

REPEAL AND REPLACE: IMPLICATIONS FOR MEDICAID





INTRODUCTION

Since the publication of our recent report titled “Grading Obamacare While Speculating About Trump: Separating Fact from Fiction” on December 21, 2016, President Donald Trump has been inaugurated, executive orders issued and alternative proposals generated. The American Health Care Act, introduced March 6, described by conservative Republicans as “Obamacare Lite”, has already cleared the House Ways & Means and House Energy & Commerce Committees, and is headed to the House Budget Committee; House vote is targeted prior to the April 10 recess. Challenges from the right (“Freedom Caucus”) and left (Democrats) create uncertainty regarding its future, especially in the Senate where Republicans have a narrow 52-48 voting margin.

In this article, we focus on Medicaid, an entitlement program providing insurance coverage for 68 million Americans and the Trump administration’s initial target for reform. Medicare, with the advocacy of AARP and political support from millions of aged Americans, will be far more difficult to reform. In addition, Medicare, unlike Medicaid, is largely administered from a central focal point, the Centers for Medicare and Medicaid Services (CMS), whereas Medicaid represents a decentralized program with significant variation among the 50 states.

LIKELY WINNERS AND LOSERS

(BASED ON ASSUMPTIONS)



Alvarez & Marsal (A&M) expects the following reform scenario for Medicaid based on the likelihood that the Republican American Health Care Act will not be approved without significant changes:

- States will be able to elect to receive federal funding for State Plan services in the form of per capita allotments or block grants. All states will be required to continue to provide basic coverage to mandated groups.
- States most likely to elect per capita allotments are states that have not adopted Medicaid expansion. These states will draw a federal match on program services up to an established cap. CMS will prescribe an income limit – likely 100 percent of the federal poverty level (FPL) – and will allow increases in the cap as beneficiary enrollment increases.
- States most likely to elect block grants are those states with robust Section 1115 demonstration waivers. These states may continue to reform their programs through “global waivers.”
- States that have adopted Medicaid expansion will be encouraged to transition expanded populations to nonpublic coverage options. For those that remain eligible for Medicaid, an enhanced match will decrease over time to be consistent with the federal match on traditional Medicaid services.
- States will be encouraged to use personal responsibility provisions such as premiums and copayments (as per Indiana). Federal personal responsibility mandates are unlikely due to the difficulty and cost to operationalize and collect.
- The Federal Matching Assistance Percentage (FMAP), the share of federal funding for Medicaid services and an approach for computing annual increases, will serve as a negotiating tool to pass “repeal and replace” legislation and achieve a predetermined budget target.
- Disproportionate Share Hospital (DSH) payment reductions authorized by the ACA to begin in FY2018 and extend through FY2025 will be pulled back with increased allotments going to states that have rejected Medicaid expansion. This signals an anticipated reversal in the downward trend of uncompensated care costs and potentially limits the availability of Delivery System Reform Incentive Payment (DSRIP) funding.
- Federal payments for DSH, administrative costs and other fees will be carved out of a per capita allotment. Notably absent from mention in proposed “repeal and replace” plans, home and community-based services (HCBS) authorized under 1915(c) waivers may also be carved out. These waivers are essential to ensuring continued rebalancing with expensive institutional services and to meeting expectations established by the Supreme Court's Olmstead decision.
- States electing block grant options will be granted broad flexibility in program design. These states will be required to continue coverage as per statutory mandates and will be pressed to have a comprehensive strategy to prevent fraud, waste and abuse.

Winners

- **Medicaid managed care organizations (MCO's).** Enrollment has been steadily increasing across the country, with extensions to high-cost populations, i.e., dual-eligible aged, disabled and those with special needs. Industry and health plan consolidation has raised prices and reduced choice. Knowledge, sophistication and analytic capabilities are a competitive advantage relative to Medicaid administrative personnel within the states. However, a possible reduction in the number of Medicaid beneficiaries will pose interim challenges to MCO's.
- **HCBS providers.** The underlying trend toward non-institutional care for the aged and disabled will accelerate.
- **States with historically high Medicaid spending and inefficient service models.** These states will be rewarded with block grants or per capita allotments that are higher, at least initially, in comparison to their more efficient and conservative counterparts. Note, however, CMS may attempt to equalize per capita allotments such that high cost states such as New York may more closely approximate spending in lower cost states such as Florida.

Losers

- **State budgets.** Block grants and per capita allotments are oriented toward a reduction in longer-term spending. Medicaid spending at the state level is forecast to increase 5.0–6.0 percent, a rate far exceeding the state budget revenue growth. Block grant and per capita caps prevent “the more you spend, the more you get” mentality. Efficient states are likely to have a lower level of baseline spending than inefficient states.
- **Acute care hospitals.** Reduction in eligible Medicaid beneficiaries will increase the number of uninsured, compounded by possible legislation affecting health exchanges. A reduction is also likely in the rate of Medicaid and Medicare reimbursement growth.
- **Providers.** Reduced federal funding is likely to affect Medicaid rate increases for physicians, hospitals, skilled nursing facilities and home care. Providers will also be negatively affected by a higher rate of uninsured and bad debt expense.
- **People on HCBS waiting lists.** It remains unclear how states will be able to afford to address the needs of people on HCBS waiting lists within a block grant or per capita allotment environment.



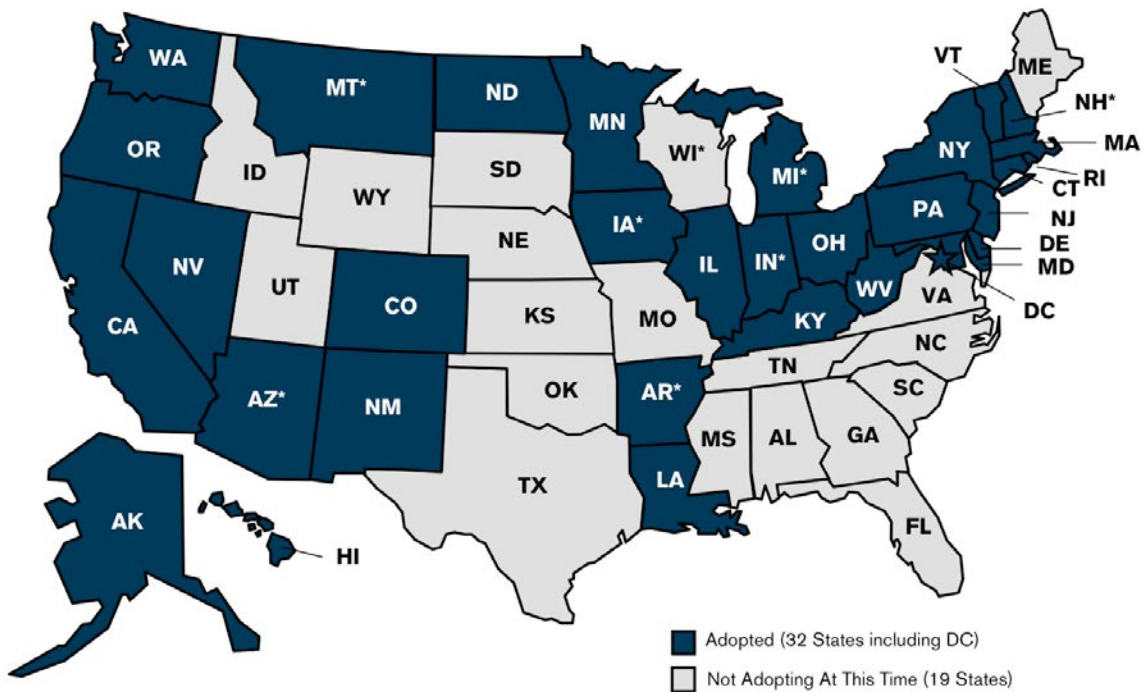
SITUATION ANALYSIS



Authorized in 1965 by Title XIX of the Social Security Act, Medicaid is an entitlement program that provides healthcare coverage to low-income Americans. Although participation in Medicaid is optional, all states have a Medicaid program. Each state receives federal matching funds to finance services provided under a Medicaid State Plan approved by CMS. While averaging 63.7 percent (2015) nationally, federal matching funds vary by state per capita income. “States have substantial flexibility to design their programs within certain broad Federal requirements related to eligibility, services, program administration and provider compensation.”¹

Prior to the 2010 enactment of the ACA, Medicaid beneficiaries included low-income children and parents, people who are blind or disabled, and seniors. The ACA enabled states to expand Medicaid by increasing income eligibility limits (from 100 percent to 138 percent of the FPL) and allowing “childless able-bodied adults” to participate. For expansion populations, the ACA provided an initial enhanced federal match of 100 percent, declining to 90 percent by 2020. As of 2016, 31 states had expanded their Medicaid program and there were 68 million Medicaid beneficiaries.

MEDICAID EXPANSION BY STATE



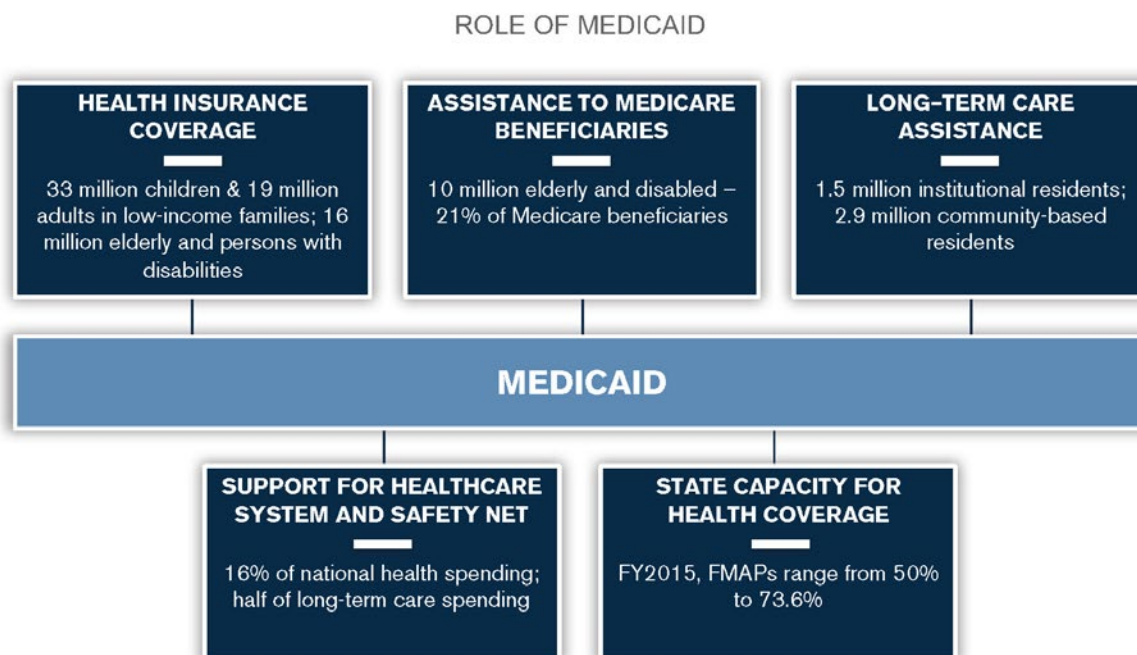
Source: <http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/>

Coverage for Medicaid beneficiaries varies by state. Every state plan must include mandatory services as specified in the federal statute, such as hospitalization, physician services, skilled nursing facility (SNF) care, screening, diagnosis and treatment for beneficiaries under age 21, and home healthcare.² States may also elect State Plan coverage of (a) several optional services, such as prescription drugs, Intermediate Care Facility (ICF) services for people with intellectual disabilities, clinic services, therapies, etc.; and/or (b) HCBS. States may also offer HCBS to targeted populations that without the benefit of these services would require care in an institutional setting such as an SNF or ICF. Rather than the State Plan, these services are typically authorized under Section 1915(c) of the Social Security Act and commonly referred to as a 1915(c) HCBS waiver.

For Medicaid expansion populations, states must provide an alternative benefit plan (ABP). A state's ABP may not necessarily include all of the benefits offered in the Medicaid State Plan. It must, however, include the

10 categories of essential health benefits required by the ACA, provide parity in coverage between physical and mental health services, and offer certain preventive services.³

Medicaid also provides financial support to hospitals that serve a large number of Medicaid and low-income uninsured patients. DSH payments supplement Medicaid fees and temper losses for the cost of uncompensated care by making payments to safety net providers at the rate paid by Medicare for inpatient services. Safety net hospitals in Medicaid expansion states have seen a significant reduction in uncompensated care costs, accounting for approximately \$4 billion of the total \$5 billion reduction in uncompensated care in 2014. ACA's planned reduction in DSH payments has a corresponding inverse relationship with DSRIP funding. As part of the 1115 waiver process used to design and customize state Medicaid expansion programs, DSRIP provides grants to providers to improve healthcare indicators by creating reimbursement systems that incentivize quality.



Source : Kaiser Foundation, Medicaid.gov

% MEDICAID AND UNINSURED BY STATE, FY 2015

1st QUARTILE				3rd QUARTILE			
STATE	% MEDICAID	% UNINSURED	% TOTAL	STATE	% MEDICAID	% UNINSURED	% TOTAL
New Mexico	27%	12%	39%	Nevada	17%	11%	28%
Arizona	25%	13%	38%	Massachusetts	23%	4%	27%
Mississippi	23%	13%	36%	Ohio	21%	6%	27%
West Virginia	29%	6%	35%	Montana	16%	10%	26%
California	26%	8%	34%	New Jersey	18%	8%	26%
Georgia	19%	14%	33%	Connecticut	19%	6%	25%
Texas	16%	16%	32%	Delaware	18%	7%	25%
Alaska	18%	13%	31%	Illinois	19%	6%	25%
Arkansas	22%	9%	31%	Michigan	19%	6%	25%
Florida	18%	13%	31%	Vermont	20%	5%	25%
Louisiana	20%	11%	31%	Wisconsin	17%	7%	24%
Oregon	24%	7%	31%	Pennsylvania	18%	6%	24%
Oklahoma	17%	13%	30%	Kansas	13%	10%	23%
AVERAGE: 33%				AVERAGE: 25%			

2nd QUARTILE				4th QUARTILE			
STATE	% MEDICAID	% UNINSURED	% TOTAL	STATE	% MEDICAID	% UNINSURED	% TOTAL
Alabama	19%	11%	30%	South Dakota	14%	9%	23%
DC	26%	4%	30%	Hawaii	18%	5%	23%
New York	24%	6%	30%	Iowa	17%	5%	22%
South Carolina	19%	11%	30%	Rhode Island	17%	5%	22%
Tennessee	19%	11%	30%	Maryland	15%	7%	22%
Washington	22%	7%	29%	Missouri	13%	9%	22%
Idaho	18%	11%	29%	Utah	12%	10%	22%
North Carolina	18%	11%	29%	Nebraska	13%	8%	21%
Colorado	19%	9%	28%	Minnesota	14%	6%	20%
Indiana	19%	9%	28%	Virginia	11%	9%	20%
Kentucky	22%	6%	28%	Wyoming	10%	9%	19%
Maine	23%	5%	28%	New Hampshire	13%	5%	18%
AVERAGE: 29%				AVERAGE: 21%			

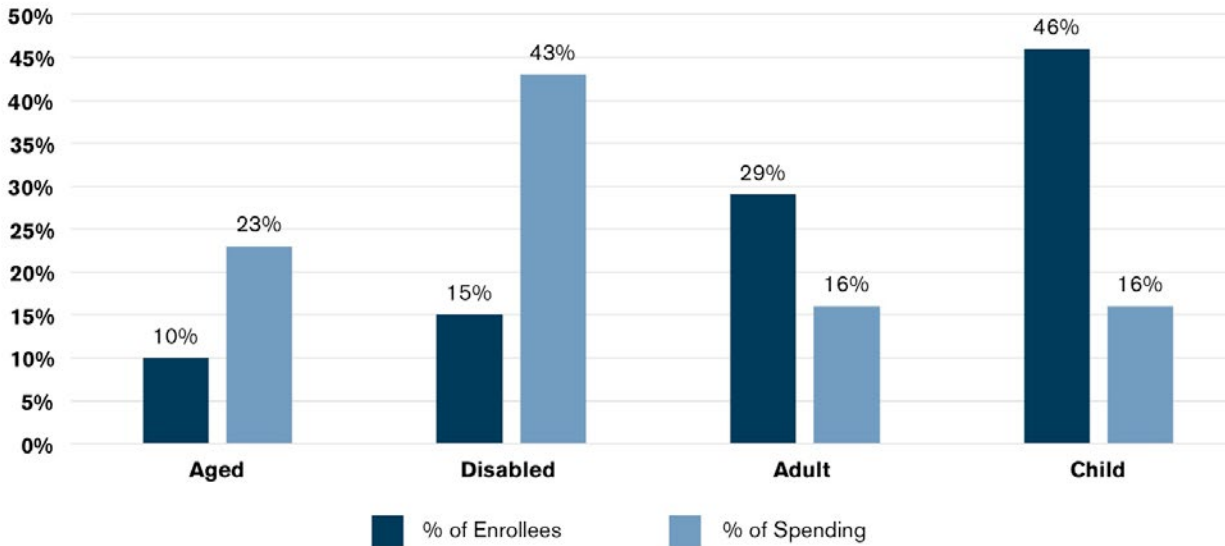
Green – Medicaid Expansion Pink – No Expansion

Source : Kaiser Foundation, Medicaid.gov

The number of Medicaid beneficiaries and uninsured as a percentage of the total population varies by state. The percentage of Medicaid beneficiaries ranges from a low of 10 percent in North Dakota and Wyoming to a high of 29 percent in West Virginia; the percentage of uninsured ranges from 4 percent in Massachusetts to 16 percent in Texas. Access is far more limited for the uninsured largely dependent upon government safety net hospitals and Federally Qualified Health Centers (FQHCs) for their healthcare.

Children and non-senior adults account for 75 percent of Medicaid beneficiaries, but only 32 percent of Medicaid spending; the aged and disabled account for 25 percent of Medicaid beneficiaries and 68 percent of spending. Spending per enrollee varies substantially across each enrollment group with the aged (\$15,346) and disabled (\$17,848) far higher than children (\$2,679) and adults (\$4,044). In FY2012, the average spending per beneficiary was \$6,833.

DISTRIBUTION OF MEDICAID ENROLLMENT AND SPENDING BY ELIGIBILITY GROUP, FY 2013

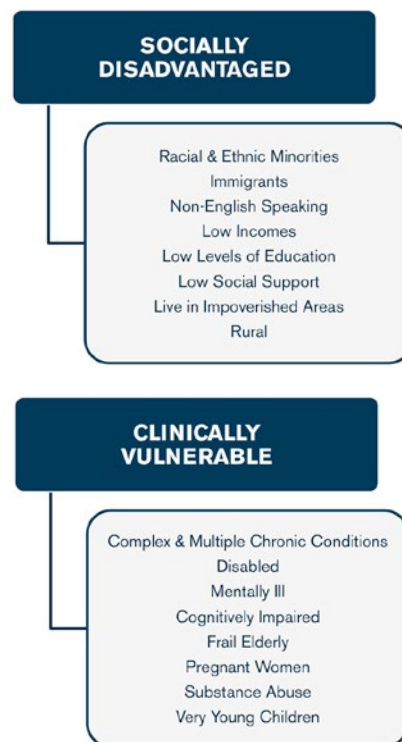


Source: MACStats: Medicaid and CHIP Data Book – December 2016
https://www.macpac.gov/wp-content/uploads/2016/12/MACStats_DataBook_Dec2016.pdf

Medicaid beneficiaries and the uninsured are also socially disadvantaged and clinically vulnerable. These populations include racial and ethnic minorities, undocumented and documented immigrants (i.e., with green cards or under Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA)), and those residing within impoverished and rural areas. Clinically vulnerable populations include those with complex comorbidities (i.e., multiple chronic medical conditions), the disabled, patients with acute and chronic behavioral health issues, and substance abusers.

