Medicaid Funding Reform: Impact on Dual Eligible Beneficiaries

Avalere Health | An Inovalon Company
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Avalere maintained full editorial control.
Executive Summary

- Medicaid capped funding arrangements remain a political priority
  - Federal Medicaid caps were included in the American Health Care Act (AHCA), and have been part of House budget proposals since 2012
- Medicaid plays an important role augmenting Medicare coverage for low-income beneficiaries
  - Medicaid pays Medicare out-of-pocket costs for most dual eligible beneficiaries
  - Almost a quarter of total Medicaid expenditures in 2011 were for certified long-term care services for dual eligibles, which are not covered by Medicare
- Capped Medicaid funding arrangements could adversely impact dual eligible beneficiaries and increase Medicare spending
  - Duals are particularly vulnerable and high-cost, which increases the importance of setting their per capita amounts and growth rates accurately
  - In a capped funding arrangement, states may focus on limiting spending for their highest growth populations, including dual eligibles
  - Because Medicare covers acute services for duals, cuts to Medicaid long-term and supportive services could drive up hospitalizations—increasing Medicare costs and harming patients

1. KFF. February 2017. Medicaid’s Role for Medicare Beneficiaries.
Understanding Links Between Medicare and Medicaid
Dual Eligibles Receive Benefits from Both Medicare and Medicaid

In 2015, 11.4 million people were enrolled in both Medicare and Medicaid

For duals, each program pays for:

- Acute care services
- Prescription drugs
- Post-acute care
- Long-term services and supports (LTSS)
- Medicare premiums and cost sharing
- Services not covered by Medicare

Dual Eligibles Are Among the Sickest and Poorest Beneficiaries Covered by Medicare or Medicaid

Dual eligibles often have multiple chronic illnesses and daily living difficulties that require long-term care, making them costly for states

Complex Health Needs

- 41% of duals have at least one mental health diagnosis
- About 60% have been diagnosed with three or more chronic health conditions
- 27% of duals receive institutional LTSS (i.e., care in a nursing home)

Share of State Spending

- Duals accounted for 14% of Medicaid population, but 33% of Medicaid spending in 2011
- About three-fourths of states spend more than 30% of their Medicaid budget on Medicare beneficiaries. Spending varies by state depending on population characteristics and the state’s choices on eligibility and services covered
- 23% of total Medicaid expenditures in 2011 were for certified long-term care services for dual eligibles
  - This amount comprised 62% of total Medicaid spending for duals, between long-term institutional care and home- and community-based services (HCBS)

States Interact with Medicare on Varying Levels to Pay for Coverage of Full Dual Eligible Beneficiaries

In general, Medicaid pays for the following benefits for full duals* but states only have minimal control over many of these program costs:

<table>
<thead>
<tr>
<th>Medicare Part A</th>
<th>Medicare Part B</th>
<th>Medicare Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medicaid pays for Medicare Part A premiums,</td>
<td>• Medicaid pays for Medicare Part B monthly premiums,</td>
<td>• Medicaid does not typically pay for duals’ drugs</td>
</tr>
<tr>
<td>deductibles, and coinsurance</td>
<td>deductibles, and 20% coinsurance</td>
<td>directly; however states make monthly “clawback”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>payments to Medicare to support the cost of drugs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>for these beneficiaries</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• States do not pay Part D premiums or cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>sharing since full duals qualify for subsidies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• States have no control over Part D “clawback”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>amount, except that they may limit coverage of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“optional” coverage categories</td>
</tr>
<tr>
<td>• States can limit cost-sharing amounts to providers</td>
<td>• States have no control over premiums, but can</td>
<td></td>
</tr>
<tr>
<td>based on state Medicaid rates</td>
<td>limit cost-sharing amounts to providers based on</td>
<td></td>
</tr>
<tr>
<td></td>
<td>state Medicaid rates</td>
<td></td>
</tr>
</tbody>
</table>

*Partial dual beneficiaries have some of their Medicare expenses paid by Medicaid including Parts A and B premiums and some cost sharing depending on their state and income level.
Medicaid Reform Policy Landscape
Initial ACA Repeal and Replace Efforts Sought to Cap Medicaid Funding to States – Have Stalled to Date

Though Congressional discussion of ACA repeal and replace has slowed, decision makers will likely continue considering Medicaid reform. Reforms could occur through legislative avenues—including ACA repeal efforts, deficit-reduction, or tax reform discussions—or through agency actions.

ACA: Affordable Care Act; AHCA: American Health Care Act; CBO: Congressional Budget Office
If Capped Funding Proposals Resurface, a Number of Components Will Determine If Funding Is Adequate

Each state will see a slightly different impact from the Medicaid funding formula based on state-specific factors.

