Potential New Financing Models for Medicaid

Our mission is to improve the oral health of all.
Signs of a Broken Oral Health System Abound

U.S. Surgeon General “…there are profound and consequential disparities in the oral health of our citizens. Indeed, what amounts to a silent epidemic of dental and oral diseases is effecting some population groups.”

Lack of access to dental care leads to expensive emergency room care

American Dental Association
• $1.6 billion spent on dental visits to Emergency Departments (2012)
• $749 per visit

An estimated 164 million work hours and 51 million school hours are lost each year due to oral disease

Dental problems are among the most common health problems experienced by older adults.

American Geriatric Society’s Health in Aging Foundation
Mission: Improve the Oral Health of All

Dental Benefit Administration
- Increasing coverage & access

Foundation
- Engaging communities & influencing policy

Institute
- Improving care efficiency & effectiveness

Care Group
- Increasing access to quality care in underserved communities
DentaQuest Foundation

- Founded in 2000
- $83 million in grant funding awarded since 2010
- Over 1,000 partners across the nation
- Grantees in all 50 states

Scope of Foundation Investments

- Oral Health 2020
- Community Water Fluoridation
- Strengthening Oral Health Safety Net
- National Interprofessional Initiative on Oral Health
Our Vision

**POLICY**
- Oral health is a key component of health policy
- Oral health policy consistent at local, state and federal levels
- Oral health measurement systems in place
- Policy to allow expanded workforce

**FINANCING**
- Sufficient funding to support care, prevention and training
- Alignment of payment with evidence, prevention, disease management and outcomes

**CARE**
- Dental workforce sufficient to meet needs efficiently & effectively
- Care based on evidence, prevention, disease management and outcomes
- Oral health integrated into all aspects of health care
- Consumer focused care delivery

**COMMUNITY**
- Oral health integrated into education and social services
- Optimal oral health literacy
- Strong community prevention and care infrastructure
- Provider base representative of community
**ORAL HEALTH ACROSS THE LIFESPAN**

**GOAL**
- Incorporate oral health into the primary education system
- Include an adult dental benefit in publicly funded health coverage
- Eradicate dental disease in children
- Build a comprehensive national oral health measurement system
- Integrate oral health into person-centered healthcare
- Improve the public perception of the value of oral health to overall health

**Oral health is essential to lifelong health and wellbeing.**

**Improved health equity results in greater social justice**

**TARGET**
- The 10 largest school districts have incorporated oral health into their systems
- At least 30 states have an extensive Medicaid adult dental benefit
- With the closing of disparity gaps, 85% of children reach age 5 without a cavity
- Medicare includes an extensive dental benefit
- Oral health is integrated into at least 50% of emerging person-centered care models
- A national and state-based oral health measurement system is in place
- Oral health is increasingly included in health dialogue and public policy.
Oral Health 2020 Network

Includes Organizations Such As….

- 33 statewide networks
- 29 State Primary Care Associations
- 20 “Grassroots” organizations in 6 states
- Grantees at national, state and community level
- 1,000 registered users of OH2020 web-based collaboration tool
Impact Potential – By the Numbers

**GOAL**
Eradicate dental disease in children

**GOAL**
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**GOAL**
Include an adult dental benefit in publicly funded health coverage

**GOAL**
Build a comprehensive national oral health measurement system

**GOAL**
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**GOAL**
Improve the public perception of the value of oral health to overall health

- Low-income (Medicaid-enrolled) adults without comprehensive dental coverage: **11.2 million**
- Medicare beneficiaries: **49.4 million growing to 81.5 million by 2030**
- Children enrolled in the 10 largest school districts: **3.8 million**
- Children under the age of 5: **21 million**
- Children to be born between now and 2020: **26 million**
Repealing the Affordable Care Act (ACA): What’s At Stake?

- Health insurance coverage for 11.5 million persons enrolled in Marketplaces
  - Subsidies for low-income persons (85% of Marketplace enrollees)
  - Oral health as an “essential benefit” for children

- 11.5 million newly-eligible low-income adults covered through Medicaid expansion

- Enhanced federal funding for the Children’s Health Insurance Program (CHIP)

- Insurance protections in the commercial market
  - Guaranteed issue and renewability
  - No-pre-existing condition restrictions/lifetime coverage limits
  - Children allowed to stay on parent’s insurance policy until age 26
  - Prohibition against rescinding coverage except for fraud

- Medicare Part D prescription drug “doughnut hole”

Recent Developments

• Some Republican Governors express concern over potential loss of Medicaid expansion funding
  – 16 of 31 states that expanded Medicaid have Republican Governors

• President Trump outlines 5 key principles for “replacement” plan
  – Guaranteed “access” to health insurance for persons with pre-existing conditions
  – Tax credits to purchase plan of choice; expand HSAs
  – Creating a national insurance marketplace that allows insurers to sell health plans across state lines
  – Legal reforms to protect doctors and patients "from unnecessary costs" and to bring down the price of high-cost drugs.
  – Give Governors "the resources and flexibility" in their Medicaid programs "to make sure no one is left out."