In 2015, Medicaid spending was \$564 billion, with the federal government, through its FMAP, accounting for 63.7 percent of the total. FMAP represents the percentage of federal matching funds of state expenditures and varies from

CATEGORIES AND OVERLAP OF VULNERABLE POPULATIONS



Source: Lewis V, et al. The Promise and Peril of Accountable Care for Vulnerable Populations: A Framework for Overcoming Obstacles. Health Affairs 31(8) August 2012

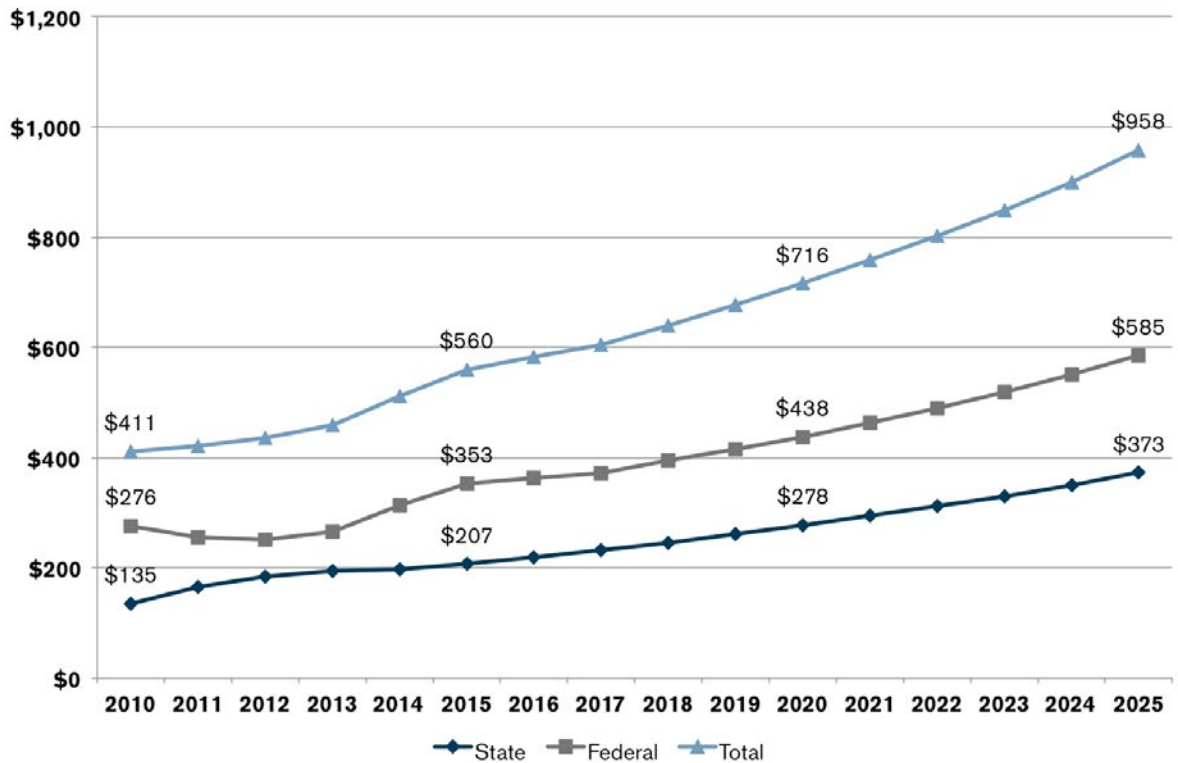
state to state based on each state's population below the FPL. The ACA for newly eligible Medicaid recipients provided 100 percent federal funding for 2014, 2015 and 2016, and provides 95 percent for 2017, 2018 and 2019, and 90 percent thereafter.

The nonfederal or state-funded portion of Medicaid represents 19.3 percent of the average state budget. State funds include revenues raised through income, sales and other broad-based state taxes, as well as restricted revenue sources applied to specific activities such as provider taxes, lottery proceeds, tobacco settlement funds, local funds and bond expenditures for capital projects.⁴

Total Medicaid spending is forecast to increase at a 5.9 percent compound annual growth rate (CAGR) to reach \$1 trillion by 2025.⁵

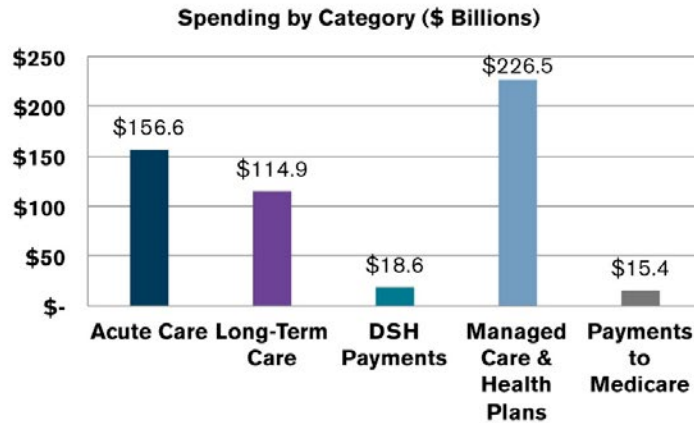
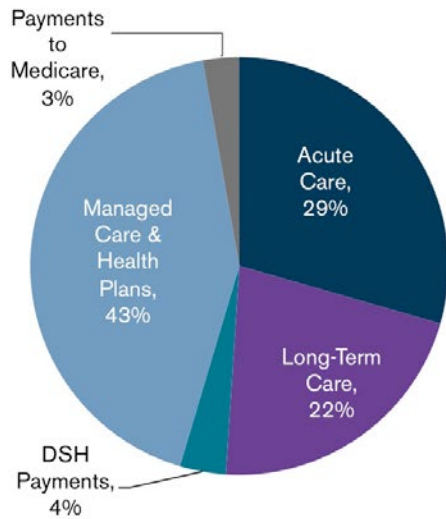
Approximately 43 percent of total Medicaid spending, a surprisingly high percentage, is spent with managed care organizations (MCO), followed by spending for FFS acute care and FFS chronic care. The high level of MCO spending reflects a desire by state governments to transfer financial risk from the state budget to the commercial payer. Population health, expenditure, resource allocation and quality data – essential for outcomes and accountability management – is far more limited for MCOs than it is for FFS providers.

PROJECTED MEDICAID EXPENDITURES BY SOURCE OF FUNDS
2015-2025 CAGR: FEDERAL 5.2% AND STATE 6.1%



Source: CMS National Health Expenditures

MEDICAID SPENDING BY CATEGORY, FY2015



Source : Kaiser Foundation, Medicaid.gov

Medicaid spending per beneficiary varies widely by state, with New Jersey, at \$13,480, more than 2.7 times that of Alabama, at \$4,983. The wide range in spending reflects the beneficiary mix between the high cost of the aged and disabled population and low costs for children and adults; the number of beneficiaries in institutional care, primarily nursing homes and, to a lesser extent, intermediate care facilities for people with intellectual disabilities; differentials in payment rates for similar levels and/or types of service (e.g., the Medicaid-to-Medicare physician fee ratio); geographical differences in labor and provider costs; the ability of state Medicaid directors to negotiate contract terms with MCOs; and other factors.

States with Medicaid expansion tend to spend more per beneficiary on Medicaid than those without expansion, reflecting, in general, a more liberal spending policy for social services.

Dual-eligible beneficiaries are those eligible for Medicare and Medicaid – either full benefits, assistance with Medicare premiums, or cost

sharing through a Medicare Savings Program such as Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) programs. Medicare pays for Part A: hospital, non-institutional (post-acute) SNF care, hospice and some home health; Part B: physician and other professional services, durable medical equipment, home health services; Part C: Medicare Advantage; and Part D: prescription drug benefits.⁶

Medicare-covered services are paid first by Medicare, as Medicaid is generally the payer of last resort. Medicaid “may cover the cost of care that Medicare may not cover or may partially cover (such as nursing home care, personal care, and home- and community-based services).”⁷

In 2013, 10.7 million Medicaid beneficiaries – 59 percent aged, 41 percent over the age of 65 and disabled – were dually eligible; 72 percent were eligible for full Medicaid benefits. The dual-eligible population represents 15 percent of all Medicaid beneficiaries and accounts for 33 percent of costs.⁸ Medicaid spending per dual beneficiary varies widely by state.

MEDICAID SPENDING PER BENEFICIARY, BY QUARTILE, FY2015

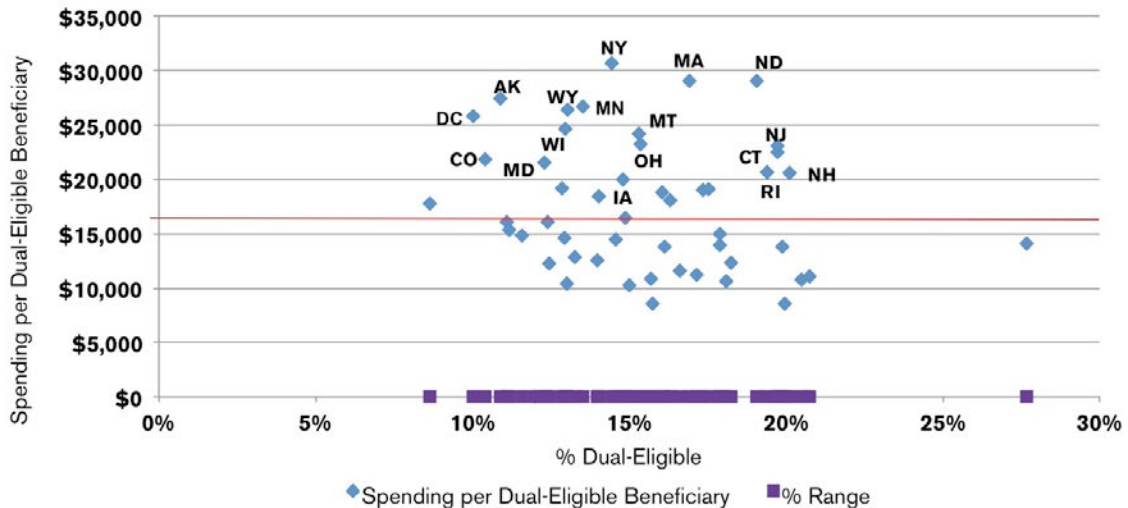
1st QUARTILE				3rd QUARTILE			
STATE	\$ SPENT	\$ LTC	% DUAL ELIGIBLE	STATE	\$ SPENT	\$ LTC	% DUAL ELIGIBLE
New Jersey	\$13,480	\$2,021	20%	Iowa	\$7,626	\$2,915	15%
Rhode Island	12,251	648	19%	Washington	7,603	1,441	13%
Oregon	11,058	1,827	15%	Indiana	7,574	2,731	14%
Massachusetts	10,316	2,510	17%	Virginia	7,558	2,632	18%
New York	10,279	2,848	14%	Texas	7,392	1,121	13%
Alaska	10,257	3,706	11%	California	7,331	918	11%
DC	10,219	3,216	10%	Hawaii	7,083	374	13%
New Hampshire	10,098	3,427	20%	North Carolina	6,901	1,026	17%
Kentucky	10,031	1,488	20%	Maine	6,862	2,247	28%
Connecticut	9,991	3,792	20%	Nebraska	6,833	3,359	16%
Minnesota	9,904	3,208	14%	Michigan	6,794	1,117	12%
Colorado	9,876	1,480	10%	Mississippi	6,597	1,980	21%
Maryland	9,793	2,247	12%	Idaho	6,365	2,092	15%
AVERAGE	\$10,581	\$2,494	16%	AVERAGE	\$7,117	\$1,843	16%

2nd QUARTILE				4th QUARTILE			
STATE	\$ SPENT	\$ LTC	% DUAL ELIGIBLE	STATE	\$ SPENT	\$ LTC	% DUAL ELIGIBLE
North Dakota	\$9,782	\$4,912	19%	Wyoming	\$6,364	\$4,092	13%
Ohio	9,610	1,951	15%	Utah	6,283	1,598	9%
Pennsylvania	9,243	3,086	18%	Louisiana	6,269	1,499	16%
Montana	8,933	2,047	15%	South Carolina	6,181	1,128	17%
New Mexico	8,562	428	12%	Wisconsin	6,141	1,542	13%
Arizona	8,416	26	12%	South Dakota	5,931	2,928	16%
West Virginia	8,380	2,653	20%	Tennessee	5,924	560	18%
Missouri	8,364	2,715	16%	Oklahoma	5,832	1,973	14%
Vermont	8,173	611	15%	Illinois	5,820	1,360	12%
Nevada	8,057	833	13%	Florida	5,799	493	18%
Arkansas	7,712	1,933	18%	Georgia	5,052	1,273	16%
Kansas	7,709	149	17%	Alabama	4,983	1,424	20%
Delaware	7,672	676	11%	AVERAGE	\$5,882	\$1,656	15%
AVERAGE	\$8,509	\$1,694	15%				

Green - Medicaid Expansion Pink - No Expansion

Source : Kaiser Foundation, Medicaid.gov

SIGNIFICANT VARIATION IN SPENDING PER DUAL-ELIGIBLE BENEFICIARY (MEDICAID & MEDICARE)



Source : Kaiser Foundation

The primary goal of the ACA was to increase coverage and not necessarily to improve the efficiency of effectiveness of care delivery, i.e., manage costs and outcomes. Since implementation, the number of uninsured Americans declined between 2013 and 2015 from 41.0 to 28.5 million, or 35 percent. This number is forecast to fluctuate by approximately +/-2 million by 2025, assuming no legislative or regulatory changes. Nearly three-quarters of individuals newly covered by the ACA gained coverage via enrollment in a state Medicaid program.

The decrease in uninsured is comprised of an increase in people with private health insurance coverage and newly enrolled

Medicaid beneficiaries. As of March 2016, more than 12.7 million people were enrolled in state or federal marketplace plans – approximately one-third newly insured. Health exchange participation figures are significantly below earlier CMS and Congressional Budget Office (CBO) projections, which estimated that by 2016, 33 million Americans would be newly covered.⁹

As of June 2016, Medicaid enrollment had grown by more than 15 million (27 percent). Of the new Medicaid enrollees, 78 percent were enrolled under the expanded coverage criteria since the period before open enrollment (which started in October 2013).¹⁰ Medicaid enrollment grew ahead of expectations by 5 million.¹¹

AFFORDABLE CARE ACT

COVERAGE:

- **Medicaid Eligibility Expansion** to those earning 138 percent of the FPL, including adults without dependents, in participating states
- **Individual Mandate**; if uninsured, 2016 penalty of \$695 or 2.5 percent of family income, whichever is greater
- **Employer Mandate**. Employers with >50 full-time employees (>30 hours per week) are required to offer health insurance coverage that meets affordability provisions; i.e., no more than 9.5 percent of gross pay for individual coverage. They will be charged a \$2,000 penalty per full-time employee that lacks health coverage
- Insurers may not deny coverage to individuals for **pre-existing conditions**; and must offer the same premiums within the same age and geographical group regardless of gender and pre-existing conditions, except tobacco use
- **Young Adult Coverage**; can remain under parents' health plan through age 26
- Health plans are required to provide **essential health benefits** (n=10 categories); i.e., ambulatory (outpatient) services, emergency services, hospitalization, pregnancy / newborn, mental health / substance abuse, Rx drugs, rehabilitation, labs, prevention, wellness and chronic disease, pediatric including oral and vision care
- Elimination of annual and lifetime **spending caps**

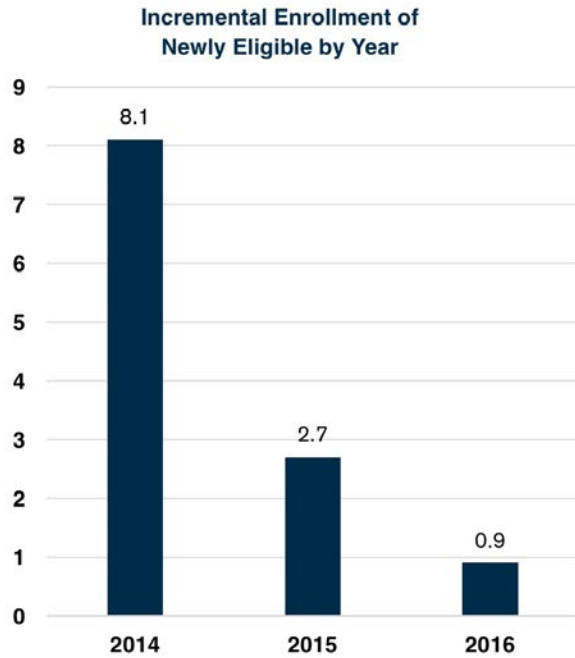
ACCESS:

- Created **Health Exchanges** at the federal and state levels to make "affordable" health plans meeting essential ("basic") health plan requirements available to uninsured and low-to-moderate income individuals and households
- Employers may not require employees to wait more than 90 days for health insurance eligibility

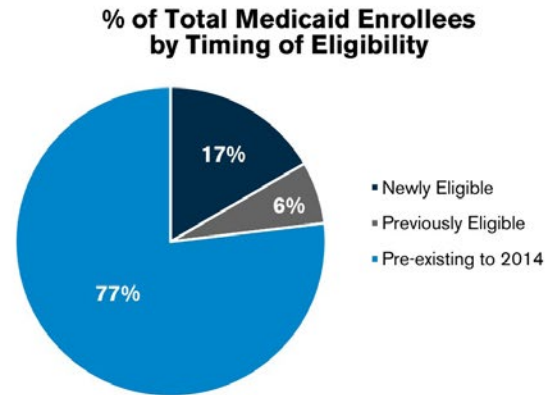
AFFORDABILITY:

- **Subsidies** (in the form of refundable tax credits) available on the state health insurance exchanges for individuals with a household income up to 400 percent of the FPL. Note, average premium subsidy of \$291/month
- **No Out-of-Pocket Costs for Preventive Services** (n=66); e.g., annual primary care visit, screenings (e.g., BP, cholesterol, colorectal cancer, depression, diabetes, hepatitis, HIV) and vaccinations
- Pretax **Health Savings Accounts** (HSAs) for enrollees in high deductible health plans
- Patients are granted the right to appeal whenever an insurer denies payment for healthcare services

IMPACT OF ACA EXPANSION ON MEDICAID ENROLLMENT



(\$MMs)	2013	2014	2015	2016
Pre-existing	55.4	55.1	54.5	54.3
Previously Eligible	-	2.7	3.7	4.6
Subtotal	55.4	57.8	58.2	58.9
Newly ACA Eligible	-	8.1	10.8	11.7
Total	55.4	65.9	69.0	70.6



Source: Medicaid.gov, Table from National Health Expenditures

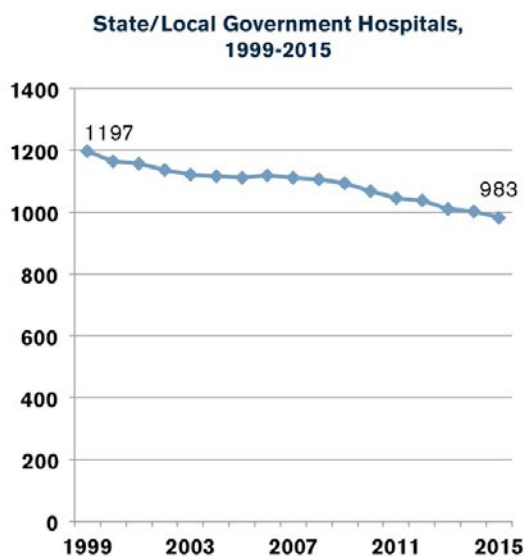
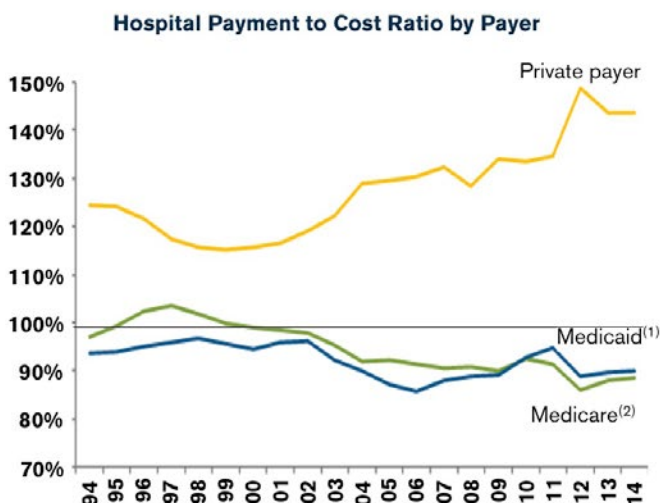
For the entire 2017–2026 period, incremental federal spending for people who the ACA made eligible for Medicaid coverage is projected to be \$100 billion per year, whereas the comparable figure for premium exchange subsidies is \$90 billion; in total, this equals \$190 billion in incremental federal healthcare spending per annum.