**Per Capita Cap**

- Fixed federal funding per beneficiary

**Core Components of the Federal Funding Formula**

- Baseline funding level
- Growth factor
- Populations and services included

**Other Factors that Will Shape the Impact on States**

- Current federal match rate
- Medicaid expansion and eligibility criteria
- Annual rate of spending
- Scope of benefits
- Role of managed care
- Cross-subsidization of BOE categories

BOE: Basis of eligibility
A Capped Funding Formula’s Growth Rate Is Critical to Ensuring Adequate Funding

If Medicaid spending growth exceeds the capped funding growth rate, then states must either pay a higher share of Medicaid costs or find ways to reduce Medicaid spending

<table>
<thead>
<tr>
<th>Growth Factor</th>
<th>Projected Average Annual Growth Rate 2017 – 2026¹</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer Price Index (CPI)</td>
<td>2.2%</td>
<td>Overall inflation includes all types of goods and services, not just medical care. Overall inflation has been at record low levels during the past few years, and consistently lower than medical inflation.</td>
</tr>
<tr>
<td>Medical Care Inflation (CPI-M)</td>
<td>3.7%</td>
<td>Medical care inflation has historically grown faster than overall inflation due to rising healthcare costs.</td>
</tr>
<tr>
<td>Medical Care Inflation plus 1 Percentage Point (CPI-M + 1)</td>
<td>4.7%</td>
<td>Index+1 caps are used to more specifically target ‘excess growth’ to 1 percent above a specified index (e.g., inflation). Actual per enrollee spending growth is driven by both price and utilization changes.</td>
</tr>
<tr>
<td>Expected Medicaid Spending Growth</td>
<td>4% - 6%</td>
<td>CMS estimates 4%-6% per enrollee spending growth for 2017-2026 across different eligibility groups.</td>
</tr>
</tbody>
</table>

¹. CBO projections are from March 2016 baseline or March 2017 report on AHCA
CBO: Congressional Budget Office; CMS: Centers for Medicare & Medicaid Services
## Questions Remain on How Medicaid Funding Reform Would Impact States and Dual Eligibles (1 of 2)

<table>
<thead>
<tr>
<th><strong>Per capita cap formula</strong></th>
<th><strong>Medicaid expansion and eligibility criteria</strong></th>
<th><strong>Annual rate of spending</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Would a single cap apply for all beneficiaries or would different caps be established for various Medicaid populations (e.g., children vs. disabled)?</td>
<td>Would enhanced federal funding continue for Medicaid expansion populations?</td>
<td>How would the base year be determined—at current spending, or lower? Would the selected growth factor sufficiently account for high-cost populations?</td>
</tr>
</tbody>
</table>

*Impact:* Dual eligibles, on average, have higher costs than other beneficiaries, and a non-specific per capita cap may not fully cover the higher costs for duals

*Impact:* If funding for ACA expansion beneficiaries were reduced, states that maintain eligibility for those individuals would need to find savings elsewhere—potentially impacting duals’ services

*Impact:* If spending on services for dual eligibles—such as LTSS, clawbacks, and Part B premiums—grows faster than the growth rate, states could seek to cut services

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ACA: Affordable Care Act; LTSS: Long-term services and supports
Questions Remain on How Medicaid Funding Reform Would Impact States and Dual Eligibles (2 of 2)

<table>
<thead>
<tr>
<th>Scope of benefits</th>
<th>Role of managed care</th>
<th>Cross-subsidization of BOE categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would states cut any optional benefits under the pressure of a funding cap? Would states seek waiver approval to cut mandatory benefits?</td>
<td>Given the need to cap spending, would states increase use of risk-based, capitated managed care to cover additional populations or services?</td>
<td>Could states use savings from one basis of eligibility (BOE) group to cross-subsidize another group that is not adequately funded through a per capita cap?</td>
</tr>
</tbody>
</table>

**Impact:** Medicaid covers community-based and institutional LTSS and the scope of these benefits could be reduced

**Impact:** Duals moved into capitated LTSS could see a change in services. Duals who currently have non-risk-based care coordination could see a reduction in services to limit costs

**Impact:** If cross-subsidization is allowed, states may be able to absorb decreases in funding for one higher-cost eligibility group if they net funds for a lower-cost group. This could make overall funding pressure less dramatic

LTSS: Long-term services and supports
If Funding Is Not Adequate, States Would Need to Reduce Costs, Likely Using Three Primary Levers

