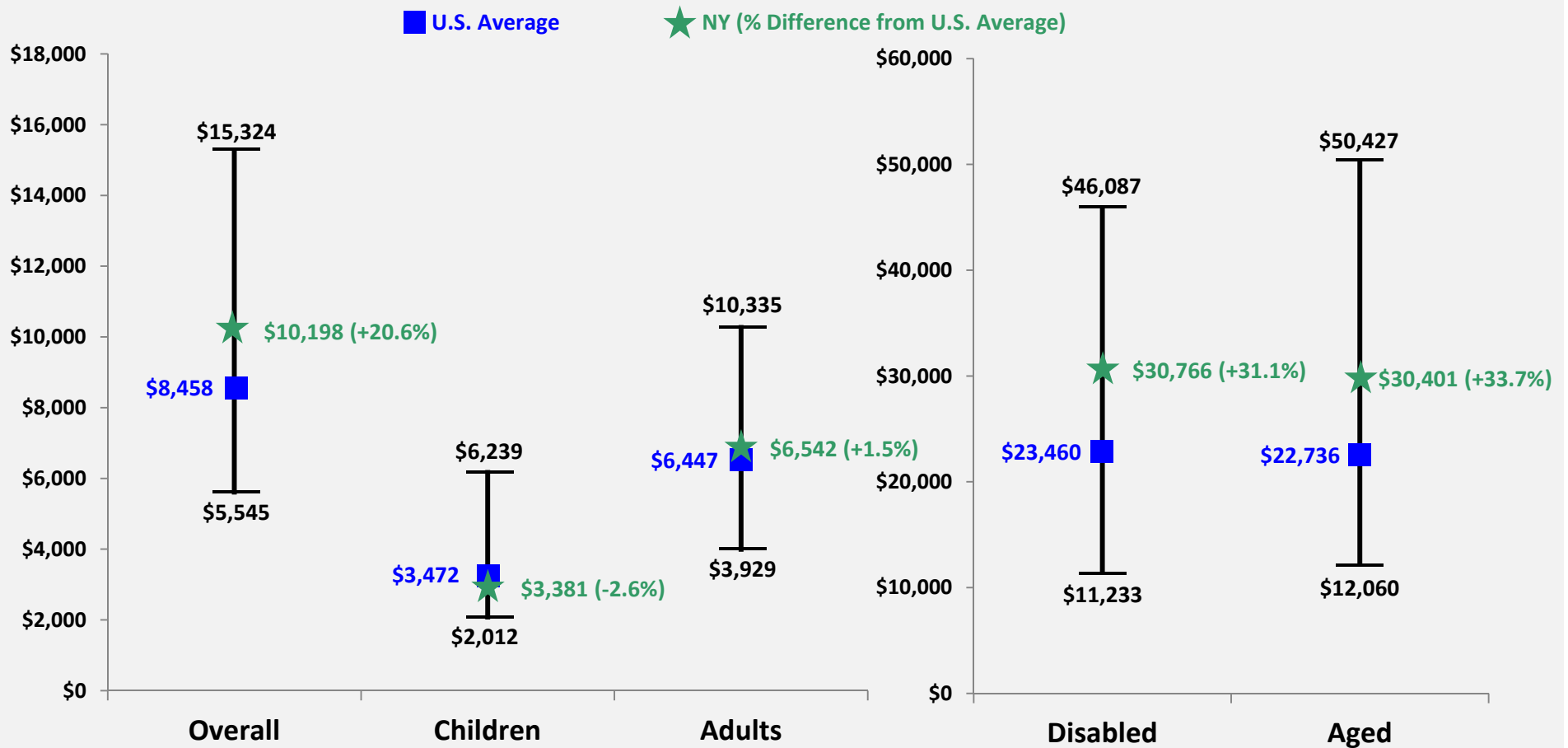
Per Capita Cap: “High/Low” Redistribution Provision