Safety net hospitals have been a major beneficiary of Medicaid expansion under the ACA. Safety net hospitals are defined as those with a low income utilization ratio exceeding 25 percent and/or inpatient Medicaid utilization

greater than one standard deviation above the mean within a specific state.¹² The number of state and local government safety net hospitals has declined by 17.9 percent since 1999, a rate 10 times the decline in the overall market. A few of the hospitals have converted to not-for-profit status (e.g., University Health Shreveport and Conroy), whereas the majority have closed. A proprietary analysis by A&M highlights the improved earnings before interest, tax, depreciation and amortization (EBITDA) margins associated with hospitals located in Medicaid expansion states.

GOVERNMENT SAFETY NET HOSPITAL OVERVIEW

	NPR \$	EBITDA \$	Margin %	n =
Expanded	393,720,808	(22,580,998)	(6.8)	131
Not	508,206,861	(61,677,826)	(11.7)	76



	1999	2015	Variance	% Change
State / Local Government	1,197	983	(214)	(17.9%)
Not-for-profit	3,012	2,845	(167)	(5.5%)
For-profit	747	1,034	287	38.4%
TOTAL	4,956	4,862	(94)	(1.9%)

In 2014, Medicaid DSH payments totaled \$18 billion, with the federal government contributing \$10 billion and states \$8 billion; alternative sources suggest a split of \$12 billion and \$6 billion, respectively.¹³

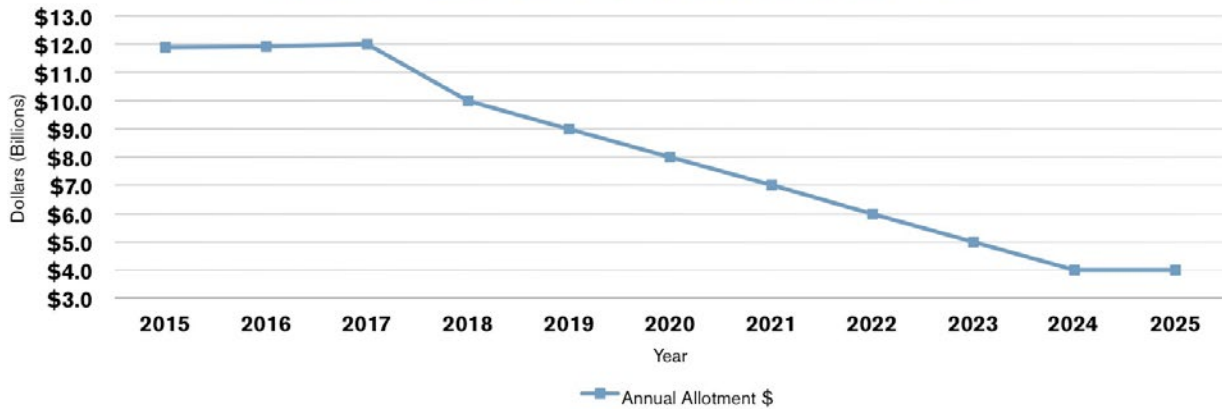
Originally set to decline in FY2014, DSH payment reductions are now scheduled to begin in FY2018 and continue to decline until FY2025. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), an opportunity exists for “DSH allotments and payments to be better targeted toward the states and hospitals that serve a disproportionate share of Medicaid and low-income patients and that have disproportionate levels of uncompensated care.”

Increased Medicaid and health exchange insurance coverage has somewhat increased provider access, especially when compared to those who remain uninsured. Increased funding for FQHCs, combined with expanded hours at certain facilities, has also helped. However, ACA expansion has not addressed other continuing barriers such as:

- Growing shortage of physicians, estimated by the American Association of Medical Colleges at 46,000–90,000 in 2025¹⁴
- Inadequate number of network providers, especially specialists in exchange plans and Medicaid
- Limited number of physicians and non-physician providers willing to accept Medicaid patients

CHANGES TO FUTURE STATE MEDICAID FUNDING
DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

Medicaid DSH Allotments with proposed reductions starting in 2018



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Annual Allotment	\$11.9	\$11.9	\$12.0	\$10.0	\$9.0	\$8.0	\$7.0	\$6.0	\$5.0	\$4.0	\$4.0
% Reduction from Prior Year		0%	-1%	17%	10%	11%	13%	14%	17%	20%	0%
% Cumulative Reduction from 2017				17%	25%	33%	42%	50%	58%	67%	67%

Sources: 2015 Allotment - Kaiser Family Foundation <http://kff.org/medicaid/state-indicator/federal-dsh-allotments>; 2016 Allotment- Federal Register; 2017 Allotment- Estimated; 2018-2025 Allotment - MACPAC <https://www.macpac.gov/subtopic/disproportionate-share-hospital-payments/>

- Patients without an identified primary care provider attribution
- Restricted availability of (timely) appointments
- Limited provider proximity and/or wheelchair transportation access, especially acute issues in rural areas

Affordability of care is the major barrier to access. Rising out-of-pocket expenses driven by higher premiums, coinsurance, copayments and, especially deductibles represent financial

challenges to many Americans. The ACA has contributed to premium increases and higher copayments and coinsurance not only for Americans newly covered under the ACA, but also for Americans who had already been covered by employer-based coverage or by their own individual insurance. Nearly three-quarters of households have incomes below \$97,000 per annum – the family of four maximum for health exchange subsidies. The average household income was \$55,755 in 2015.¹⁵



MANAGED CARE: INTEGRAL TO MEDICAID SPENDING AND OUTCOMES

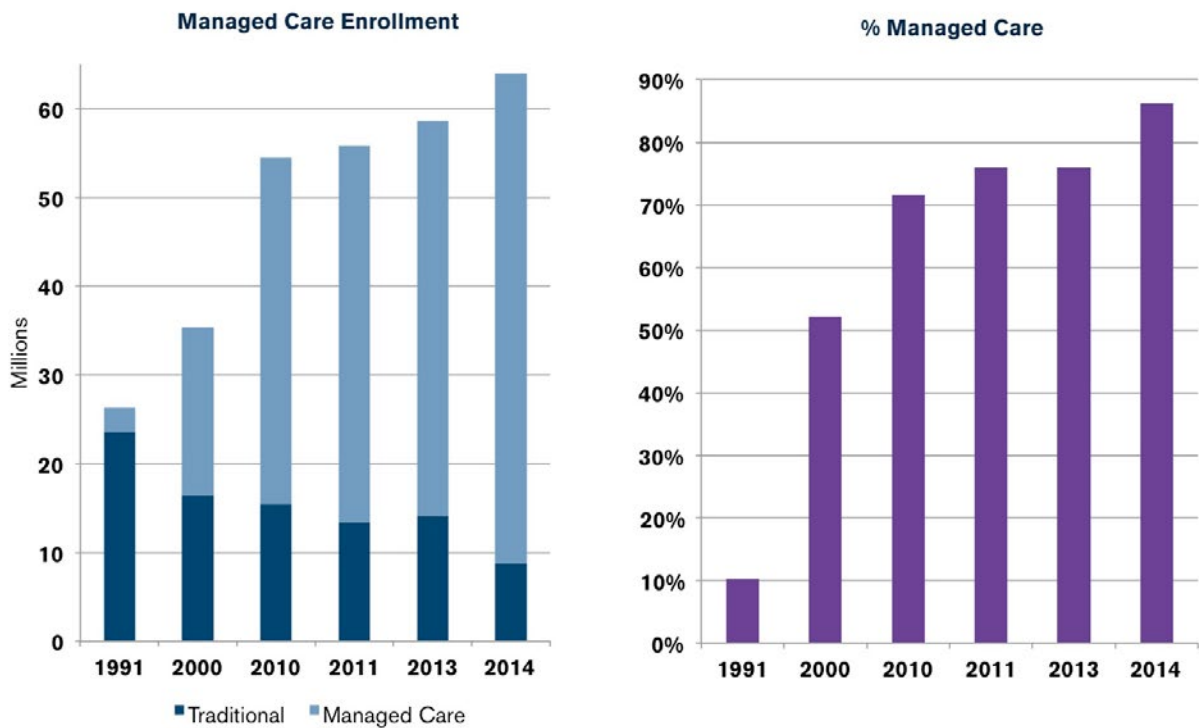
Medicaid MCO enrollment has increased nearly threefold since 2000, from 18.8 million to 55.2 million beneficiaries. Though the growth is dramatic, it is slower than in the prior decade when enrollment grew nearly sevenfold from 2.7 million. During this period there has also been dramatic health plan consolidation whereby five major competitors – Anthem/Wellpoint, United Health, Centene (HealthNet), Molina and Wellcare – have a 42 percent aggregate market share, and the top 10 firms have a 55 percent share.¹⁶

Despite accounting for more than 80 percent of Medicaid beneficiaries in 2015, Medicaid MCO expenditures of \$227 billion represent 43 percent of the total. Combined, FFS acute care

and long-term care expenditures totaled \$272 billion or 51 percent of the total. Expenditures per beneficiary for managed care beneficiaries are \$4,118, whereas expenditures for FFS beneficiaries are \$19,963, reflecting the difference in served populations, i.e., children and adults versus the aged and disabled. Enrollment in Managed Long-Term Services and Support (MLTSS) programs that finance and support institutional and/or home-based care services approximate 1.8 million or 2.6 percent of the Medicaid population.¹⁷

Future MCO growth will require a different approach to the management of the high-cost aged and disabled beneficiary population.

MEDICAID MANAGED CARE ENROLLMENT TRENDS



Source: <https://www.macpac.gov/wp-content/uploads/2015/11/EXHIBIT-10.-Medicaid-Enrollment-and-Total-Spending-Levels-and-Annual-Growth-FYs-1966%E2%80%932015.pdf>
<http://kff.org/medicaid/state-indicator/total-medicare-mc-enrollment/?activeTab=graph¤tTimeframe=0&startTimeframe=3&selectedDistributions=total-medicare-managed-care-enrollment>

TYPES OF MEDICAID MANAGED CARE PLANS

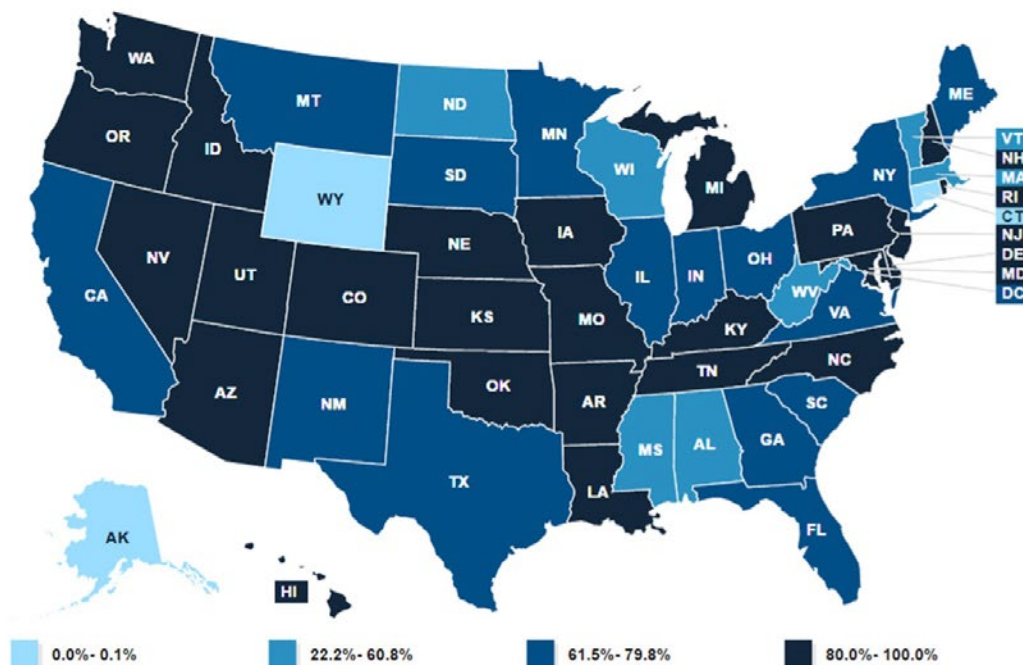
TYPE OF PLAN	ENROLLMENT	DESCRIPTION
Medicaid-only HMO (capitated)	27%	Provides comprehensive services to only Medicaid beneficiaries.
Commercial HMO (capitated)	20%	Provides comprehensive services to both Medicaid and commercial and/or Medicare.
Prepaid Ambulatory Health Plan – PAHP (capitated)	20%	Provides less than comprehensive services on an at-risk or other than state plan reimbursement basis, and does not provide, arrange for, or otherwise have responsibility for the provision of any inpatient hospital or institutional services. For example, a Dental PAHP is a managed care entity that provides only dental services.
Prepaid Inpatient Health Plan – PIHP (capitated)	16%	Provides less than comprehensive services on an at-risk or other than state plan reimbursement basis, and provides, arranges for or otherwise has responsibility for the provision of any inpatient hospital or institutional services. For example, a Mental Health (MH) PIHP is a managed care entity that provides only mental health services.
Primary Care Case Management provider – PCCM (fee-for-service, and a monthly fee for care coordination)	14%	A physician, physician group practice, or an entity employing physicians, nurse practitioners, nurse midwives, or physician assistants who contracts directly with the State to locate, coordinate, and monitor covered primary care (and sometimes additional services).

Source: <http://www.statehealthfacts.org/comparetable.jsp?ind=218&cat=4>

There are five major types of Medicaid managed care plans providing a range of inpatient and ambulatory services including diagnostic tests, as well as drug coverage. Several states – Alabama, Colorado, Idaho, Montana, North Carolina, Oklahoma, South Dakota and Vermont

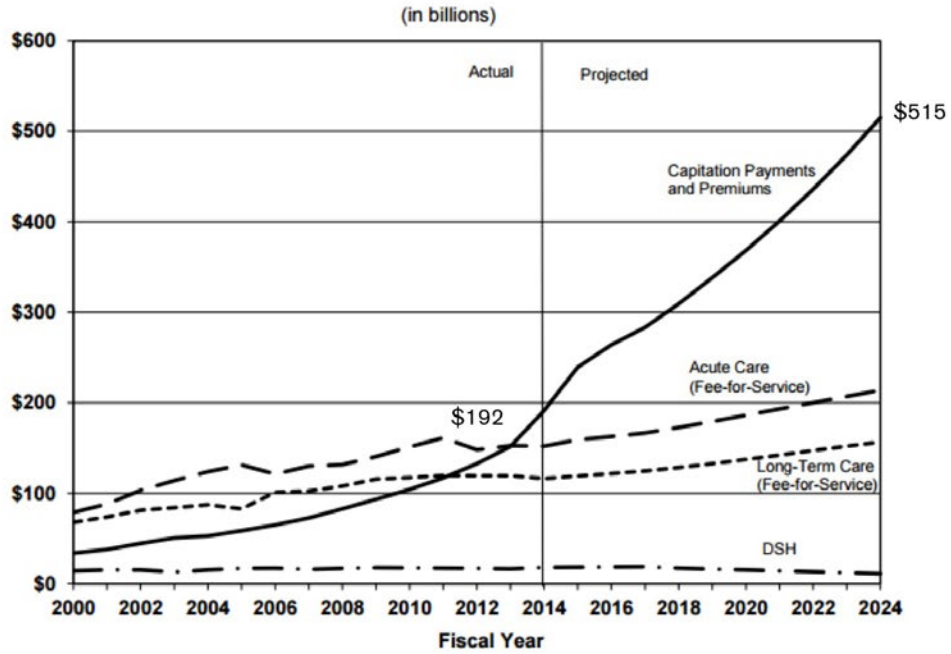
– have a majority enrollment in primary care case management (PCCM) provider plans. Medicaid special needs plans (SNPs) exist for HIV and dual-eligible populations requiring enhanced management.

MEDICAID MANAGED CARE ENROLLMENT BY STATE, FY 2014



Source: <http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/?currentTimeframe=0>

MEDICAID EXPENDITURES BY TYPE OF PAYMENT

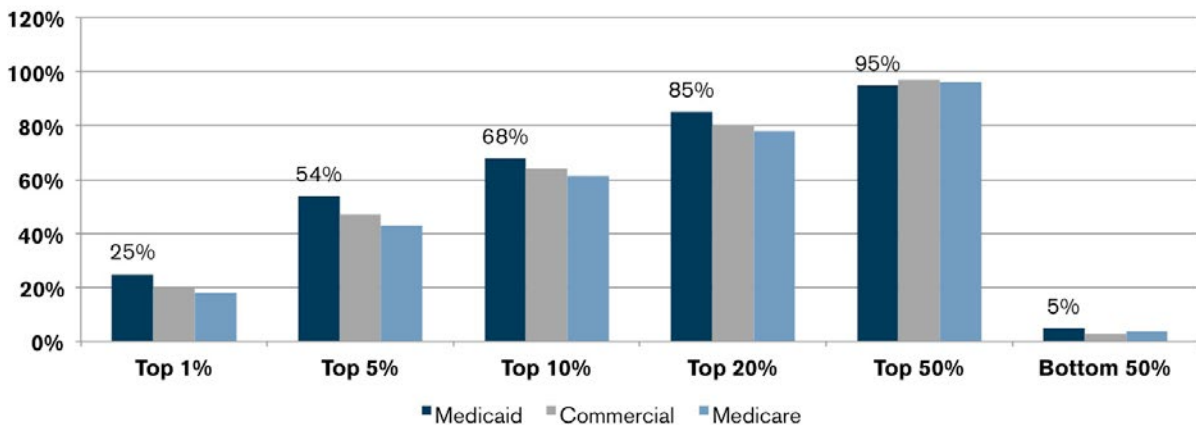


Source: <https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2015.pdf>

Medicaid managed care enrollment varies by state, with 23 states having more than 80 percent of eligible beneficiaries enrolled in MCOs. Another 15 states have enrollment between 61 percent and 80 percent. Capitation premiums and payments for managed care plans are projected to increase from \$192 billion in 2014 to \$515 billion in 2024 for a CAGR of 10.4 percent. The limited increase in FFS acute and long-term care suggests an additional transfer of risk to health plans.

