Key Considerations in Affordable Care Act Repeal & Replace Initiatives

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The National Association of Medicaid Directors (NAMD) is a bi-partisan, consensus-driven organization representing the Medicaid Directors in all 50 states, the District of Columbia and the territories. Medicaid is the nation's health care safety-net program and is collectively responsible for the health of 73 million Americans, including those with the most complex health care needs. States and the federal government have shared financial and programmatic responsibilities for Medicaid, making an effective federal-state partnership critical to the operation and success of this program.

NAMD has not taken positions on the broad political questions around repealing and replacing the Affordable Care Act (ACA). The resource, however, aims to outline key Medicaid issues that the Administration and Congress should consider as they move forward in evaluating those proposals. Careful consideration of these issues is needed to ensure that reform proposals do not have major unintended cost or operational impact on Medicaid, the beneficiaries the program serves, or otherwise impede successful state-led efforts to advance health system transformation. Medicaid Directors welcome the opportunity to engage with the Administration and congressional leaders further on these important considerations.

- **Modified Adjusted Gross Income (MAGI) Eligibility Standard.** The ACA required states to implement a new standard for determining income-based eligibility for the Medicaid program. MAGI replaced the previous standard for calculating Medicaid eligibility, which used income disregards. States dedicated significant resources to implement this new standard by making significant IT systems and policy changes, including standing up new eligibility and enrollment systems. Revising this income eligibility standard would come at a significant cost to states and the federal government, and possibly cause states to re-procure new eligibility systems once again. Careful consideration should be given to the impact that reverting to prior eligibility standards would have on Medicaid operations.

- **Prescription Drug Rebates.** The ACA required pharmaceutical manufacturers to provide rebates for drugs dispensed to Medicaid beneficiaries receiving care from a managed care organization (MCO). These rebates were previously only available for drugs covered under a fee-for-service system. This policy reflected the growing role of managed care as the predominant delivery model in Medicaid, and created equity between the managed care and fee-for-service delivery systems for pharmacy services. As a result, some states have carved the pharmacy benefit into their comprehensive managed care contracts. Other states, which already carved in pharmacy services, reflected the

costs savings in capitation rates and state budgets. Eliminating this policy would have fiscal implications for states and could open the door for manufacturers to recover rebates on already paid managed care claims. Such a change would also require complex and costly IT systems changes. Federal policymakers should ensure policies provide equity around the use of managed care and fee-for-service delivery models, and avoid cost impacts on states.

- **State-led Innovation Supported through the Center for Medicare and Medicaid Innovation (CMMI).** Medicaid Directors are working to reorient the health care system to achieve better services, better health and lower costs. This state-led innovation, which is being supported and championed by the broader health care delivery system, is beginning to show early signs of success at reversing the trajectory of ballooning health care cost growth. But successful state-led innovation requires time and sustained investment for states to build the complex infrastructure necessary to support reform. The State Innovation Model (SIM) initiative out of CMMI has fueled 35 states' efforts to build the infrastructure needed to transform the health care system. In ACA repeal discussions, federal policymakers should consider how to ensure continuity and ongoing investment in state-led transformation of the health care delivery system.

- **Medicaid-Medicare Coordination Office (MMCO) and Financial Alignment Demonstrations.** The creation of the MMCO was an important first step in addressing the bi-furcation in coverage and care for individuals served by Medicare and Medicaid, which are often both programs' most costly beneficiaries. States historically faced insurmountable barriers in partnering with the Medicare program. The MMCO has begun to address these barriers and facilitate state efforts to coordinate with Medicare and improve care for dually eligible individuals. For example, 13 states are participating in MMCO's Financial Alignment Demonstrations, which are testing new coordinated financing and administrative alignment for dually eligible beneficiaries. This work is beginning to demonstrate success, as evidenced by a recent evaluation of Minnesota's demonstration.[1] Federal policymakers should consider the structure for state/Medicare coordination for duals going forward, and the future of successful innovations to align financing and administration of services.