• House Republicans introduce “American Health Care Act” as “reconciliation” bill to repeal portions of ACA/modify other provisions, and transform Medicaid financing to a *per capita cap* model
Overall Approach of “American Health Care Act”

• Repeal almost all ACA revenue provisions that funded coverage expansions

• Repeal ACA mandates (2016), standards for health plan actuarial values (2020) and premium/cost sharing subsidies (2020)
  – Impose late enrollment penalty (30% premium increase) for people who don’t maintain continuous coverage

• Replace ACA income-based tax credits with flat tax credits adjusted for age in 2020
  – For 2018-2019, existing ACA tax credits are modified in several ways
  – In 2020, annual age-adjusted credit amounts range from $2,000 per individual (up to age 29) to $4,000 per individual (age 60 and older)

• Retain private market rules (guarantee issue coverage; no pre-existing condition exclusions; dependent coverage to age 26)
  – Change age rating variation from 3:1 to 5:1

• Retain health insurance marketplaces and annual Open Enrollment periods

• Encourage use of Health Savings Accounts

SOURCE: Kaiser Family Foundation “Compare Proposals to Replace Affordable Care Act” March 7, 2017
March-The-American-Health-Care-Act&utm_source=hs_email&utm_medium=email&utm_content=44056092&hsenc=pZANqtz-
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Overall Approach of “American Health Care Act” (cont.)

• Establish State Innovation Grants and Stability Program; federal funding of $100 Billion over 9 years

• Repeal funding for Prevention and Public Health Fund at end of FFY18; provide supplemental funding for community health centers of $422 Million for FFY 2017

• Enact no change to Medicare benefit enhancements or provider/Medicare Advantage plan payment savings

• Create Medicaid Safety-Net Fund: $10 Billion over 5 years for states that have not implemented Medicaid expansion as of July 1 of the preceding year. Applies to coverage year 2018-2022. Funding may be used to adjust payment amounts to Medicaid providers.


Overall Approach of “American Health Care Act” (cont.)

- Repeal state option to expand Medicaid for adults up to 138% FPL as of December 31, 2019

- Eliminate Medicaid expansion enhanced funding as of January 1, 2020, except for those who are enrolled as of December 31, 2019 and do not have a break in eligibility of more than 1 month.

- Convert Medicaid to a per capita allotment and limit growth beginning in 2020

- Prohibit federal Medicaid funding for Planned Parenthood Clinics

SOURCE: Kaiser Family Foundation “Compare Proposals to Replace Affordable Care Act” March 7, 2017 [link to source]

Congressional Budget Office has not issued its impact analysis

NASHP: A Crosswalk of ACA Provisions with Proposed Language Under the House American Health Care: [link to source]
Medicaid “Per Capita Cap” Financing Model

• “Per capita cap” financing model would begin in 2020
• Cap amounts would be based on a state’s 2016 expenditures trended forward to 2019 by medical component of Consumer Price Index (CPI)
• Separate caps would be established for:
  – Children
  – ACA expansion adults
  – Elderly
  – Persons with disabilities
  – Other “non-ACA” adults
• For states that adopt expansion after January 1, 2016, the cap for this group would be the same as the “other adult” group
• Cap amounts would be increased yearly based on medical component of CPI-urban
• States that exceed their cap will receive reductions to their Medicaid funding in the following fiscal year equal to the excess amount

Medicaid/CHIP Eligibility Levels: Missouri and U.S.