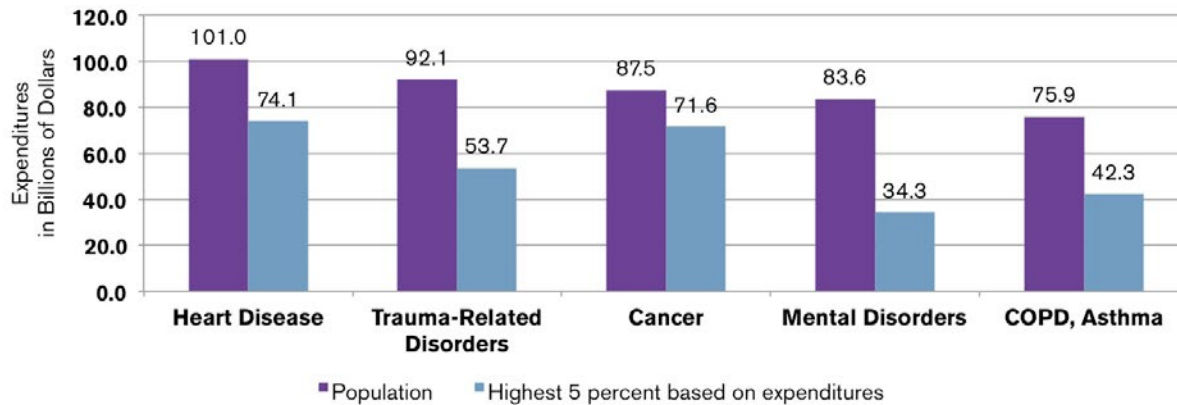
Healthcare spending is highly concentrated, especially within the Medicaid program, with 1 percent of beneficiaries accounting for 25 percent of spending, 5 percent accounting for 54 percent, and 10 percent accounting for 68 percent, or more than two-thirds of the total. Per beneficiary expenditures for the aged and disabled far exceeds that of children and adults.

DISTRIBUTION OF HEALTHCARE COSTS BY PAYER



Source: Medicaid – CMS FY2008; Commercial - Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2008.; Medicare – CMS 2001

TOTAL EXPENDITURES FOR THE 5 MOST COSTLY CONDITIONS AMONG THE OVERALL POPULATION AND AMONG THE HIGHEST 5 PERCENT BASED ON THEIR OVERALL MEDICAL EXPENDITURES, 2012

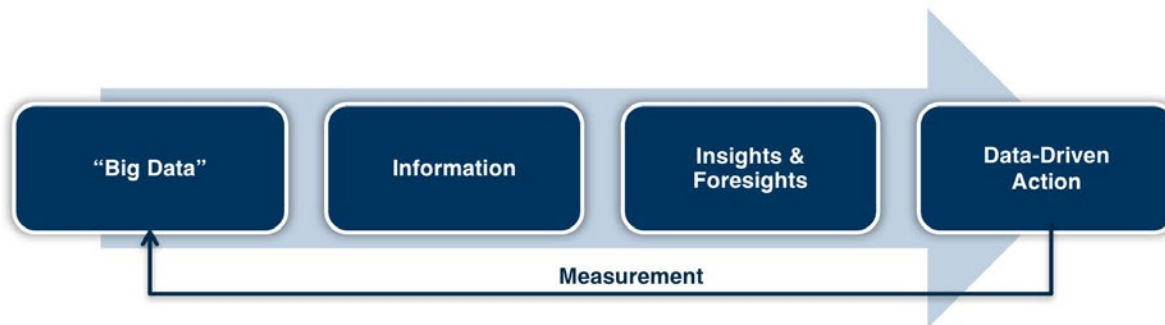


Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey (HC=155), 2012

Opportunities exist to better understand the distribution of spending among the highest cost conditions including diabetes / endocrine conditions (\$255 billion), cardiovascular disease (\$231 billion), mental health and substance abuse (\$188 billion),

musculoskeletal conditions (\$183 billion), injuries (\$168 billion), chronic respiratory disease (\$132 billion), neurological disease (\$101 billion) and others.¹⁸ Many of the same patients, especially among the aged, have multiple comorbidities.

ANALYTICS ESSENTIAL FOR RISK STRATIFICATION AND MCO PERFORMANCE MEASUREMENT



SPENDING / RESOURCE ALLOCATION:

- Public health targeting at-risk behaviors: smoking, alcohol, diet, activity, substance abuse
- Social determinants: economic stability, physical environment, food, education, community and social context
- Prevention: primary, secondary, tertiary
- Acute care: hospital, physician, ancillary services, prescription drugs
- Long-term care: skilled nursing, home-based care services, intermediate care facilities

CLINICAL RISK STRATIFICATION MODELS:

- **Hierarchical Condition Categories (HCCs):** 70 condition categories selected from ICD codes and includes expected health expenditures
- **Adjusted Clinical Groups (ACG):** Uses both inpatient and outpatient diagnoses to classify each patient into one of 93 ACG categories; used to predict hospital utilization
- **Elder Risk Assessment (ERA):** For adults >60, uses age, gender, marital status, number of hospital days over the prior two years and selected comorbid medical illness to assign an index score
- **Chronic Comorbidity Count (CCC):** Total sum of selected comorbid conditions grouped into six categories
- **Minnesota Tiering (MN):** Based on Major Extended Diagnostic Groups (MEDCs); groups patients into one of five tiers: Tier 0 (Low: 0 Conditions), Tier 1 (Basic: 1 to 3), Tier 2 (Intermediate: 4 to 6), Tier 3 (Extended: 7 to 9), and Tier 4 (Complex: 10+ Conditions)
- **Charlson Comorbidity Measure:** Predicts the risk of one-year mortality for patients with a range of comorbid illnesses

Analytics are essential for risk stratification, i.e., identifying the high and moderate-cost population at-risk for hospitalization, repeated visits to the emergency department, use of expensive medications and potential for nonadherence to treatment regimens. Current approaches often result in confusion due to the multiplicity of risk stratification models and a failure to assess the total cost of care, i.e., hospital, post-acute care, ambulatory and pharmaceuticals.

Analytics are also essential to understand cost drivers such as provider variation, site of service differentials and test redundancy; improve population health, quality (outcomes), care navigation / coordination and the experience of care; and negotiate more favorable MCO contracts.

“Big data” does not equate with insights and foresights; the organization of data into dashboards by itself also has limitations. Insights should lead to targeted actions that are measureable and subject to continuous process improvement.

Despite the significant expenditures for Medicaid made under the ACA, inequities in access to care and outcomes continue to exist (see Appendix). The rapid growth of MCOs may require state agencies to become more active in monitoring and managing performance in several dimensions including the efficiency and effectiveness of care delivery, as well as the beneficiary experience of care.

STATE IMPERATIVES FOR MEDICAID MANAGED CARE

CREATE MAXIMAL VALUE

- Stratify at-risk population
- Identify opportunities for wellness and prevention, clinical improvement, quality outcomes and cost reduction
- Assess less costly alternatives for institutional care; home care-based services
- Prioritize resource allocation in a cost-effective manner
- Integrate efforts with other community-based resource

AUGMENT OVERSIGHT

- Establish objective and measureable near- and longer-term goals
- Identify performance incentives and disincentives focused on goals
- Measure and monitor performance relative to goals; process, outcome and experience of care
- Develop internal and/or third-party non-MCO capabilities for data collection and analysis; e.g., claims, etc.

MANAGE DRUG COSTS

- Drug formulary
- Generic substitution
- Step therapy
- Specialty drugs; e.g., HIV, hepatitis C, cancer, etc.

DEVELOP NEW PROCUREMENT AND CONTRACTING STRATEGIES

- Coordinate efforts among responsible state agency personnel overseeing fee-for-service and managed care contracts; i.e., procurement (target beneficiaries, state regions), RFP generation, bidder selection and contract administration
- Rationalize number of MCO contracts, as appropriate

Sources: National Academy for State Health Policy; A&M Analysis



PRELIMINARY STEPS

TO ACA REFORM

Following the 2016 presidential election, the Trump transition team outlined on a single webpage the tenets that will guide its healthcare policy, which in most respects mirror what the candidate said on the campaign trail. Despite its publication, the challenge has always been to distinguish between the president's campaign rhetoric and actual policy position.

On January 13, 2017, the Senate passed and the House concurred with a joint resolution allowing revisions to the ACA via budget reconciliation, i.e., passage via a majority without possibility of a Senate filibuster. This resolution clears the legislative path for changes to the ACA.

TRUMP TRANSITION TEAM WEBSITE: TRANSLATED

VISION FOR HEALTHCARE IN TRUMP ADMINISTRATION SUMMARIZED AND TRANSLATED

- Affordable Care Act (“Obamacare”)
 - In some form or fashion ACA will be “repealed and replaced” or significantly changed
 - Replacement statute may include Health Savings Accounts
 - Health insurance regulation to return to states from federal government (e.g., no federally mandated benefits)
 - Health insurance policies may be sold across state lines
 - High-risk pools (possibly state-based) will be established or expanded
- “Right to life” positions to be advanced (e.g., Hyde Amendment continuation)
 - No birth control, etc., mandates for health insurers (i.e., Little Sisters of the Poor lawsuit)
- Additional funding for healthcare research
- FDA / drug approval reforms to speed approval of innovative medical products
- “Modernize Medicare”: Promotion of Medicare Advantage plans, possible turn to Paul Ryan plan to “defined contribution” versus “defined benefit”
- More Medicaid waivers and possible Medicaid “block grants”

JOINT BUDGET RESOLUTION – S. CON. RESOLUTION 3

On January 13, 2017, the Senate passed and House concurred in “joint resolution” on the federal budget. This resolution permits revisions to Obamacare via “reconciliation.”

- In passing the budget resolution on January 13, revisions to the Affordable Care Act can be attempted via the “reconciliation process.”
- Under budget reconciliation rules, measures affecting the budget can pass on a simple majority vote in the Senate and cannot be filibustered through a 60 vote requirement.
- The budget resolution charges two Senate committees and two House committees to draft changes to laws - like the ACA - that would have the effect of reducing the deficit.
- Practical impact of the budget resolution is to permit the House and Senate to make changes to the ACA that have a financial impact to the budget, e.g., repeal Medicaid expansion, eliminate health exchange subsidies, etc.
- Budget resolution charged committees to report changes to law by January 27, 2017.

S. Con. Res. 3

Agreed to January 13, 2017

One Hundred Fifteenth Congress of the United States of America

AT THE FIRST SESSION

*Began and held at the City of Washington on Tuesday,
the third day of January, two thousand and seventeen*

Concurrent Resolution

Resolved by the Senate (the House of Representatives concurring).

SECTION 1. CONCURRENCE RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2017.

(a) DECLARATION.—Congress declares that this resolution is the concurrent resolution on the budget for fiscal year 2017 and that this resolution sets forth the appropriate budgetary levels for fiscal years 2018 through 2026.

(b) TABLE OF CONTENTS.—The table of contents for this concurrent resolution is as follows:

Sec. 1. Concurrent resolution on the budget for fiscal year 2017.

TITLE I—RECOMMENDED LEVELS AND AMOUNTS

Subtitle A.—Budgetary Levels in Both Houses

Sec. 1101. Recommended levels and amounts.

Sec. 1102. Major functional categories.

Sec. 1201. Social Security in the Senate.

Sec. 1202. Postal Service discretionary administrative expenses in the Senate.

TITLE II.—RECONCILIATION

Sec. 2001. Reconciliation in the Senate.

Sec. 2002. Reconciliation in the House of Representatives.

TITLE III.—RESERVE FUNDS

Sec. 3001. Deficit-reducing reserve fund for health care legislation.

Sec. 3002. Reserve fund for health care legislation.

TITLE IV.—OTHER MATTERS

Sec. 4001. Enforcement flag.

Sec. 4002. Budgetary treatment of administrative expenses.

Sec. 4003. Applicability and effect of changes in situations and appropriate.

Sec. 4004. Exercise of rulemaking power.

TITLE I—RECOMMENDED LEVELS AND AMOUNTS

Subtitle A—Budgetary Levels in Both Houses

SEC. 1101. RECOMMENDED LEVELS AND AMOUNTS.
The following budgetary levels are appropriate for each of fiscal years 2017 through 2026:

Repeal of the ACA continues to be the stated policy of the Trump administration. On Inauguration Day, January 20, 2017, President Trump signed an executive order that does not repeal the ACA, but serves as a notice from the administration of its intentions to seek “prompt repeal” and to “write new regulations and exercise discretion,” as legally allowable. This may include a more liberal interpretation of existing regulations (or a moratorium on enforcing those ACA regulations the Trump administration does not like), expanded criteria for application of the individual mandate

hardship clause (i.e., fewer Americans to pay a penalty with non-coverage), increased use of Medicaid waivers for demonstration projects and, most significantly, possible elimination of health exchange premium subsidies.¹⁹ The immediate impact of the executive order may be limited, though departments responsible for ACA enforcement – the Department of Health and Human Services, the Treasury Department and the Internal Revenue Service – may use the executive order to direct changes to or suspension of current ACA rules and regulations.

PRESIDENT TRUMP'S EXECUTIVE ORDER ON AFFORDABLE CARE ACT

On January 20, 2017, hours after being sworn in, President Donald Trump issued one of his first executive orders setting out his position on repealing the ACA

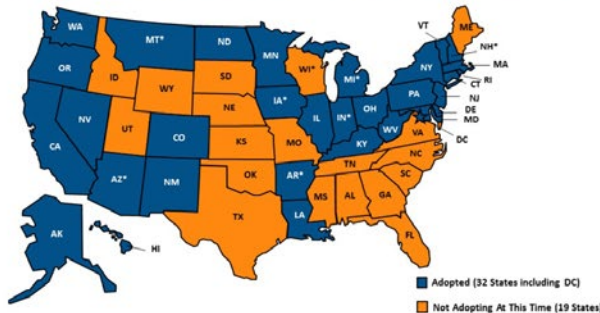
- On Inauguration Day, President Trump issued his first executive order, titled ***“Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal.”***
 - Presidential executive orders are not laws per se, but they are written to help officers and agencies of the executive branch manage operations within the federal government itself.
 - Executive orders do have the full force of law when they take authority from a legislative power that grants its power directly to the executive by the Constitution, or are made pursuant to acts of Congress that explicitly delegate to the president some degree of discretionary power.
 - Executive orders may be overridden by legislation or by a court when they are not based on legislative or constitutional authority.
 - All presidents since George Washington have issued executive orders. The most famous executive order is Abraham Lincoln's order of January 1, 1863, the Emancipation Proclamation.
- Trump's executive order says: ***“It is the policy of my Administration to seek the prompt repeal of the Patient Protection and Affordable Care Act.”***
- While the ACA remains in effect, the executive order says that *“pending such repeal, it is imperative for the executive branch to ensure that the law is being efficiently implemented, take all actions consistent with law to minimize the unwarranted economic and regulatory burdens of the Act, and prepare to afford the States more flexibility and control to create a more free and open healthcare market.”*

A major challenge for the Trump administration will be the large number of states with Republican senators and Republican House representatives, governors and/or Republican-controlled state legislatures that have

supported Medicaid expansion and associated benefits, i.e., increased coverage largely paid for by the federal government, health exchange premium subsidies and a reduction in the uninsured population.

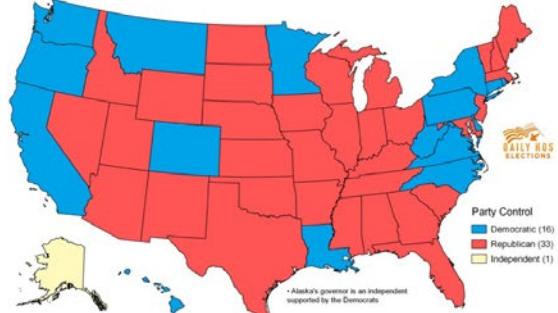
MEDICAID EXPANSION IN DEMOCRATIC- AND REPUBLICAN-CONTROLLED STATES

Current Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KCMJ tracking and analysis of state executive activity. *AR, AZ, IA, IN, MI, MT, and NH have approved section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

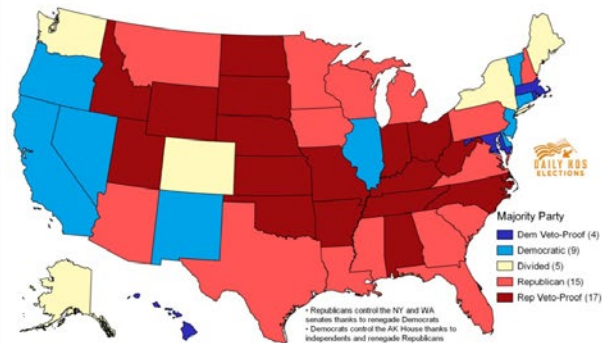
State Governors after the 2016 Elections



Composition of Senate: January 2017 (115th Congress)



State Legislatures after the 2016 Elections



Source: Status of State Action on the Medicaid Expansion Decision,' KFF State Health Facts, updated October 14, 2016. <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

Rather than a complete repeal of all ACA provisions, there is a growing consensus that acknowledges the value in preserving some popular components of the Obamacare legislation. Coverage for young adults under their parents' health insurance policy is one provision example that has broad bipartisan support, as well as support from President Trump. Bringing in premium dollars on a relatively healthy sector of the population promotes affordable coverage. Other popular ACA provisions, such as required coverage of pre-existing conditions and the prohibition of annual and lifetime benefit limits, have price tags that may become unaffordable when coverage mandates are eliminated and healthy people choose to become or remain uninsured; i.e., many of the provisions have interdependencies and thus are not necessarily

amenable to standalone elimination. The pre-existing condition provisions, however, may be addressed through the adoption of "high-risk" pools or some federally backstopped insurance coverage for individuals with significant pre-existing medical conditions.

Several pieces of legislation or legislative outlines have emerged since January, suggesting the possibility of "repeal and repair" rather than "repeal and replace," given the emerging consensus that the ACA is "not all bad" and that "repeal and replace" may not be feasible, given coverage requirements for 20 million Americans. The Patient Freedom Act (PFA), introduced on January 23, 2017, by Senators Susan Collins, R-ME, and Bill Cassidy, R-LA, is one example of legislation that attempts to keep the parts of Obamacare that people like and eliminate the unpopular provisions.

CASSIDY / COLLINS "PATIENT FREEDOM ACT"

On January 23, 2017, Senators Bill Cassidy (R-LA) and Susan Collins (R-ME) offered their own healthcare reform legislation for "repairing" Obamacare.