- **Health Home Programs.** Twenty-one states have implemented health home programs under Section 2703 of the ACA to provide coordinated care and linkage to needed social supports for individuals with chronic conditions. States are standing up these programs with enhanced federal support in the first eight fiscal quarters of the program for health home services. This has provided the up-front investment necessary for states to implement these care coordination initiatives. Policymakers should ensure state-led innovations that are underway to improve quality and contain costs can continue to advance.

- **Program Integrity Provisions.** States have committed significant resources and made changes in their program integrity approaches, processes and systems in response to the ACA. States have implemented new provider screening requirements for providers that have demonstrated the highest risk rates of fraud, waste and abuse (i.e., background checks). It also included new provider

[1] Wayne Anderson, PhD, Zhanlian Feng, PhD, and Sharon Long, PhD. RTI International and Urban Institute. "Minnesota Managed Care Longitudinal Data Analysis." March 31, 2016. https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis.

enrollment approaches (i.e., enrollment for providers who order, prescribe, or refer services for Medicaid beneficiaries). As appropriate in the context of each state's landscape, states may find it beneficial to continue using these tools. Consideration should be given to the value created by various program integrity tools, as well as how states can work within a menu of program integrity mechanisms to prevent fraud, waste and abuse.

- **Changes to Home and Community-based Services (HCBS).** The ACA expanded the authority for states to provide HCBS through state plan authority (rather than though a HCBS waiver). First, the law made a number of changes to Section 1915(i) state plan authority for HCBS. It expanded financial eligibility for HCBS provided under a Section 1915(i) state plan amendment (SPA); established a new optional Medicaid coverage group for individuals who receive HCBS through the state plan and are otherwise ineligible for full Medicaid benefits; allowed states to target 1915(i) services to specific populations; and expanded the services states may cover under the option. Seventeen states currently provide HCBS services through Section 1915(i) SPAs. In addition, the ACA created the Community First Choice (CFC) option for state Medicaid programs under section 1915(k) of the Social Security Act. CFC allows states to provide home and community-based attendant services and supports under the state plan. Five states currently have approved 1915(k) SPAs. Policymakers should engage with states to better understand the impact of potential changes to HCBS authorities under section 1915(i) or 1915(k).

- **Medicaid Emergency Psychiatric Demonstration (MEPD).** Eleven states participated in this demonstration to test the cost effectiveness of delivering emergency psychiatric services in institutions for mental disease (IMDs). After the initial demonstration period, Congress extended the effort. However, statutory parameters and CMS interpretation of them has prevented states from continuing this demonstration. States involved in the initial demonstration identify value in continuing to test the cost effectiveness of delivering specialized inpatient psychiatric services in IMDs.

- **Preventive Services.** The ACA amended section 1905(a) of the Social Security Act to incorporate preventive services into the Medicaid benefit. The addition of this provision has provided states with additional flexibility in their benefit design around preventive services. It has also, in part, driven changes around autism services in Medicaid, which has created complexity in the program. Policymakers should work with states to better understand the impact and implications of this policy.

- **Children's Coverage.** Children's eligibility under Medicaid was increased to a uniform percentage of the federal poverty level (FPL) under the ACA (previously children were covered at different eligibility levels based on age). Children that moved from CHIP to Medicaid as a result of this change received the higher CHIP federal matching percentage (FMAP). For some states, this policy change displaced CHIP funding, and along with the enhanced FMAP for CHIP, led to an expansion of coverage to additional children under CHIP. Consideration should be given to how eligibility and financing changes to Medicaid and CHIP might affect coverage across both programs.

- **Adult Medicaid Coverage Expansion and Federal Matching Percentage.** Thirty-two states have adopted the Medicaid expansion to childless adults under the ACA. States operationalized the

expansion based on a structure where the federal government finances 100 percent of costs for this population for the first two years, phasing down to 90 percent by 2020. State budgets, which are often implemented on a biennium, and mechanisms to finance the Medicaid state share of the program, reflect this structure. In FY 2015, states received an estimated $58 billion in federal funding for this coverage expansion. Consideration should be given to the programmatic and fiscal implications of policy changes in this area.