Minimum Medicaid eligibility (138% FPL) under health reform

- **Children**: 305% (MO) vs. 255% (U.S. Median)
- **Pregnant Women**: 305% (MO) vs. 205% (U.S. Median)
- **Parents**: 138% (MO) vs. 138% (U.S. Median)
- **Seniors & Persons w/ Disabilities**: 85% (MO) vs. 74% (U.S. Median)
- **Childless Adults**: 0% (MO) vs. 0% (U.S. Median)

Different Models of “Capped” Federal Medicaid Financing

- Two types of “capped funding” models:
  - **Block Grants** (fixed amount of federal funds to each state; amount would not change when actual Medicaid costs exceed block grant)
  - **Per Capita Spending Caps** (a variation of the block grant approach which is a “per enrollee” amount; allows federal amount to increase/decrease based on enrollment fluctuations)

- Included in “American Health Care Act” proposed by House Republicans
Federal Gov’t Currently Pays 50-73% of States’ Medicaid Costs

Crucial Components of Capped Funding Models

• **Formula for calculating block grant/per capita amount** (e.g., what costs are recognized in block grant or per capita cap)
  – 2016 base year trended to 2019 (AHCA)

• **Process for indexing block grant/per capita cap** (e.g., GDP, CPI) to account for future program growth/costs
  – Medical component of CPI (AHCA)

• **Are per capita caps applied to some or all categories of eligibility?**
  – Separate caps for 5 eligibility groups (AHCA)

• **Details and impact of the “per capita cap” financing proposal included in American Health Care Act (AHCA) are still being analyzed**
Arguments For/Against Capped Federal Financing

- **Proponents** of “capped federal funding” for Medicaid cite the following advantages:
  - Reduced federal expenditures
  - Greater state flexibility in program administration and spending
  - Incentive for more innovative program design
  - Less federal oversight

- **Opponents’ arguments** include:
  - Significant financial burden on states to “backfill” loss of federal funding
  - Program improvements (e.g., enhanced benefits, eligibility levels, provider rates) likely would be borne totally by states
  - Unanticipated program costs (e.g., technology breakthroughs, blockbuster drugs, epidemics/catastrophic events) likely not reflected in capped amounts
  - Depending on indexing formula, funding may not support enrollment growth (less concern with per capita caps)
Previous Capped Financing Proposals Would Have Significantly Reduced Federal Medicaid Funds

- CBO analysis of Speaker Ryan’s 2011 Medicaid block grant proposal
  - “Under the proposal, CBO estimates federal spending for Medicaid would be 35 percent lower in 2022 and 49 percent lower in 2030 than currently projected federal spending with those adjustments.”
  - “Even with additional flexibility, however, the large projected reduction in payments would probably require states to decrease payments to Medicaid providers, reduce eligibility for Medicaid, provide less extensive coverage to beneficiaries, or pay more themselves than would be the case under current law.”

- “The Medicaid block grant proposal included in the House Budget Committee proposal for 2017 advanced by Committee Chairman...Tom Price...would have reduced federal Medicaid spending by nearly a trillion dollars over 10 years.”

2016 House Budget Resolution Would Have Lowered Federal Medicaid Expenditures $2.1 Trillion (2017-2026)

In Billions of Dollars

<table>
<thead>
<tr>
<th>Current Law, Including ACA (CBO January, 2016 Baseline)</th>
<th>ACA Repeal: -$1,063 B</th>
<th>ACA Repeal and Other Medicaid Cuts: -$1,028 B</th>
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<td>$5,049</td>
<td>$3,986</td>
<td>$2,958</td>
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Total Cut: -$2,091 B (41%)

Federal Medicaid Reductions in 2026 Based on House Budget Resolution From March, 2016

Medicaid Baseline with ACA: $642 Billion

- Cut from Federal Caps, $169
- Remaining Medicaid, $329
- Cut from ACA Repeal, $144

House Budget Resolution from March, 2016= 49% Cut in 2026 from ACA Repeal and Medicaid Caps

Other Medicaid Changes Can Be Implemented Through Administrative Actions

- Presidential Executive Orders
- Approve additional Section 1115 waiver provisions used by states to operate/expand Medicaid
  - Higher premium requirements & “lock-out” for non-payment
  - Stricter healthy behavior incentives/requirements
  - New work/work search requirements
- Issue directives through other regulatory interpretations and guidance
  - Waiver approvals
  - Regulations/Sub-regulatory guidance
  - State Health Official Letters
  - Medicaid Director Letters
  - Frequently Asked Questions (FAQs)
Staying Focused and Engaged Through 2017 & Beyond

• Advocating for improvements in oral health will be more important than ever
  – Sharpening our message in ways that resonate with new leadership
  – Continuing to engage non-partisan/bi-partisan partners
  – Emphasizing economic development/“employability” impact of oral health; connection to overall health; improved academic performance
  – Illustrating how dental benefits must continue to be available in any new Medicaid financing models