- Senators Cassidy and Collins introduced the Patient Freedom Act of 2017, the first of what will likely be many Republican attempts to replace or in this case "revise" the ACA.
- The PFA is notable for several reasons. It is the first replacement plan introduced in the new Congress and it is sponsored by two relatively conservative to moderate senators.
- The PFA does not "repeal" the ACA, it just makes revisions. The PFA allows states, rather than the federal government, to decide the path to take on healthcare reform.
- The PFA eliminates several controversial ACA provisions including: the individual and employer mandates, the community rating provision, the essential benefits requirements and the establishment of the health benefit exchanges.
- **The PFA would maintain bans on lifetime and annual coverage limits, maintain the ACA ban on coverage exclusions based on pre-existing conditions and would permit adult children to remain on their parents' plan until age 26.**



- The PFA would leave many Obamacare features in place, such as Medicaid expansion and several of the ACA taxes.
- The PFA would allow states to select among three options: 1) maintain the current ACA model using subsidies and health benefit exchanges to provide insurance coverage; 2) enact a market-based option or "state alternative;" or 3) elect to design its own health system without federal funding. If a state fails to select one of the options by a certain date it will be deemed to have selected the market-based option.
- **Although the Cassidy / Collins bill is unlikely to be enacted, it sets the stage for "repeal and repair" of Obamacare versus "repeal and replace."**

HOUSE REPUBLICAN LEADERSHIP OUTLINE FOR ACA REFORM

On February 16, 2017, House Republican leaders met with the Republican Caucus to outline in more detail their “repeal and replace” strategy.

The House Obamacare “repeal and replace” plan is built on the following principles:

- There will be a stable transition between the current ACA structure (health exchanges, Medicaid expansion, etc.) and the new Republican plan.
- Subsidies under the ACA will be replaced by portable, monthly “tax credits” that will be paid to citizens and legal residents who do not have employer-sponsored coverage or are not eligible for Medicare or Medicaid. These tax credits will increase based on the age of the recipient.
- The individual and family contribution limit to Health Savings Accounts (HSAs) will be significantly increased.
- Medicaid “expansion” under the ACA will be phased out and eliminated. During the transition period, states with expanded Medicaid populations will only be reimbursed under the traditional Medicaid match rate or “FMAP” instead of the more generous ACA match for Medicaid expansion.
- The unlimited Medicaid “match” would be replaced by a “per capita” allotment.
- States will be permitted to receive their per capita allotment as a “block grant” instead of as a match for state Medicaid expenditures.



- CMS will establish “State Innovation” grants that states can spend to assist individuals with insurance or to establish or bolster “high risk” pools.
- Medicare DSH (“disproportionate share”) payments, which were eliminated under the ACA, would resume.
- A variety of ACA taxes will be eliminated including taxes on: the individual mandate, the employer mandate, employer-provided insurance, medical devices and prescription drugs.
- ***The Republican House leadership ACA “repeal” plan stresses continuity a transition that would be phased over several years.***

On February 17, 2017, House Republicans identified their underlying principles associated with “repeal and replace” including the use of a multiyear transitional period, a reduction in the newly insured Medicaid share of the enhanced federal match from a maximum of 90 percent to the traditional FMAP, a cap on matched expenditures via per capita allotments or block grants, and the establishment of high-risk pools.

The American Health Care Act (AHCA) introduced by House Speaker Paul Ryan on March 6, 2017, tracks the “repeal and replace” concepts floated by the Speaker in February including: replacing ACA subsidies with tax credits and moving Medicaid from an open ended entitlement program to a per-head or capitated funding program.

Conservative leaders of the Republican Freedom Caucus described the AHCA as “ObamaCare Lite” primarily due to the delayed timing of Medicaid expansion repeal (2020), and continued federal funding of newly enrolled Medicaid expansion beneficiaries (at 90% of the total actuarial cost) and low income health exchange enrollees. Negotiations are ongoing with the conservative leaders.

The AHCA was also criticized by Democrats for many reasons including the elimination of open ended entitlements (via per capita allotments) and funding for Planned Parenthood clinics, reduced insurance payment subsidies for low income enrollees using health exchanges, and lower taxes on affluent households and drug, medical device and insurance companies,

HOUSE GOP LEADERSHIP REFORM PLAN: AMERICAN HEALTHCARE ACT

On March 7, 2017, the House Republican leadership unveiled its “repeal and replace” package entitled: the “American Healthcare Act” (AHA)

- In keeping with the principles in its February 17, 2017 “repeal and replace” outline, the House Republican leadership’s bill, *keeps popular parts of the Affordable Care Act (ACA)*
 - Pre-existing condition protection
 - Adult children remaining on parent insurance policy through age 26and *jettisons the unpopular tax parts:*
 - Individual and employer mandates
 - Health insurance premium tax
 - Medical device and drug tax
 - Medicare surtax on high income earners.
- AHA replaces ACA income-based subsidies to purchase health insurance with a *monthly tax credit* based on income for low and middle income individuals and families who do not receive employer insurance or are not covered by Medicare, Medicaid or a government program.
 - Value of tax credit could be between \$2,000 and \$14,000 per year.
- While AHA would *eliminate the “individual mandate”* it would permit insurance companies to impose a premium penalty on individuals who do not maintain continuous coverage.
- AHA would also change the 3 to 1 age-based premium variation limit to a 5 to 1 ratio.
- AHA would transition Medicaid to a “block grant” type program, with a “per capita allotment” to states, in varying amount per person based on age, disability, dual-eligible (Medicare) status, etc.
- Permits states with Obamacare Medicaid expansion to continue expansion programs through a transition period through December 31, 2019
 - States that did **not** expand Medicaid under the ACA will be provided with certain financial relief during the transition period, such as reinstated DSH (disproportionate share) payments - to help them with their uninsured populations.
- AHA would establish a “Health Stabilization Fund” which would provide up to \$100 billion to the States between 2018 and 2026 to assist state residents with enrollment in high risk pools, or with insurance premiums or copayments, preventive health services, or direct payments to healthcare providers.

estimated by the Joint Committee on Taxation at \$266 billion over 10 years. Lower federal Medicaid funding, estimated by the Center on Budget and Policy Priorities at \$370 billion over 10 years, would likely result in fewer services, less eligibility, reduced affordability and a rise in the number of uninsured.²⁰ In addition, new enrollees who exit Medicaid due to income (temporarily) exceeding the 138% Federal Poverty Limit threshold would not be allowed to re-enroll under the new guidelines.

Despite the criticisms, the proposal was approved by the Ways and Means and the Energy and Commerce committees on party-line votes and is heading to the Budget Committee. There are currently 237

Republicans, 193 Democrats and 5 vacancies in the House; passage requires 218 votes. A House vote is likely prior to Congressional recess scheduled for April 10-21, 2017.²¹

On March 13, 2017 the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) provided an estimate of the number of uninsured and cost savings for the period 2017-26:

- The number of uninsured will increase by 14 million in 2018, 21 million in 2020 and 24 million in 2026. The near-term increase reflects a decision by the previously insured to drop coverage due to the elimination of the fine provision associated with the insurance mandate and those

NEXT STEPS: COMMITTEE MARKUP, HOUSE VOTE AND THEN TO SENATE

GOP Leadership's plan – American Healthcare Act – will be sent for “markup” to the two House committees with jurisdiction. The resultant mark up bill would go to the House floor for vote

- Republican House leadership will send its legislation to the two committees with jurisdiction – House Ways & Means Committee and House Energy and Commerce Committee – for legislation “mark-up” (e.g., amendment). Bill language voted out of both committee will be harmonized before sending bill language to the House floor for vote.
- House leadership anticipates bringing legislation to the House floor before the April recess.
- If passed by the House, the bill would go to the Senate for additional revision and mark-up, or even whole-sale replacement with a new bill. Any Senate amendments would have to be agreed to by the House.
- As a “reconciliation bill” the legislation would not be subject to a 60 vote “filibuster” threshold in the Senate.



no longer able to afford premium costs estimated to rise by 15-20% in 2018 and 2019, respectively. In the intermediate and longer-term, the rise in insured will be driven by Medicaid spending caps and enrollment reductions.

- A reduction in the federal deficit of \$337 billion results from a decline in healthcare outlays (Medicaid, subsidies for non-group health insurance) by \$1.2 trillion partially offset by a \$900 million decrease in revenues (payroll tax and investment income surtax for high net worth, insurer fees). The reduction in healthcare outlays per annum represents 63% of the ACA-related incremental spend associated with Medicaid expansion and premium subsidies.

If approved by the House, the bill heads to the Senate for additional committee hearings and revision. Already, four of the 52 Republican Senators have indicated that they would not support the bill, as drafted. Passage of the Joint Resolution on January 13, 2017 permits revisions to the ACA via the reconciliation process; only 51 votes will be necessary in the Senate, rather than the usual 60 vote filibuster, motion to proceed.

In the period between House passage, should it occur, and Senate consideration, and if the reform bill makes its way to President Trump, it will likely undergo significant amendment and revision.

A close-up photograph of a person's hand holding a silver pen, writing on a document. The document is held open by another hand. The background is blurred, showing a meeting table with papers and a glass of water. The overall scene suggests a professional or business environment.

HAELA AS A TEMPLATE

FOR CHANGE

[DISCUSSION DRAFT]

114TH CONGRESS
2D SESSION

H. R. _____

To eliminate the individual and employer health coverage mandates under the Patient Protection and Affordable Care Act, to expand beyond that Act the choices in obtaining and financing affordable health insurance coverage, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Despite submission of the AHCA, additional insights might still be gleaned from Republican plans proposed in 2016. Approaches described in the Republican House leadership's "Better Way" proposal and a House budget resolution seek to replace individual and employer mandates and use Medicaid block grants to extend states more flexibility in reforming their Medicaid programs. Presented as discussion draft legislation, the Health Access, Empowerment and Liberty Act (HAELA) provides greater detail in operationalizing the Republicans' approach.

Sponsored by Congressman Pete Sessions, R-TX, and Senator Cassidy, HAEA *eliminates mandates on insurers, employers and individuals. Health plans would no*

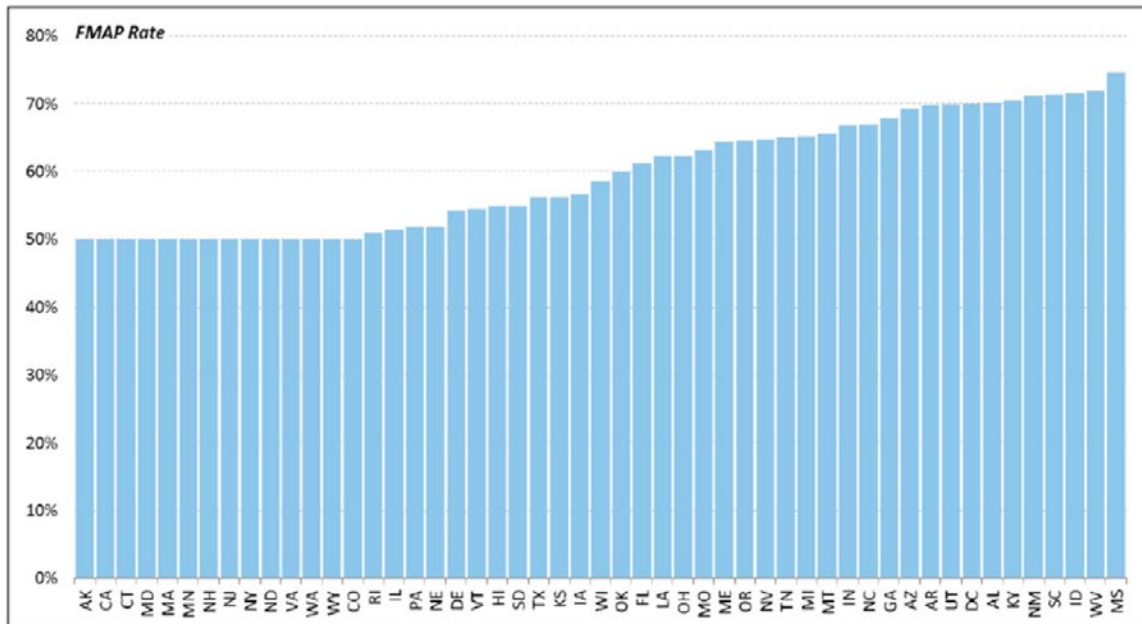
longer be compelled to meet minimum coverage requirements, increasing options for less coverage and lower premiums. In eliminating the employer mandates imposed by Obamacare, small businesses would no longer be forced to offer group coverage that, for some, pushed them beyond the brink of profitability. Rather than imposing penalties, *tax credits for premiums and tax-free health saving accounts would serve as the vehicles to enable individuals to choose and encourage them to maintain their coverage.* HAEA also offers some specific details on Medicaid reforms absent in House Republicans' other high-level plans.



HAELA AND MEDICAID

PER CAPITA ALLOTMENTS

STATE DISTRIBUTION OF REGULAR FMAP RATES, FY2017

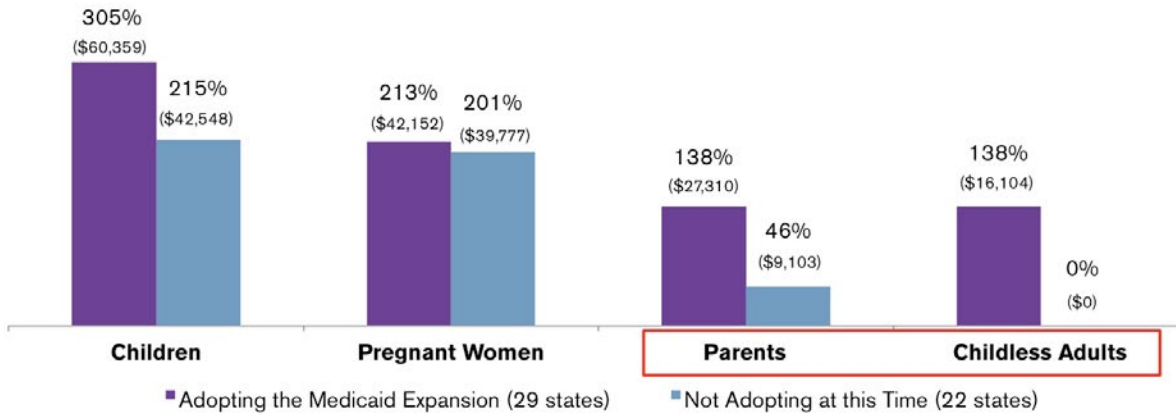


Source: Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2016 Through September 30, 2017," 80 Federal Register 73781, November 25, 2015.

While past plans to reform Medicaid have focused on the use of state block grants, HAELA refines that approach in its proposal to establish per capita allotments. Similar to the approach used to administer funding for the popular Children's Health Insurance Program (CHIP), *per capita allotments are calculated using a beneficiary spending average multiplied by the number of enrollees to establish a cap for federal funding.* The state then draws down the federal match as services are provided to beneficiaries. *The state cannot draw federal dollars in excess of the established cap.* The cap, however, increases with enrollment, mitigating state expenditures during periods of economic decline. HAELA proposes a 75 percent FMAP, which is higher than the pre-ACA FMAP national average of 63.7 percent (2015) and lower than the 95 percent (2017) enhanced FMAP for ACA expansion populations.

The increased share of the federal match would be balanced by a decrease in the number of people eligible for Medicaid. HAELA proposes an income eligibility limit of 100 percent of the FPL. Those losing Medicaid eligibility due to decreased income limits would be parents in families with income between 100 percent and 138 percent of FPL. Childless adults would return to the status of "categorically ineligible," regardless of income. As an alternative to Medicaid, HAELA proposes that those losing coverage transition to private health insurance. Rather than drawing a federal match on the Medicaid services people no longer are eligible to receive, states could draw a federal match on private health insurance premiums paid by the state.

MEDIAN MEDICAID / CHIP INCOME ELIGIBILITY THRESHOLDS, MARCH 2015



NOTE: Eligibility levels are based on 2014 federal poverty levels (FPLs) for a family of three for children, pregnant women, and parents, and for an individual for childless adults. In 2014, the FPL was \$19,790 for a family of three and \$11,670 for an individual. Thresholds reflect the standard income disregard equal to five percentage points of the FPL.

Source: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015, with additional data updates. <http://kff.org/health-reform/issue-brief/medicaid-moving-forward/>

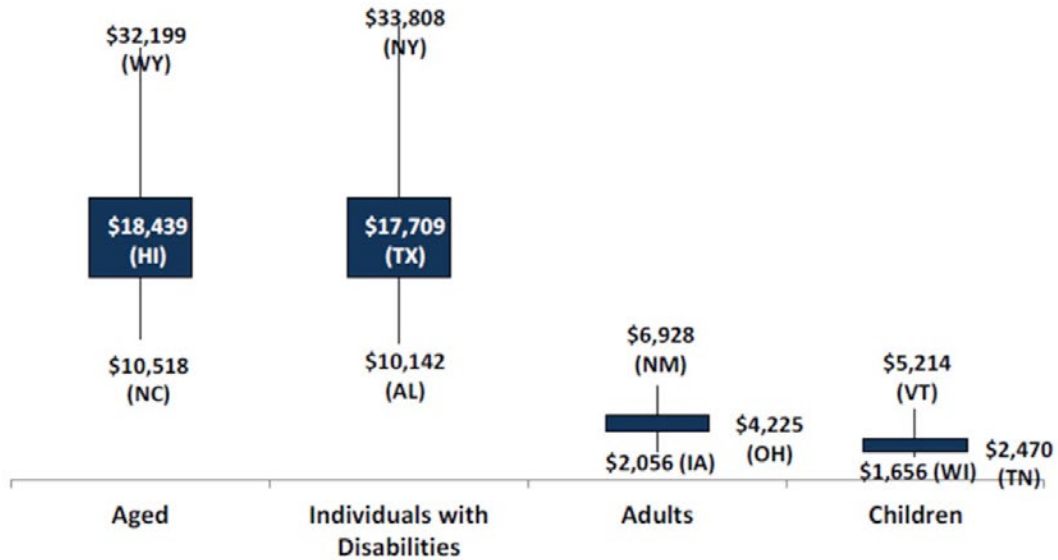
HAELA also provides specificity on the key issues of calculating beneficiary spending, annual increases to per capita allotments and the status of 1115 demonstration waivers. Absent specific legislative language, it seems most likely that HAELA's focus is on the physical health component of Medicaid spending, comprised of medical, acute and primary. Across the United States, state spending per beneficiary has vast variation. Within the sphere of Medicaid physical health spending, four categories of beneficiaries (aged, blind and disabled, children, and non-disabled adults) emerge, each with differing levels of average costs. Rather than relying on either a national average or single state average, *HAELA proposes to use a state-specific per capita allotment comprised of an average of spending amounts and enrollment for each of these four groups to produce what is essentially a "weighted average" to derive a state's allotment.* This approach would provide for higher allotments for states with historically higher spending. HAELA seeks to address the

potential inequities of this approach through annual increases.

Historical growth in Medicaid expenditures has exceeded growth in the gross domestic product (GDP) but, for all four categories of beneficiaries, it has lagged behind the 6.7 percent growth in private health insurance expenditures. Growth would be further constricted under HAELA.