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- Relative to other states, New York has high spending per enrollee overall and for aged and disabled enrollees
- As a result, even if the state manages its per enrollee spending to live within its own cap and BCRA’s trend rates, it could still face a federal funds reduction of up to 2%—with impacts reaching several hundred million dollars in FY 2020 alone
- Based on current spending patterns, New York is at risk in FYs 2020 and 2021 because its average spending across all eligibility groups is 21% percent above the national mean—close to the 25% level that could trigger an adjustment
- In future years, the state could receive a downward adjustment for people with disabilities (31% above national mean) and aged enrollees (34% above national mean)
- In practice, whether New York is affected will depend on its spending per enrollee relative to the national mean, which in turn will depend on future spending choices made in other states
- New York has no way of knowing in advance whether it will be hurt by the redistribution provision, and if so, the size of the downward adjustment it will receive

Range of Per Enrollee Spending Subject to “High/Low” Redistribution Provision

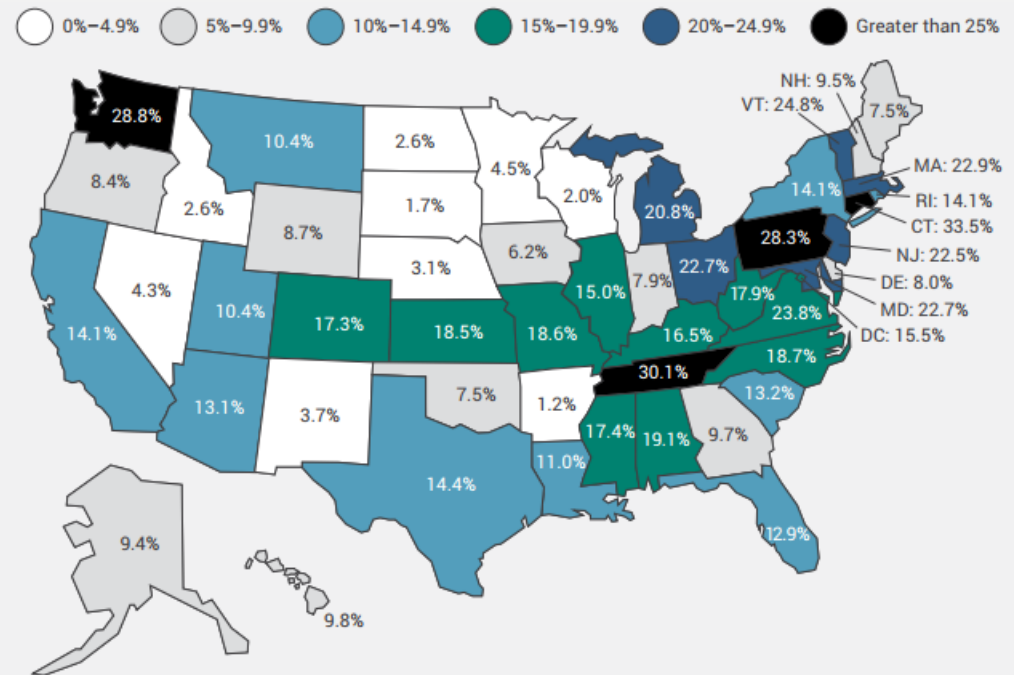
Projected Medicaid Spending Per Enrollee, FY 2019



Note: Reflects full-benefit enrollees.
Source: Manatt Medicaid Financing Model.

