BACKGROUND ON POTENTIAL MEDICAID PROPOSALS FOR BUDGET RECONCILIATION

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CUTS TO THE MEDICAID PROGRAM WILL HURT AGING SERVICES PROVIDERS AND THOSE THEY SERVE

This document provides background and general talking points on current proposals being consider to cut Medicaid. There is a second document that has more talking points specific to aging services.

IMPLEMENT PER CAPITA CAPS

Currently, states receive federal matching funds based on the cost of providing services to enrollees. If federal Medicaid financing switched to a per capita cap, states would receive a capped allotment per enrollee. The cap may increase by a set amount every year (CPI, chained CPI), but the increase is not tied to or set to keep up with actual costs.

- The amount per person does not rise even if costs of care rise or new needs emerge
- Proposals for per capita caps may or may not include specificity by population. For example, there may be separate caps for different Medicaid eligibility group (i.e., the Medicaid expansion population, older adult duals without long term services and supports (LTSS) needs; adults with LTSS needs; kids, etc.)
- The federal funding cuts under a per capita cap would be highly unpredictable and largely beyond states' control, not necessarily reflecting factors such as rising medical care prices, population aging and other demographic changes, and, possibly, natural disasters and epidemics. Factors like a new drug or procedure could lead to an unexpected increase in costs that would be highly variable across states.
- Medicaid enrollees who use Medicaid long-term services and supports (LTSS) due to chronic illness or disability have health care costs around nine times higher than other enrollees. Adults aged 85 and older are more likely to use LTSS, so states expected to have growing shares of older adults are more likely to substantially exceed a per capita cap for the aged 65 or over eligibility group.
- States would not be rewarded for efficiency; because a per capita cap is initially based on current per person costs, a per capita cap is going to lock in existing differences in spending across states. States with lower initial per-enrollee costs would continue to receive less federal funding than states with higher initial costs.
- If per capita caps had been implemented in 2018, almost all states would have exceeded their caps in one or more years between 2018-2022. Some state specific data can be found here.

REDUCE OR ELIMINATE PROVIDER TAXES

Provider taxes support Medicaid programs in all states but Alaska. States collect revenue from a nursing home, hospital, managed care plan, ambulance or other class of provider based on a specified and agreed upon formula between the states and the federal government. That funding is then typically used as the non-federal share of Medicaid dollars; federal funds are matched to double or triple the

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value (depending upon your Federal Medical Assistance Percentage (FMAP)).

- Provider taxes allow states to meet their unique state needs; one size does not fit all.
- States use provider taxes to expand coverage, offer additional benefits, and increase reimbursement rates to providers–which is critical given that Medicaid rates often do not cover the cost of care, even with provider tax dollars.
- Providers are not guaranteed to get their dollars back; they pay the taxes to help finance their state's Medicaid system

  - Current proposals regarding provider taxes are structured to reduce federal spending without consideration as to the impact on state budgets if provider tax revenue were reduced or any reductions should be anticipated to be significant enough to cause states to make broad Medicaid program adjustments as the taxed class alone would not be able to absorb those reductions.
  - MACPAC reported in 2018 that 17% of total state funds came from provider taxes (note: this is not limited to funds serving that particular provider class.)
  - LeadingAge would be willing to work on alternative funding solutions for the Medicaid program but until a permanent way to ensure rate sustainability for nursing homes and others that benefit from the provider tax system is created, we do no support reductions or elimination of the provider tax system,.

IMPLEMENT MANDATORY MEDICAID WORK REQUIREMENTS

This proposal would add a work requirement (or community engagement requirement) to the Medicaid program for those who are not exempt.

- A recent KFF brief showed that only 64% of Medicaid beneficiaries were already working full or part time. Of those not working, 12% were not working due to caregiving and 10% due to illness or disability. 20% were working part time, which might not be sufficient depending on how a work requirement's proposal was structured.
- Congressional District level data of who is at risk of losing coverage due to work requirements can be found here.
- Promises to "carve out" certain populations or beneficiaries from work requirements are insufficient and raise a host of questions: How would a carve out be created for a family caregiver? What about for someone with a disability who did not qualify for Medicaid due to categorical eligibility based on disability?
  - More than 1 in 3 family caregivers are between the ages of 50 and 64 and have limited time to do other work or may not be able to find a job that accommodates their caregiving duties.
- For a carveout for older adults, how would older adults be defined? In existing federal programs, older adults are defined in multiple ways- 55 and older for the Program for All Inclusive Care for the Elderly (PACE), 65 for Medicare, 62 for Social Security and for the Section 202 housing program.
  - Raw age doesn't account for differences in circumstances such as homelessness, and jobs that are tougher on the body, leading younger people to have significant limitations earlier in life.
  - 1 in 5 people aged 50-64 get their health insurance through Medicaid and half of that population have a disability.

    - 7 in 10 low-income adults aged 50-64 report having fair or poor health or chronic conditions that make it harder for them to work on a consistent basis – inconsistent work would likely fall outside of the definition of a work requirement
    - In Arkansas, when they had a work requirement, 18,000 people lost coverage most of whom were eligible for exemptions but lost coverage due to administrative burden.
- Work requirements represent a large cost shift to states, both for human capital administration and the cost to build information technology (IT) infrastructure that could otherwise be spent on services.
    - Georgia: spent 26.6 million dollars on its "Pathways" program, an addition to their Medicaid program that includes a work requirement. 90% on administrative and consulting costs. 5,100/175,000 eligible beneficiaries enrolled in the program to date.

FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) CHANGES

Every state gets a different FMAP with a minimum floor of 50%, but all states get a 90% FMAP for the Medicaid expansion population. There are a couple of FMAP related proposals under consideration.

- Cut funding for the Medicaid expansion by reducing the 90% FMAP for this population to the state's regular FMAP
    - This would be a massive cost shift to states who would either have to remove people from coverage or cover the additional costs themselves.
    - There are a number of states with "trigger laws" where there would be immediate changes to coverage if this FMAP dropped below 90%: Arkansas, Arizona, Idaho, Illinois, Indiana, Iowa, Montana, New Hampshire, New Mexico, North Carolina, Utah, and Virginia. (CCF)
    - This provision would prevent adoption of expanded Medicaid by the remaining 10 states and could end expansion in other states
- Cut FMAP for all populations ("remove the floor")
    - Currently all states get at least 50%; proposals to move that to 40% or just remove entirely.
    - This proposal represents a massive cost shift to states; particularly impact on high per capita income states.