In year 1, HAELA would permit growth in the per capita average at a predetermined inflation rate, likely tied to a budgetary target. In years 2 and 3, HAELA's per capita average would be increased by the projected growth in GDP plus 1 percent. In years 4 through 10, the draft legislation seeks to level the playing field by establishing a corridor of state averages by population category, allowing for higher growth for states with lower averages. *Inflation and other policy decisions that create winners and losers have the potential to pit states against each other and create a political firestorm.*

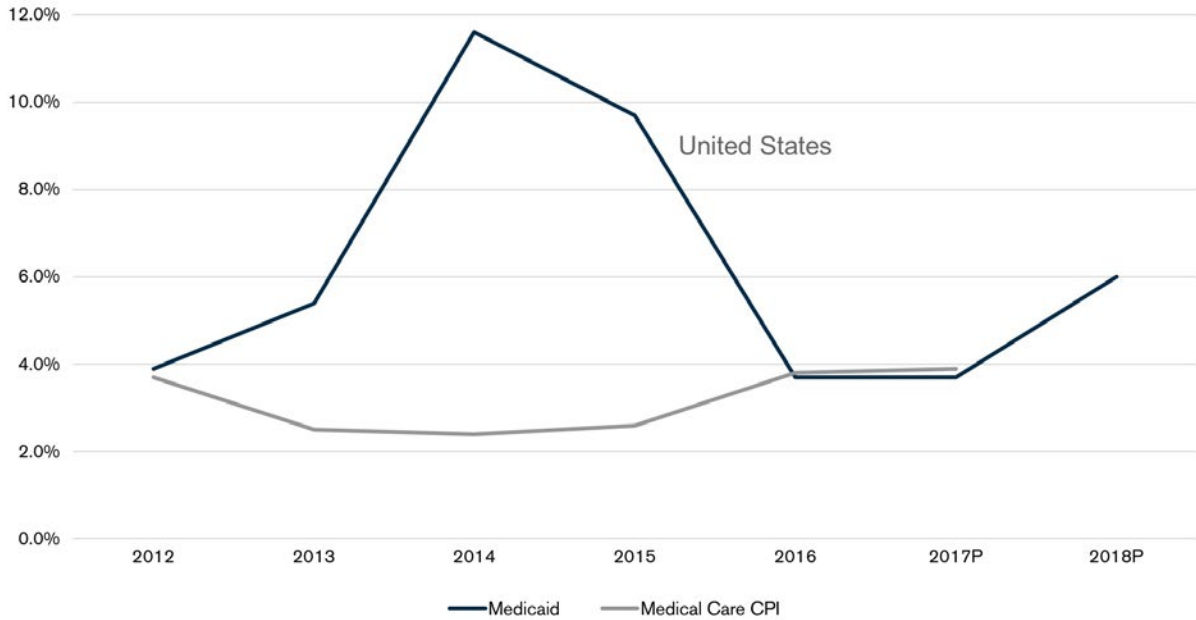
AVERAGE PER CAPITA MEDICAID SPENDING VARIES WIDELY ACROSS ELIGIBILITY GROUPS AND STATES, FY2011



NOTE: Spending per capita was calculated only for Medicaid enrollees with unrestricted benefits or those enrolled in an alternative package of benchmark equivalent coverage. Outliers are included in the figure, but not marked as outliers.

Source: Kaiser Family Foundation; KCMU and Urban Insitute estimates based on data from FY2011 MSIS and CMS-64 reports. Because 2011 MSIS data were unavailable, 2010 MSIS & CMS-64 data were used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT. Due to data quality issues, New Mexico's data point for the aged is withheld.

MEDICAID SPENDING GROWTH IN EXCESS OF THE MEDICAL CARE CPI POTENTIALLY CAUSES A SHORTFALL IN STATE MEDICAID SPENDING DUE TO LOWER FEDERAL ALLOCATION (WITH PER CAPITA ALLOTMENTS OR BLOCK GRANTS)



Sources: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>
<https://knoema.com/qhswkwc/us-gdp-growth-forecast-2015-2019-and-up-to-2060-data-and-charts>
<http://www.coinnews.net/tools/cpi-inflation-calculator/consumer-price-index-cpi-and-annual-percent-changes-from-1913-to-2008/>
<http://www.tradingeconomics.com/united-states/consumer-price-index-cpi/forecast>



HAELA, WAIVER PROGRAMS AND
THE LIKELIHOOD OF MCO, LTSS AND
HCBS “CARVE-OUTS”

There is also a specific provision within HAELA that allows approved 1115 demonstration waivers to continue throughout the current approval period. Medicaid 1115 waiver authority has been available to states for decades to design and test reforms to federally funded programs. States have used 1115 waivers to implement Medicaid managed care and to customize their approaches to ACA Medicaid expansion. In recent years, 1115 waivers have been used to promote coordination between physical care, behavioral health and addiction services, and long-term services and supports. Unwinding Medicaid expenditures authorized by 1115 waivers from more traditional Medicaid spending may prove to be a difficult task. This portion of Medicaid spending may not easily align with plans for per capita allotments and may explain why most of the Republican plans allow states to choose either a per capita allotment or a block grant.

States that have rejected Medicaid expansion or otherwise have austere Medicaid programs are at a comparative disadvantage in a block grant environment. With per capita allotments, the federal government would share fiscal risk of an economic downturn and be required to raise the cap as enrollment of eligible beneficiaries (assumed at 100 percent of the FPL) increased. In theory, these conservative states could operate in status quo mode with expenditures under prescribed caps. These states can be contrasted with states that have taken innovative approaches to reform their Medicaid programs.

Several states have successfully used 1115 demonstration waivers to make significant strides in healthcare reform. A per capita allotment threatens to stagnate this progress by limiting flexibility and state control of program administration. A block grant, referred to in the PFA as a “global waiver,” would allow states to continue these reform initiatives.

USE OF WAIVERS

1115 DEMONSTRATION BASICS

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid- or CHIP-eligible
- Providing services not typically covered by Medicaid
- Using innovative service delivery systems that improve care, increase efficiency and reduce costs.

1915(b) WAIVER BASICS

States can also implement a managed care delivery system using waiver authority under 1915(b). There are four (4) 1915(b) waivers:

- (b)(1) Freedom of Choice – restricts Medicaid enrollees to receive services within the managed care network
- (b)(2) Enrollment Broker – utilizes a “central broker”
- (b)(3) Non-Medicaid Services waiver – uses cost savings to provide additional services to beneficiaries
- (b)(4) Selective Contracting waiver – restricts the provider from whom the Medicaid-eligible may obtain services

CMS has begun the process of “modularizing” its current 1915(b) waiver application to separate the various statutory authorities. First in this process is a streamlined application for states to selectively contract with providers under their fee-for-service delivery system. It simplifies the process for documenting the cost-effectiveness of the waiver but requires that states demonstrate maintenance of beneficiary access. Below are links to both the fillable PDF application as well as the technical guide for completing the application.

The biggest differences between a 1915(b) waiver program and a state plan program are that states are able to require dual eligibles, American Indians and children with special healthcare needs to enroll in a managed care delivery system.

- States must demonstrate that the managed care delivery system is cost-effective, efficient and consistent with the principles of the Medicaid program.
- The approval period for the state’s 1915(b) waiver program is limited to two years. (Medicaid state plan authority does not have an expiration term).

1915(c) Home & Community-Based Services Within broad federal guidelines, States can develop HCBS waivers to meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting. In 2009, nearly one million individuals were receiving services under HCBS waivers. Nearly all states and District of Columbia offer services through HCBS waivers. States can operate as many HCBS waivers as they want – currently, more than 300 HCBS waiver programs are active nationwide.

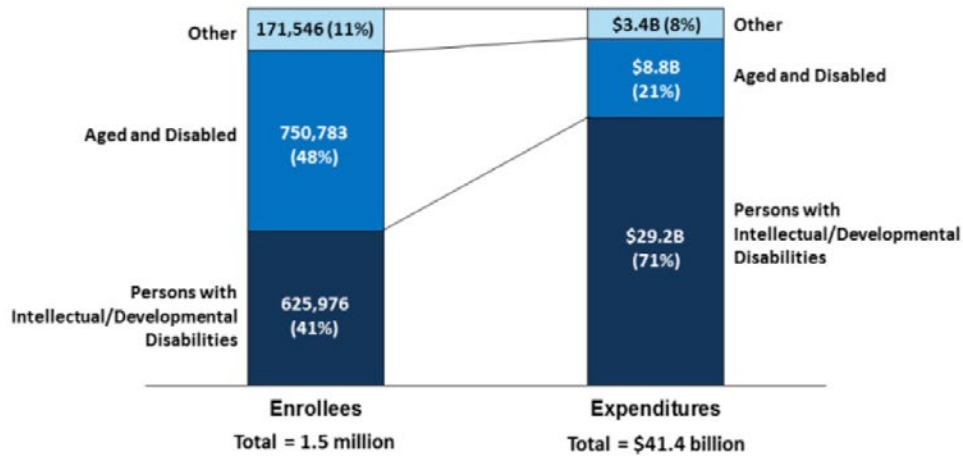
HCBS WAIVER PROGRAM BASICS

State HCBS waiver programs must:

- Demonstrate that providing waiver services won’t cost more than providing these services in an institution
- Ensure the protection of people’s health and welfare
- Provide adequate and reasonable provider standards to meet the needs of the target population
- Ensure that services follow an individualized and person-centered plan of care.

Source: <https://www.medicaid.gov/medicaid/managed-care/authorities/index.html>

MEDICAID §1915(C) HCBS WAIVER ENROLLEES AND EXPENDITURES,
BY ENROLLMENT GROUP, 2013



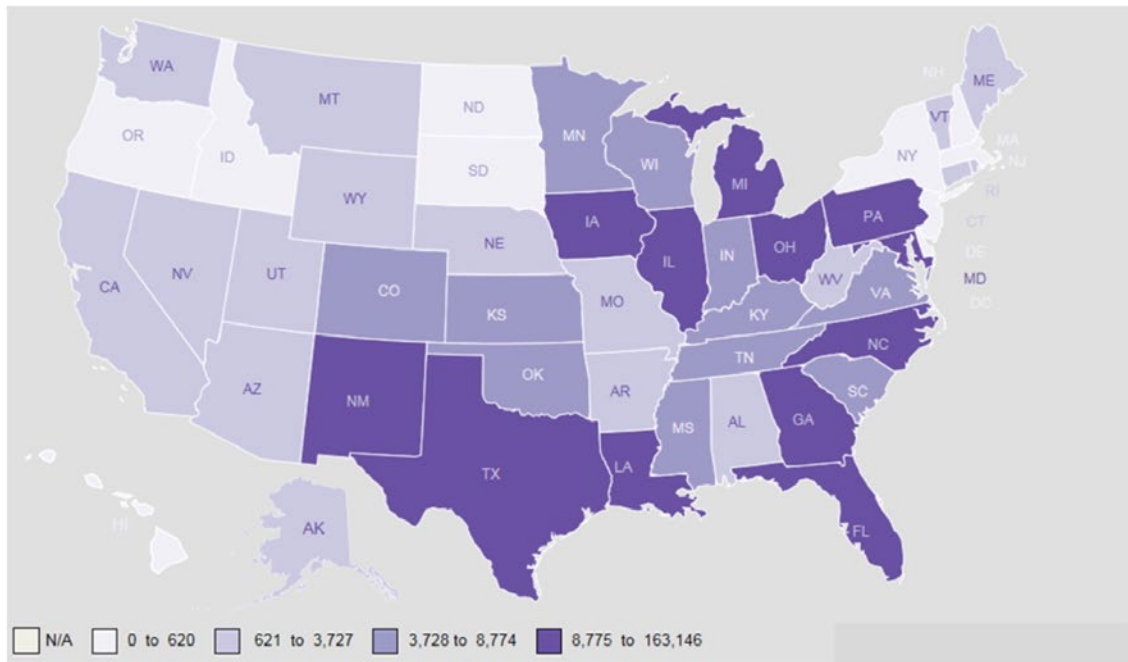
NOTES: Percentages may not sum to 100 percent due to rounding. Data exclude enrollment and spending for Community First Choice, Section 1915 (i) HCBS, and Section 1115 waivers that include HCBS. The "Other" enrollment group includes waiver enrollees who are people with physical disabilities, children, people with HIV / AIDS, people with mental health needs, and people with traumatic brain and spinal cord injuries.

Source: Kaiser Family Foundation; KCMU and UCSF analysis of CMS Form 372 data.

Typically administered under the authority of §1915(c) of the Social Security Act, HCBS waivers may also be carved out of initial Medicaid reforms. Long-term services and supports encompass a broad range of institutional services and HCBS that people may need – for several weeks, months, or years – when they experience difficulty completing daily tasks as a result of aging, chronic illness or disability. Long-term services and supports (LTSS) spending accounts for roughly one-quarter of Medicaid spending, whereas HCBS spending account for just over half of LTSS spending. In spite of its \$40.1 billion 2013 price tag, references to §1915(c) waivers have been notably absent from proposed reform plans including the PFA and HAELA. The nature of HCBS services and the population served by §1915(c) waivers introduces a complexity to and has cost implications for per capita allotments.

In 2015, the average §1915(c) waiver expenditure for a person with an intellectual or developmental disability (I/DD) was \$46,647.²² This amount does not include the costs for physical healthcare covered by Medicaid State Plan services. HCBS remain a cost-effective option to care provided by a state-operated ICF that averages \$256,400²³ (2015) annually. HCBS offer an alternative to care that is appealing to people with I/DD, their families and their communities. §1915(c) waivers provide states with a vehicle to meet the expectations established by the Supreme Court's 1999 Olmstead decision that held that people with disabilities have a qualified right to receive supports and services in the community rather than institutions.

NUMBER OF PERSONS ON MEDICAID 1915(c) HCBS WAIVER WAIT LISTS



Source: ADA PARC (2014) Number of Persons on Medicaid 1915(c) HCBS Waiver Waitlists http://centerondisability.org/ada_parc/utis/indicators.php?id=9

In 2015, more than 640,000 people nationally were on 133 Section 1915(c) waiver waiting lists. The average length of time a person spent on a waiting list for I/DD waiver services was 43 months. As new enrollees into a per capita allotment environment, the average cost (\$47,795) of waiver services for people on I/DD waiting lists would exceed the average per capita allotment for people in the blind / disabled category, estimated nationally at \$17,709. Absent a policy mechanism to adjust the per capita allotment for the provision of waiver services, it would be increasingly difficult for states to reduce waiting lists within a per capita allotment capitation.

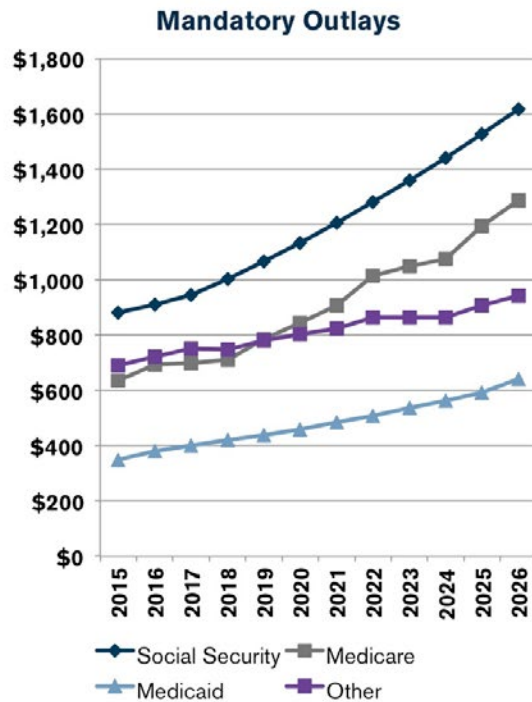
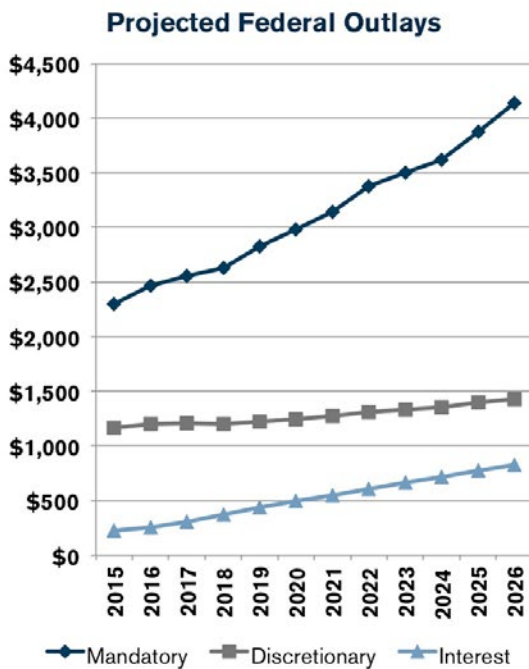
It seems by design rather than coincidence that a Republican-introduced bill (Bill Flores, R-TX) sets aside funding for reducing HCBS waitlists. If passed, this legislation would make funding for HCBS available to states on a competitive basis, giving priority to states with the highest number of individuals on a waiting list. While the language of this draft legislation is unclear, it implies that participating states would receive a payment equal to 90 percent of their typical FMAP rate.



BLOCK GRANTS VS.

PER CAPITA ALLOTMENTS

PROJECTED FEDERAL OUTLAYS, 2016-2026



Source: <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/511129-2016Outlook.pdf>

From 2016–2026, according to the CBO, mandatory federal outlays are forecast to increase from \$2.5 to \$4.1 trillion (CAGR: 5.3 percent), discretionary outlays from \$1.2 to \$1.4 trillion (CAGR: 1.8 percent) and interest from \$255 to \$830 billion (CAGR: 12.5 percent). Medicare (\$596 billion) and Medicaid (\$261 billion) alone account for 51 percent of the federal increase in mandatory outlays, whereas Social Security accounts for 42 percent. A deficit of \$544 billion in 2016 is forecast to reach \$1,366 billion in 2026, leading to an increase in the debt held by the public of \$23.8 trillion.²⁴ The figures exclude the \$1.0 trillion dollar infrastructure investment as discussed by President Trump, as well as offsetting tax increases.

The projected increase in state-funded Medicaid spending of 5.0–6.0 percent (based on alternative estimates) far exceeds the rate of state revenue growth, thereby creating likely budgetary shortfalls.

Republicans in Congress and several conservative think tanks have long suggested that the way to gain control over entitlement spending, and Medicaid in particular, is to give states a fixed amount of funding. An often used phrase is allowing “50 state experiments for Medicaid reform.” The two widely discussed ways to control funding are block grants to states and payments made on per capita allotments. States may be given the option to “select and stick” with one option or the other, or Congress may impose a selection for all states. Both involve a fundamental shift away from an open-ended Medicaid entitlement program to one where, at least at the federal level, spending is capped. The figure on the next page outlines the key components of a block grant and per capita allotments.

One key takeaway from the discussion of paying states fixed amounts to run Medicaid is how spending baselines are established.