Projected Decrease in New York's Federal DSH Funds

- Under BCRA, New York and other expansion states would receive Medicaid DSH cuts that are slated under current law, while non-expansion states would receive an increase in DSH funds
- An updated rule will be issued by HHS, but MACPAC estimates that New York would face a 14.1% cut in FY 2018 under the existing DSH reduction methodology*
- Would result in federal reduction of \$250.4 million (\$500.8 million if state and local matching funds are included) for New York, and the cut would grow each year



* <https://www.macpac.gov/wp-content/uploads/2017/03/Analyzing-Disproportionate-Share-Hospital-Allotments-to-States.pdf>

Essential Plan

New York has leveraged the Basic Health Program to provide affordable coverage with significant state savings

- **New York is one of two states utilizing the ACA Basic Health Program option, creating the “Essential Plan”**
- **The Essential Plan covers over 665,000 New Yorkers (as of January 2017) who are:**
 - Individuals with incomes between 138% and 200% FPL who are ineligible for Medicaid/CHIP and do not have access to affordable employer-sponsored coverage
 - Legal immigrants with incomes below 138% FPL who are eligible for Medicaid but for their immigration status*
- **Federal government provides the State with 95% of the premium tax credits and cost-sharing reductions that would have been available for coverage through the New York State of Health**
- **Implementing the Basic Health Program has resulted in significant State savings due to decreases in State-only Medicaid expenditures for the *Aliessa* population.**
 - State saved \$1 billion in its first year alone, and projects savings of \$635 million in SFY 2017

* The New York State Court of Appeals decision in *Aliessa v. Novello* requires the state to provide Medicaid coverage for this population; New York funded this coverage using state only dollars until 2016 when it transitioned this population, known as the “Aliessa population,” to the Essential Plan, and began funding their coverage through a combination of ACA federal tax subsidy funding and state dollars.

Source: <https://info.nystateofhealth.ny.gov/sites/default/files/Essential%20Plan%20-%20At%20a%20Glance.pdf>;
<https://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202017%20Open%20Enrollment%20Report.pdf>;
https://www.health.ny.gov/health_care/managed_care/essential/docs/2016_basic_health_program.pdf

Coverage and Budget Implications of Marketplace Subsidy Changes

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Changes to Marketplace subsidies have serious coverage and budget consequences for the Essential Plan

Both BCRA and the earlier House-passed AHCA cut aggregate funding for tax credits substantially and eliminate payments for cost-sharing reductions

- Not only does this have serious affordability implications for New Yorkers who purchase coverage on the Marketplace, it makes it infeasible to continue the Essential Plan at current levels

New York would need to replace federal dollars with State-only dollars to maintain coverage at the current levels for the Essential Plan population

- Alternatively, New York could dissolve the Essential Plan, losing another affordable coverage option for New Yorkers, and move the *Aliessa* population back into Medicaid, at full state and local expense

New York State estimates* net impact of AHCA changes on the Essential Plan at \$1.5 billion during SFYs 2020 and 2021; provisions in BCRA would lead to a similar result

* https://www.health.ny.gov/press/releases/2017/docs/aca_repeal_analysis.pdf

Key Implications

The Stakes for New York: Recap

36

- Medicaid covers nearly one in three people in New York—more than 6 million individuals
- BCRA imposes substantial cuts on New York that grow over time: The state is expected to lose \$40 billion in federal Medicaid funds through FY 2026, with the reduction in federal funding exceeding 12% during FYs 2020-2026 when both expansion and per capita cap changes are in effect
 - \$24 billion due to loss of enhanced funding for expansion—including \$1.7 billion over the next three years, before cuts grow substantially starting in FY 2021
 - \$16 billion due to the new cap on federal Medicaid funding
- Offsetting federal cuts would be difficult: New York would need to increase its own Medicaid spending by \$40 billion to maintain its current program
- “Collins-Faso” provision in BCRA also requires New York to find an alternative state funding source for \$2.3 billion annually in county contributions, or face a further federal per capita cap reduction
- BCRA’s continuation of Medicaid DSH cuts under current law for expansion states results in an additional \$250.4 million federal funding cut to New York in FY 2018, which will increase over time
- Loss of federal funds for the Essential Plan that covers an additional 650,000 low-income New Yorkers also results in substantial state costs, estimated at over \$1.5 billion in SFYs 2020 and 2021 alone

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