<table>
<thead>
<tr>
<th>Enrollment</th>
<th>Services</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Tighten eligibility criteria</td>
<td>● Limit covered benefits</td>
<td>● Reduce provider payment rates for long-term care providers</td>
</tr>
<tr>
<td>● Reduce income thresholds</td>
<td>● Eliminate coverage for some services, like LTSS</td>
<td>● Reduce capitation rates to health plans</td>
</tr>
<tr>
<td>● Eliminate coverage for some categories of enrollees</td>
<td>● Cap benefits (e.g., fixed number of visits or length of stay)</td>
<td>● Increase beneficiary cost sharing</td>
</tr>
<tr>
<td></td>
<td>● Tighten utilization management</td>
<td>● Premiums</td>
</tr>
<tr>
<td>● Require beneficiaries to meet job search or work requirements</td>
<td></td>
<td>● Copays / Coinsurance</td>
</tr>
<tr>
<td>● Enact lockout period for when beneficiaries miss payments, appointments, or other program requirements</td>
<td></td>
<td>● Contributions to HSAs</td>
</tr>
</tbody>
</table>

HSA: Health Savings Account
Modeling the Impact of Medicaid Funding Reform on the Dual Eligible Population
Modeling Approach Considered Two Growth Rates

- Avalere used its Medicaid forecasting and simulation model to analyze the potential impact of Medicaid per capita cap policies on dual eligible beneficiaries.
- In this analysis, Avalere estimates the potential impact of Medicaid per capita caps policies on federal Medicaid spending: in total, for aged and disabled enrollees, and for dual eligible beneficiaries.
  - Dual eligible beneficiaries would fall into either the aged or disabled beneficiary groups.
- Avalere uses the set of considerations below in modeling two versions of a per capita cap policy:

<table>
<thead>
<tr>
<th>Baseline Funding Level</th>
<th>Growth Factor (two versions)</th>
<th>Other Considerations</th>
</tr>
</thead>
</table>
| Per capita caps based on 2016 federal Medicaid spending for each of five beneficiary groups: | **CPI-M Proposal:**  
• CPI-M (the medical care component of the consumer price index) | Per capita caps would begin in 2020 |
| o Aged | **CPI-M + 1% Proposal:**  
• CPI-M + 1% for aged and disabled eligibility groups  
• CPI-M for other eligibility groups | |
| o Blind and disabled | | |
| o Children | | |
| o Non-expansion adults | | |
| o Expansion adults | | |
Federal Medicaid Spending on Aged and Disabled Would Vary Meaningfully Based on Growth Rates

If the cap formula increases the growth rate for aged and disabled beneficiaries by 1%, it meaningfully impacts federal funding changes for these groups. A smaller reduction or an increase in funding would reduce pressure to cut duals’ benefits.

Change in Federal Medicaid Spending, 2020-2026

<table>
<thead>
<tr>
<th></th>
<th>CPI-M</th>
<th>CPI-M + 1%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Aged</td>
<td>-$13</td>
<td>$26</td>
</tr>
<tr>
<td>All Disabled</td>
<td>-$44</td>
<td>-$8</td>
</tr>
<tr>
<td>All Dual Eligibles*</td>
<td>-$91</td>
<td>$20</td>
</tr>
</tbody>
</table>

Note: Change in federal Medicaid spending excludes the effect of any resulting changes in Medicaid enrollment. Simulation assumes Medicaid funding policies start in 2020 (using 2016 as the base year for federal spending levels) and that states do not alter enrollment or benefits. Projections for Medicaid enrollment and Medicaid spending come from CMS 2016 Medicaid Actuarial Report. Projections for CPI-M are from the Congressional Budget Office.

*Projections for spending changes for dual eligibles are based on weighted averages of the spending changes for the aged and disabled. Capped funding proposals have not included a dual-specific category to date, but duals would be either aged or disabled beneficiaries.
Spending for Duals Is Expected to Grow Faster than CPI-M

The selection of growth factor will determine the extent of impact on dual eligibles. A CPI-M growth factor would likely drive states to constrain costs for both aged and disabled duals by cutting enrollment, services, and/or provides rates.

Note: Projections for Medicaid per enrollee spending growth come from CMS 2016 Medicaid Actuarial Report. Projections for CPI-M are from the Congressional Budget Office. Avalere estimated the composition of dual eligibles that are aged or disabled using a combination of MACPAC reports, MSIS data, and Census population projections.
Direct reductions in federal Medicaid spending for duals stem from federal caps for aged and disabled enrollees. States would either choose to similarly reduce state Medicaid spending, or be forced to pay their own share plus the federal shortfall.