Baseline is an arcane federal budget term defined as “expenditures in a specified time period that will be used to determine the federal contribution to a state Medicaid program for a designated period into the future.” State Medicaid spending often is reported with a significant lag by CMS. “Is it the most recent years’ spending levels? Does it represent an average of X number of years’ spending? What happens if I expand enrollment?” These are just a few questions that have yet to be answered in the reform efforts. *How and when a state’s Medicaid spending baseline level is set will be the subject of intense negotiation with Congress.*

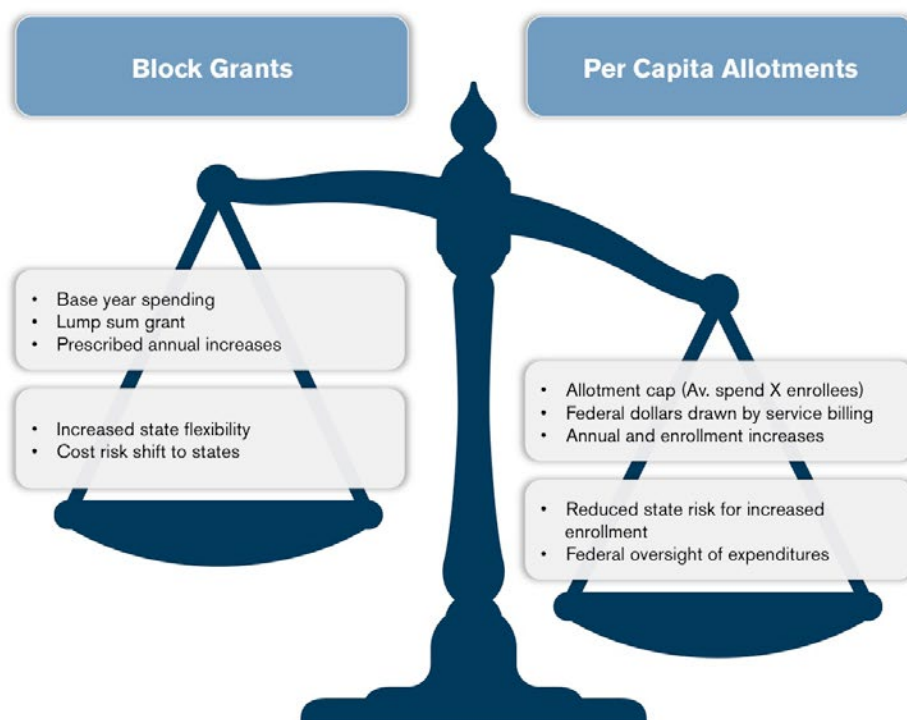
A second key takeaway is the inflation factor applied to the baseline. Some reform plans set a fixed amount (i.e., 3 percent) and others utilize some sort of index such as medical cost inflation. The challenge, as one can imagine, is which factor to choose and does the factor

chosen actually control entitlement spending as envisioned? Regardless of which factor is chosen, there will be states that have higher and lower medical cost inflation factors. This will almost surely result in states that “win” and states that “lose,” given the factor applied. ***How much a state’s Medicaid spending is increased annually – based on factors applied to baseline spending levels – will also become the subject of intense negotiation with Congress.***

As the chart below illustrates, a block grant sets one lump sum amount to fund state Medicaid programs while the per capita allotments (as indicated in the proposed HAELA legislation) would allow states to draw federal financial participation (FFP) on Medicaid-eligible services until an expenditure cap is reached. Four caps would be calculated by establishing an average expenditure for each of the categories that comprise

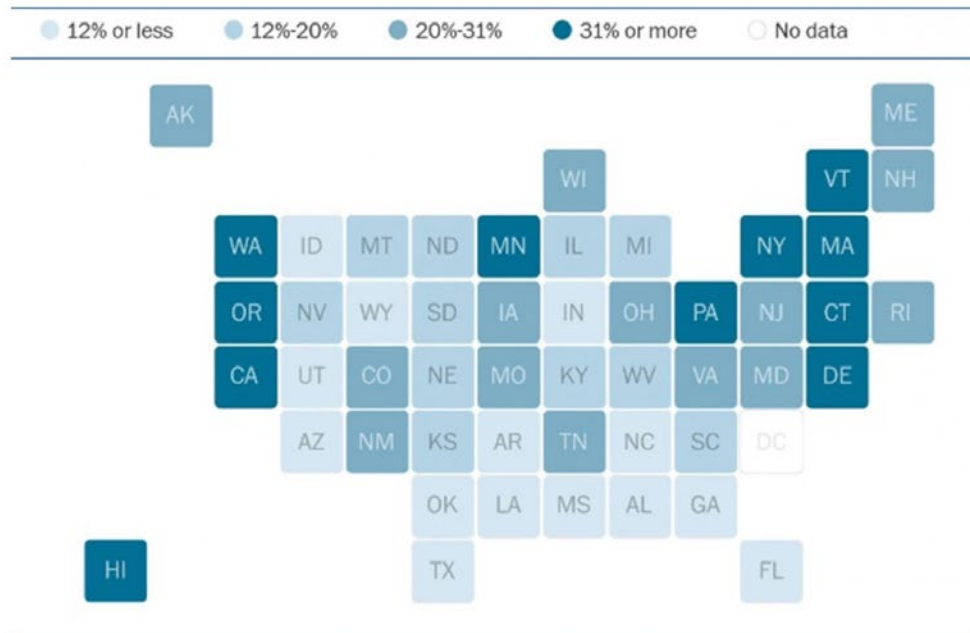
MEDICAID REFORM DETAILS

Block Grants or Per Capita Allotments?



FEWER POOR FAMILIES RECEIVE WELFARE IN SOME STATES

Overall, fewer than one in four poor families receive cash assistance - although many receive other forms of aid from the government, such as food stamps.



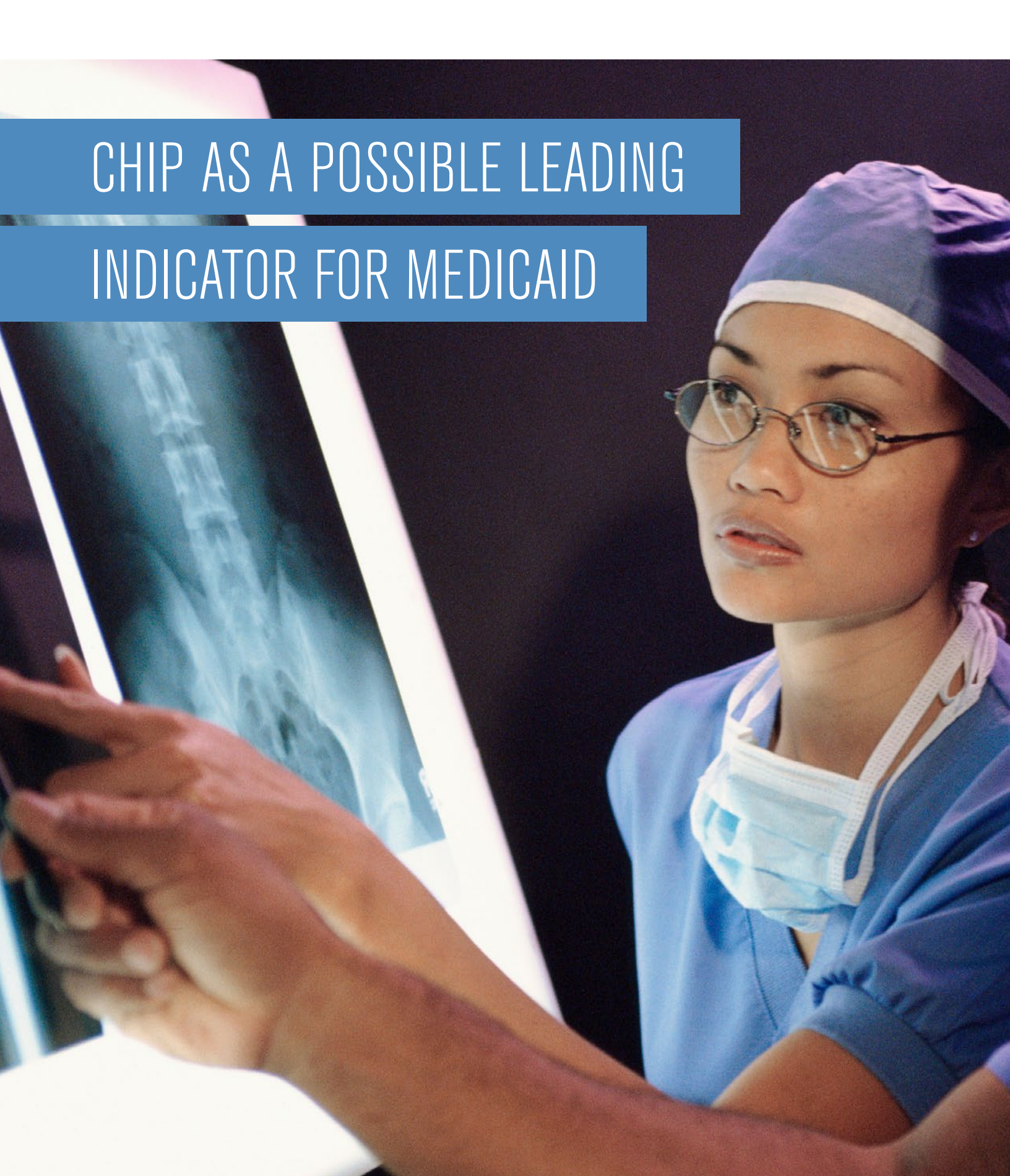
Share of families with children in poverty receiving Temporary Assistance for Needy Families, 2013 – 2014

Source: CBPP, The Washington Post

Medicaid beneficiaries – aged, individuals with disabilities, adults and children – multiplied by the number of eligible beneficiaries in each group. Each of these categories would potentially have separate growth factors applied. The HAELA legislation also proposes to reimburse states by category as they spend (up to category caps), which is similar to how Medicaid is reimbursed today.

Block grants and per capita allotments are not new concepts. In 1996, federal funding for the welfare reform program, Aid to Families with Dependent Children (AFDC), was block

granted. States were allotted their share of \$16.5 billion in federal funding based on their expenditures in a selected baseline year. While welfare reform was successful in reducing the number of families receiving Temporary Assistance for Needy Families (TANF) welfare checks, critics contend that many families that lost benefits moved deeper into poverty. Although states were required to spend TANF funding for one of four priority areas, these areas were open to broad interpretation, making federal oversight of TANF spending difficult and limited.



CHIP AS A POSSIBLE LEADING INDICATOR FOR MEDICAID

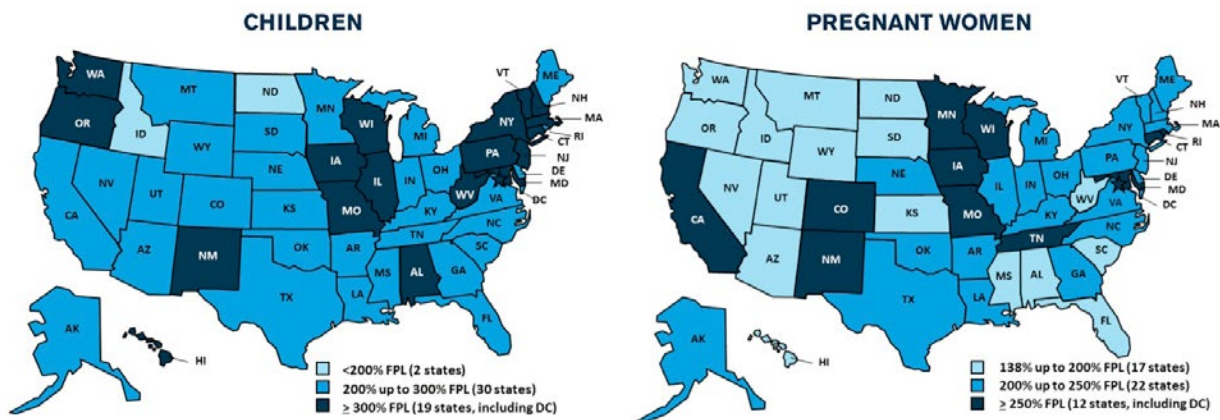
CHIP extends flexibility to the states to customize coverage of children and pregnant women within a capitated allotment that in some ways resembles the per capita allotments proposed in HAELA. States that elect to administer CHIP programs must establish a mandated income eligibility floor. Pre-ACA, the floor was set at 100 percent of the FPL, requiring those under that limit to be covered by Medicaid. Children and pregnant woman with income above that floor could receive coverage under CHIP at an enhanced FMAP, ranging from 65 to 88 percent. Reauthorized by the ACA, the CHIP eligibility floor was raised to 138 percent and enhanced FMAP was increased by 23 percent. *ACA repeal would return CHIP to the 100 percent of FPL floor and decrease FMAP by 23 percent.*

CHIP's similarity to per capita allotments is found in the capitation of federal funding and

how states "draw down" federal dollars. Rather than a grant of lump-sum funding, CHIP draws federal dollars as a percentage match on the cost of services purchased. States cannot spend more than their allotment.

CHIP differs from HAELA's proposed per capita allotments in that CHIP establishes a federal spending limit regardless of enrollment. Under HAELA, states' Medicaid per capita allotments would increase as enrollment increases. This difference is explained by states' flexibility to set CHIP income eligibility limits. Some states have CHIP income eligibility limits as high as 400 percent of FPL and may be forced to manage expenditures by limiting benefits or maintaining waiting lists. HAELA sets an income eligibility limit of 100 percent and allows for growth in states' allotment during periods of economic recession when increased numbers of people meet income eligibility limits.

INCOME ELIGIBILITY LEVELS IN MEDICAID / CHIP, JANUARY 2017



NOTE: Eligibility levels are based on 2016 federal poverty levels (FPLs) for a family of three. The FPL for a family of three in 2016 was \$20,160. Thresholds include the standard five percentage point of the FPL disregard.

Sources: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2017.

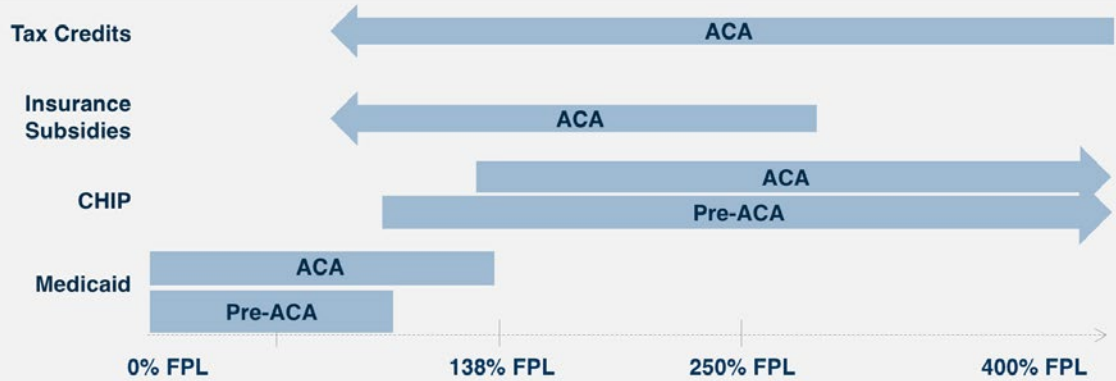


MEDICAID REFORM SCENARIOS

MEDICAID REFORM – THE POSSIBILITIES

When considering the options within each of the components of Medicaid policy, the picture of reform begins to emerge

- ✓ **1115 waivers** – maximize state flexibility
- ✓ **Block grants or per capita allotments** – control state and federal spending
- ✓ **Enrollment groups** – “Childless adults”
- ✓ **FMAP** – fewer people eligible; reduced state share of spending
- ✓ **Income eligibility standards**



Ohio, Michigan and Indiana are among 14 states with Republican governors and Medicaid expansion plans authorized by 1115 demonstration waivers. Governors from these states, including now Vice President Mike Pence, have justified their requests to continue with expansion by citing the benefits of reductions in uninsured populations and uncompensated care. For these and other states, taking health insurance away from citizen voters is a risky proposition. Because Medicaid coverage is closely coordinated with CHIP and private health insurance subsidies and tax credits, repeal without replacement of any one of these components of Obamacare threatens a domino effect.

For those states that have expanded Medicaid eligibility under ACA, repeal means a return to income limits of 100 percent of the FPL. Under repeal, expansion populations drawing

federal funding on services at an FMAP ranging from 90 to 100 percent would no longer be eligible for Medicaid. One benefit that the reformers are potentially offering in the HAELA proposed legislation is a standard FMAP of 75 percent. This is very different from the way Medicaid works today, which is calculated based on each state's per capita income. HAELA's 75 percent FMAP may likely be a placeholder representative of a nationwide average that anticipates state to state variance as established by the way FMAP currently “works.” A single standard FMAP seems unlikely as this would be a substantial benefit to “wealthy” states at the expense of states with less personal income. This 75 percent placeholder may also be indicative of the fact that FMAP may be negotiable – either as a bargaining tool to gain state support to pass legislation or to meet a predetermined federal spending target.

MEDICAID/CHIP REFORM DETAILS – FMAP

States required to cover fewer people with increased federal match

- ✓ **Repeal enhanced FMAP**
 - Reduction of CHIP FMAP (-23%)
 - Elimination of expansion populations at 100%
- ✓ **HAELA proposes 75% FMAP**
 - Will FMAP continue to reflect state per capita income?
 - 75% may be a target national average
- ✓ **Pre-ACA FMAP averaged 61% nationally**

Other elements of Medicaid reform include whether to allow states (or whether to mandate states) to require beneficiaries to meet elements of personal responsibility as a condition of Medicaid coverage or eligibility. These efforts typically emanate from more conservative governors and legislatures. Personal responsibility provisions in Medicaid can take many forms but typically involve premiums and copays for physical health coverage and work requirements for those who are able. Reform efforts currently underway in Indiana and other states also include reduced coverage if premiums are not paid or coverage is not obtained in a timely manner. The Indiana reform efforts may be instructive since President Trump has nominated Seema Verma to be his head of CMS. Ms. Verma, a

consultant and contractor to the state, was the architect of the Indiana Medicaid reform efforts when Vice President Pence was governor. As the figure indicates – despite valid policy reasons for including personal responsibility in Medicaid reform efforts – *operationalizing these personal responsibility requirements like premium payments can be very challenging and costly.*

States have long utilized Section 1115 of the Social Security Act of 1933 to incorporate more flexibility into their Medicaid programs. A key item to watch in the coming years is how much flexibility the new administration is willing to provide states via 1115 waivers. This is true regardless of what form Medicaid reform / “repeal and replace” of the ACA takes.

MEDICAID REFORM DETAILS – PERSONAL RESPONSIBILITY

State option for personal responsibility adds administrative complexity

- ✓ **Premiums and cost sharing for Medicaid**
 - CHIP provides state options for premiums and cost sharing
 - 30 states charge premiums
 - 26 states collect copays
 - ACA expansion groups
 - 40 states charge parents nominal copays
 - 23 states share childless adult copays
 - 5 states charge premiums under 1115 authority
- ✓ **Work requirements**
 - Sound better than they work in practice
 - Complex to administer
 - Value derived in supporting people to return to work

MEDICAID REFORM DETAILS – 1115 WAIVERS

1115 waivers offer flexibility in customizing state Medicaid programs

- ✓ **States have used 1115 waivers to reform Medicaid programs**
 - Research / evaluate design options
 - Managed care delivery models
 - Medicaid expansion
- ✓ **1115 programs must be cost neutral**
 - Does this imply more paying for value vs. volume?
 - More care coordination?
- ✓ **HAELA allows 1115 waivers to endure through their approval period**

States will be encouraged to continue using 1115 to craft Medicaid reform

Sources: Rudowitz, R., & Musumeci, M., (November 20, 2015), Kaiser Family Foundation, The ACA and Medicaid Expansion Waivers, at <http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/>.

Kaiser Commission on Medicaid and the Uninsured, (June 30, 2011), Five key questions and answers about section 1115 Medicaid waivers, at <http://kff.org/health-reform/issue-brief/five-key-questions-and-answers-about-section/>.

States have long utilized 1115 waivers to engage CMS in discussions about program reform efforts in LTSS Medicaid programs. LTSS programs involve institutional care in SNFs and ICFs. Included in LTSS is the provision of services in home and community-based settings that are essential to support people who are elderly and disabled to live outside of institutions. These programs continue to grow at rates that outpace revenues at both the federal and state level.