Simulation assumes Medicaid funding policies start in 2020 (using 2016 as the base year for federal spending levels) and that states do not alter enrollment or benefits. Projections for Medicaid enrollment and Medicaid spending come from CMS 2016 Medicaid Actuarial Report. Projections for CPI-M are from the Congressional Budget Office. Avalere’s projections of enrollee churn in the newly eligible adult population (under more frequent eligibility redeterminations established by the AHCA) are based on CBO’s assumptions.
Impact on Medicare-Related Spending
Under Capped Funding, States Could Face Pressure for Duals’ Costs Related to Medicare Spending

• States have limited control over many of their costs for duals, including for premiums
  o Capped funding proposals to date have excluded duals’ Part B premiums from caps
  o If federal cap policies do not distinguish state payments for Medicare from other Medicaid payments, this could force states to pay a larger share of Medicare costs

• Reductions in federal Medicaid spending could potentially lead states to reduce benefit eligibility or generosity, especially for populations that have the highest spending growth (such as aged and disabled beneficiaries)

• State changes in Medicaid coverage for duals around long-term care could trigger increased Medicare costs, such as higher hospital costs due to a lack of LTSS services

• Faced with funding reductions under a per capita cap, states may decrease investment in activities to improve care coordination for the dual eligible population
States Can Use Flexibility in Paying Medicare Cost Sharing to Providers

- States have flexibility in how they pay providers for Part A and Part B cost sharing if total payment to the provider (deductible, coinsurance, and copayments) for a service would exceed the state’s Medicaid rate.
- The state Medicaid-to-Medicare physician fee index measures the state Medicaid rates relative to Medicare rates for similar physician services.
- Most states choose to pay the lesser of:
  - The full amount of Medicare deductibles and coinsurance
  - The amount by which the Medicaid rate exceeds the amount paid by Medicare
- In states where the Medicaid rate is less than Medicare, the “lesser of” policy results in states paying less than the Medicare cost-sharing requirement.
- Some states have chosen to pay more than what is required and pay the full Medicare rate for services provided to duals despite the Medicaid-to-Medicare index.

Data Sources: MedPAC and MACPAC. 2017. Beneficiaries Dually Eligible for Medicare and Medicaid.
Despite Lower Medicaid Rates, Five States Pay Full Medicare Rates for Services Provided to Duals

Five states (AR, IA, ME, VT, WY) pay the Medicare rate in full for services provided to certain categories of duals despite the Medicaid rate in the state. Under pressure from per capita caps, states with higher Medicaid-to-Medicare index rates could be incentivized to cut Medicare provider reimbursement levels leading to potential access issues for patients.

*No data available for Tennessee because it does not have a FFS program

**State pays the full Medicare rate for outpatient hospital, inpatient hospital, skilled nursing facilities, and physician services

Data Sources: KFF. 2014. Medicaid-to-Medicare Fee Index; MACPAC. 2017. State Medicaid Payment Policies for Medicare Cost Sharing

FFS: Fee-for-service
For Dual Eligibles, Cuts to Medicaid-Funded Benefits Could Lead to an Increase in Medicare Costs

Many studies show LTSS and HCBS for the dual eligible population reduces total health expenditures

- Dual eligibles have a higher prevalence of physical and cognitive impairments and are more likely to have multiple chronic conditions
- Initiation of LTSS, including HCBS, among the dual eligible population reduces growth in total healthcare costs—with significant reductions in inpatient stays (paid by Medicare)
- Beneficiaries with unmet needs related to activities of daily living (ADL) are at a higher risk for acute care admissions and readmissions

Given these findings, a reduction or elimination of LTSS under capped Medicaid funding could potentially lead to an increase in otherwise preventable hospitalizations, which is bad for beneficiaries’ health and costly for Medicare

ADL: Activities of Daily Living; LTSS: Long-term services and supports; HCBS: Home- and community-based services
1. Allen, SM, Piette, ER and Mor, V. The Adverse Consequences of Unmet Need Among Older Persons Living in the Community: Dual-Eligible Versus Medicare-Only Beneficiaries. Journals of Gerontology, Series B: Psychological Sciences and Social Sciences, 69(7), S51–S58.
Appendix: Methodology
Methodology

Avalere used its Medicaid forecasting and simulation model to understand the potential implications of Medicaid per capita cap policies for the dual eligible population. The model is constructed using a variety of publicly available data sources on Medicaid spending and enrollment, demographic trends, and inflation.

Data Sources: For its Medicaid forecasting and simulation model, Avalere used a combination of the Centers for Medicare & Medicaid Services’ (CMS) Medicaid Statistical Information System (MSIS) and Medicaid Budget and Expenditure System (MBES) data to estimate recent and historical Medicaid spending and enrollment. Avalere relies on the 2016 CMS Medicaid Actuarial Report for future Medicaid spending and enrollment, and on the U.S. Census Bureau for state-level population projections. Avalere uses CBO assumptions for future overall inflation and medical care inflation.

Time Period: Avalere’s forecast period for this analysis aligns with the most recent CBO budget window, 2017-2026.

Medicaid Enrollment Changes: Avalere simulated the effect of the Medicaid per capita cap policies by first estimating the effect of the policy under the assumption that Medicaid enrollment does not change from current-law. This approach identifies the direct changes in federal Medicaid funding stemming from the new policy. State responses to federal funding changes could include changes to enrollment, payment rates, and/or benefits, among other changes. Federal Medicaid spending falls further if states decrease enrollment.