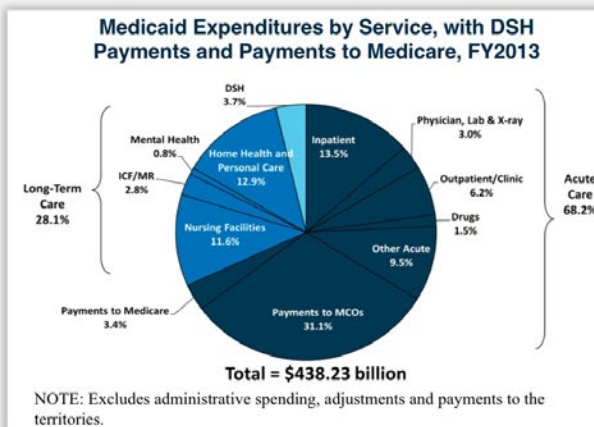
Unlike physical health, most of the LTSS participants are in the program for life once

they enter. While there has been significant movement of LTSS services for the elderly and physically disabled to managed care, most LTSS for people with developmental disabilities have been carved out of managed care. So while there has been movement to 1115 waivers in LTSS programs, “reform” – beyond simply a change in payment methods – will be very challenging given the fiscal and programmatic differences in each of the states. *As such, our current prediction is that LTSS will likely be carved out of broader Medicaid reform - at least in the near term.*

MEDICAID REFORM DETAILS – LTSS

Unsustainable spending and operational challenges will drive reform but are unlikely to occur in the short to mid-term

- ✓ Long-term services and supports account for 28.1% (2013) of total Medicaid spending (\$123 billion)
- ✓ Over half of the spending is HCBS
- ✓ Much of HCBS spending is authorized through either 1115 or 1915(c) waivers
- ✓ These programs will likely be carved out of Medicaid reform

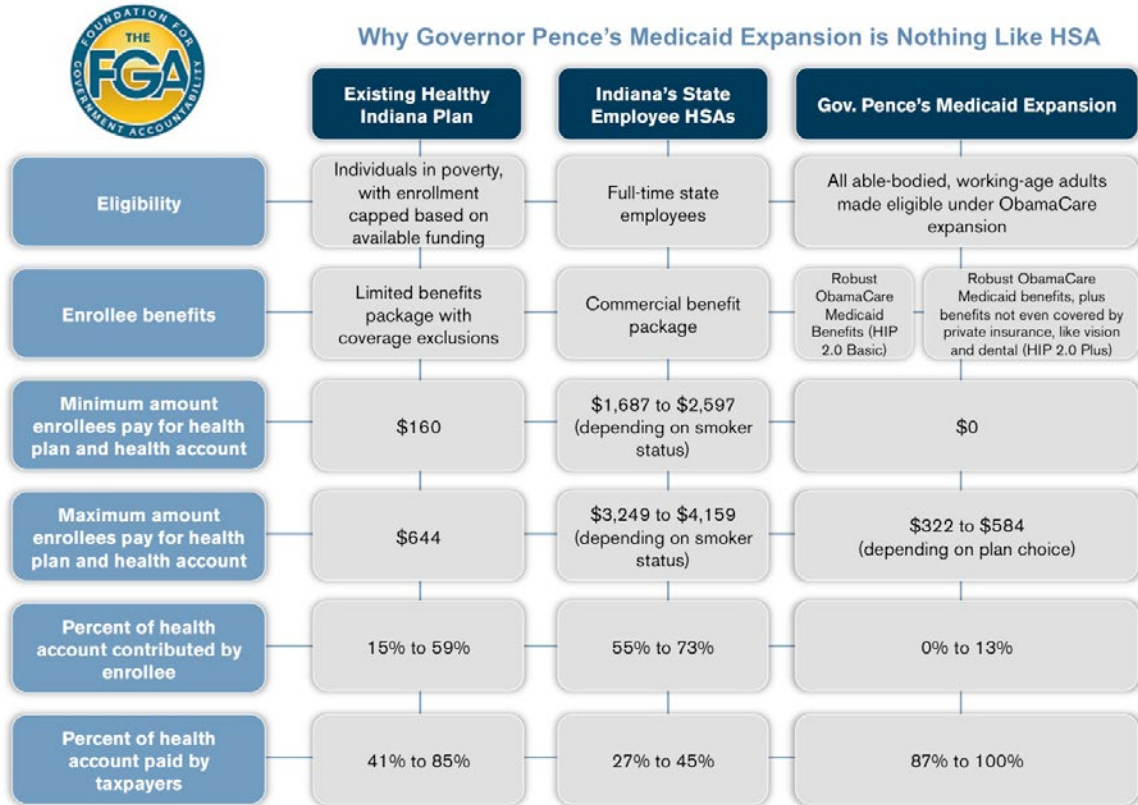


Source: Paradise, J., (March 9, 2015), Kaiser Family Foundation, Medicaid moving forward, at <http://kff.org/health-reform/issue-brief/medicaid-moving-forward/>; Gates, A., Rudowitz, R., and Guyer, J., (September 29, 2014), Kaiser Family Foundation, An overview of the delivery system reform incentive payment waivers.

CASE STUDY: INDIANA



INDIANA MEDICAID EXPANSION



Source: <http://www.forbes.com/sites/theapothecary/2015/02/12/mike-pences-obamacare-medicaid-expansion-reading-between-the-lines/#3ed9884b25d5>

Vice President Pence, the former governor of Indiana, and Seema Verma, the CMS Administrator and architect of Indiana's Medicaid expansion and former Governor Mitch Daniels' high-deductible plan for Medicaid recipients, are intimately involved in the ACA "repeal and replace" effort. An understanding of the Healthy Indiana Plan 1.0 and 2.0 may provide additional insights into Washington deliberations.

The Healthy Indiana Plan, approved under a 1115 federal waiver in 2008, allows the "state to provide a Medicaid benefit package modeled after a high-deductible plan and health savings account to a low-income population."²⁵ The deductible of \$1,100 is withdrawn from a POWER Account funded by the enrollee (to a maximum of 2–5 percent of income) and/or government. Failure of payment (as low as \$4 per month) may result in ineligibility.²⁶

Indiana received approval for an amendment to its 2008 waiver for Medicaid expansion in January 2015. The amendment provided coverage for adults with incomes up to 138 percent of the FPL – an estimated 350,000 to 400,000 residents. Administrative complexity exists with the need to track "premium payments or co-payments, compliance with healthy behaviors, health savings account balances and rollover funds, presumptive eligibility determinations, and services that would have been covered retroactively for certain groups."²⁷

Administrator Verma's company, SVC Consulting, has also been involved in Kentucky's 1115 waiver application, submitted in August 2016, that imposes work requirements (such as unpaid community service) on beneficiaries three months after enrollment as a condition of enrollment.

APPENDIX: HEALTHCARE DISPARITIES

Healthcare disparities or “differences in the health status rates between population groups” have been reported for Medicaid beneficiaries and the uninsured.²⁸ Low-income Americans are far more likely to have cardiovascular, pulmonary, kidney and liver disease, as well as diabetes. Adults with a low socioeconomic status (i.e., lower income and/or education levels) are disproportionately more likely to be obese, have a higher rate of cigarette smoking and abuse alcohol and/or drugs.²⁹ Environmental factors such as child abuse and neglect and/or a history of parental substance

abuse, combined with genetics and comorbid mental illness, may also contribute to the poor health behaviors and outcomes.³⁰

Healthcare inequities or the disparity in health status rates due to differences in socioeconomic and/or health resources also exists.³¹ Poor Americans, especially the uninsured but also Medicaid beneficiaries, often lack a primary care physician, have difficulty accessing specialists and use the emergency department for non-urgent conditions.

HEALTH DISPARITIES BY INCOME

Prevalence of Diseases by Income (2011)
Urban Institute April 2015 Report

DISEASE OR ILLNESS	ANNUAL FAMILY INCOME				
	Less than \$35,000	\$35,000 -49,999	\$50,000 -74,999	\$75,000 -99,999	\$100,000 or more
Coronary heart disease	8.1	6.5	6.3	5.3	4.9
Stroke	3.9	2.5	2.3	1.8	1.6
Emphysema	3.2	2.5	1.4	1.0	0.8
Chronic bronchitis	6.3	4.0	4.4	2.2	2.4
Diabetes	11.0	10.4	8.3	5.6	5.9
Ulcers	8.7	6.7	6.5	4.7	4.4
Kidney disease	3.0	1.9	1.3	0.9	0.9
Liver disease	2.0	1.6	1.0	0.6	0.7
Chronic arthritis	33.4	30.3	27.9	27.4	24.4
Hearing trouble	17.2	16.0	16.0	16.2	12.4
Vision trouble	12.7	9.8	7.5	5.7	6.6
No teeth	11.6	7.8	5.5	4.2	4.1

HOUSEHOLD INCOME AFFECTS HEALTH OUTCOMES

Americans earning less than \$35k are far more likely to develop serious chronic health conditions than those earning over \$100k.

HOW MUCH MORE LIKELY?

233%
MORE LIKELY TO HAVE
KIDNEY DISEASE

186%
MORE LIKELY TO HAVE
LIVER DISEASE

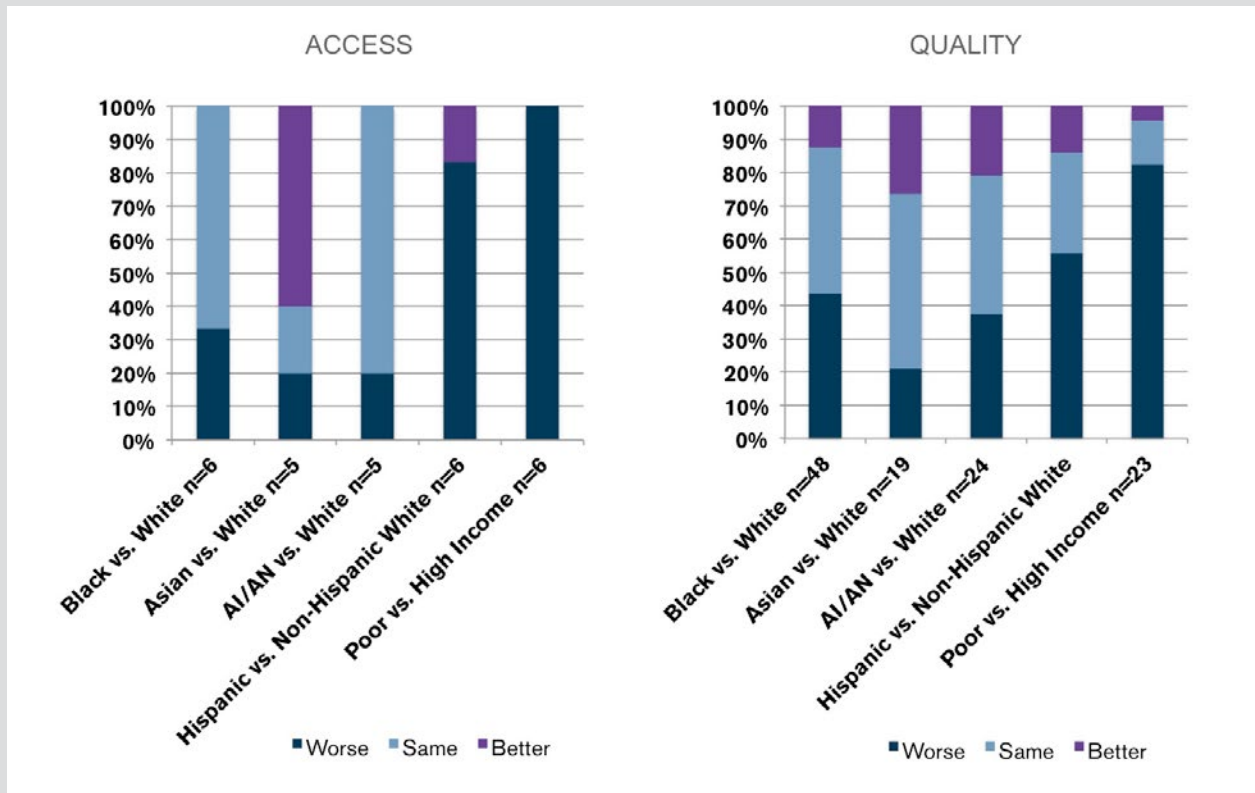
163%
MORE LIKELY TO HAVE
CHRONIC BRONCHITIS

144%
MORE LIKELY TO SUFFER FROM
A STROKE

86%
MORE LIKELY TO HAVE
CHRONIC DIABETES

65%
MORE LIKELY TO HAVE
HEART DISEASE

Sources: J. S., Schiller, J. W. Lucas, and J. A. Peregoy, “Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2011.” Vital and Health Statistics 10, no. 256 (2012): 1–207, tables 1, 4, 8, and 12. <http://www.cdc.gov/nchs/>
World Economic Forum 06/2016
https://www.weforum.org/agenda/2016/06/transforming-healthcare-for-the-low-income?utm_content=buffer29a3c&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer



Source: National Healthcare Quality and Disparities Report, 2010. Figure H.1 and H.2. Distribution of core quality measures for which members of selected groups experienced better, same or worse quality of care compared with reference group. www.ahrq.gov/qual/nhdr10/nhdr10.pdf

A study published in the *Annals of Surgery* based on a review of 893,658 patient records in the National Inpatient Sample found a far lower mortality rate in patients with private insurance irrespective of the type of operation. “After controlling for age, gender, income, geographic region, operation, and 30 comorbid conditions, Medicaid payer status was associated with the longest length of stay and highest total costs ($P < 0.001$).”³²

BEHAVIORAL HEALTH

“The good physician treats the disease; the great physician treats the patient who has the disease.” –Sir William Osler³³

According to the definition suggested by the Patient-Centered Primary Care Collaborative, “behavioral health is an umbrella term for

care that addresses any behavioral problems impacting health, including mental health and substance abuse conditions, stress linked physical symptoms, patient activation and health behaviors.”³⁴

According to the National Institute of Mental Health, mood disorders and anxiety affect 9.5 percent to 18.1 percent of the adult population in any given year.³⁵ Mood may be elevated (mania, hypomania), depressed (major depressive disorders, dysthymia disorders) or cycled (bipolar, cyclothymia) in the same patient. Despite being highly treatable, 60 to 80 percent of people with major depression disorders are under-diagnosed or inadequately treated by physicians.³⁶ Approximately 14.8 million adults (6.7 percent) live with major depression, 6.1 million (2.6 percent) have bipolar disorder and 42.0 million (18.1 percent) exhibit a range of anxiety disorders, such as

HEALTH OUTCOME DISPARITIES

Unadjusted Outcomes for All Patients Undergoing Major Surgical Operations by Primary Payer Group

Outcome	Private Insurance	Medicaid	Uninsured
In-hospital mortality	1.3%	3.7%	3.2%
Wound complication	1.1%	1.7%	1.4%
Infectious complications	2.0%	3.4%	2.8%
Urinary complications	1.0%	1.0%	0.8%
Pulmonary complications	6.7%	9.3%	8.3%
Gastrointestinal complications	4.3%	4.7%	4.6%
Cardiovascular complications	4.0%	4.1%	4.3%
Systemic complications	1.5%	1.8%	1.4%
Procedure-related complications	3.1%	3.8%	3.5%
Length of stay (days)	7.4 ± 0.1	12.7 ± 0.4	10.1 ± 0.3
Total cost (\$)	63,057 ± 53.0	93,567 ± 251.4	78,279 ± 231.0

In-Hospital Mortality for All Patients Undergoing Major Surgical Operations by Primary Payer Group

Outcome	Private Insurance	Medicaid	Uninsured
Lung resection	2.0%	4.3%	6.2%
Esophagectomy	3.0%	7.5%	6.5%
Colectomy	1.8%	5.4%	3.9%
Pancreatectomy	2.7%	5.8%	8.4%
Gastrectomy	3.5%	5.4%	5.0%
Abdominal aortic aneurysm	7.0%	14.5%	14.8%
Hip replacement	0.1%	0.2%	0.1%
Coronary artery bypass graft	1.4%	2.8%	2.3%

Sources: CDC/NCHS, National Health Interview Survey, 2009-13. Huffington Post http://www.huffingtonpost.com/2015/05/28/mental-health-coverage_n_7456106.html

panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), generalized anxiety disorder and phobias.³⁷

Somatization, a tendency to experience and communicate somatic (body) distress in response to psychosocial stress and to seek medical treatment, may accompany depression and anxiety. About 9.2 million (42.6 percent) of the 21.6 million adults with substance dependence and abuse disorders have co-occurring mental health disorders.³⁸

Mood disorders may also occur in response to a medical condition. The risk of depression in patients with a serious medical condition is estimated at 25–33 percent.³⁷ The rate varies by the type of condition (e.g., heart

attack, stroke, cancer), its lifecycle and severity, presence of comorbidities, impact on functional status, degree of psychosocial support and whether it is life-threatening or terminal. Nonmedical risk factors also contribute to the underlying emotional state and include social isolation, bereavement, retirement, job loss, relocation and substance abuse, most commonly involving prescription medications and alcohol.

Mental Health America, a leading nonprofit advocacy organization, has measured access to mental healthcare based on nine measures:

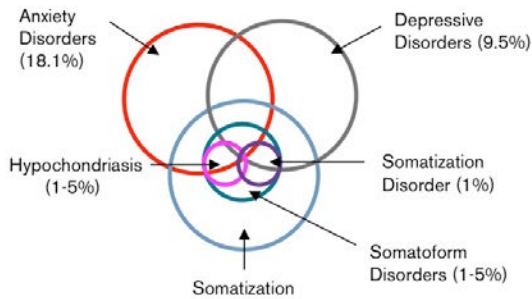
- Adults with an acute mental illness (AMI) who did not receive treatment
- Adults with an AMI reporting an unmet need

- Uninsured adults with an AMI
- Adults with a disability unable to see a doctor due to costs
- Youth with a major depression episode (MDE) not receiving mental health services
- Youth with a severe MDE who received some consistent treatment
- Children with private insurance not covering mental or emotional problems
- Students identified with an emotional disturbance for an individualized education program (IEP)
- Mental health workforce availability

Nearly 60 percent of adults with a mental illness did not receive treatment in 2012–2013.⁴⁰ The availability of mental health providers varies widely by state, with Massachusetts, Maine and Vermont having approximately 250 individuals for every one mental health provider, compared to West Virginia, Texas and Alabama, where there are approximately 1,100 individuals for every one provider. Many of the states with the lowest access to mental healthcare did not expand Medicaid coverage.

BEHAVIORAL HEALTH UNDER-DIAGNOSED AND TREATED

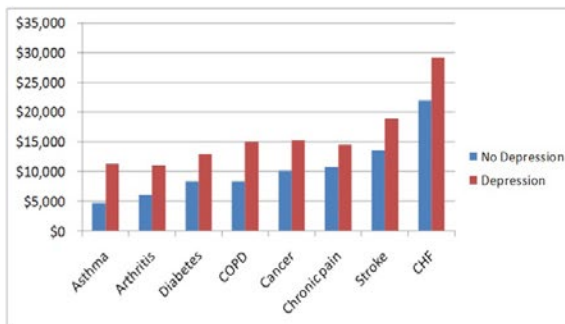
Behavioral Health Prevalence



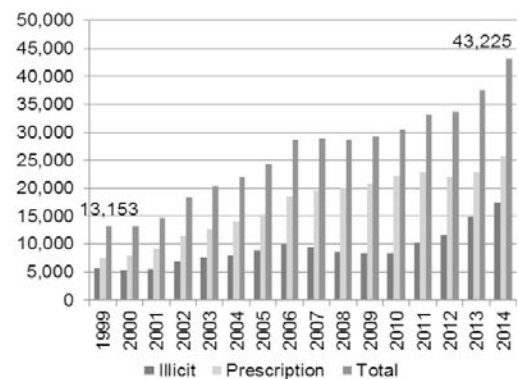
Comorbid Depression & Chronic Disease



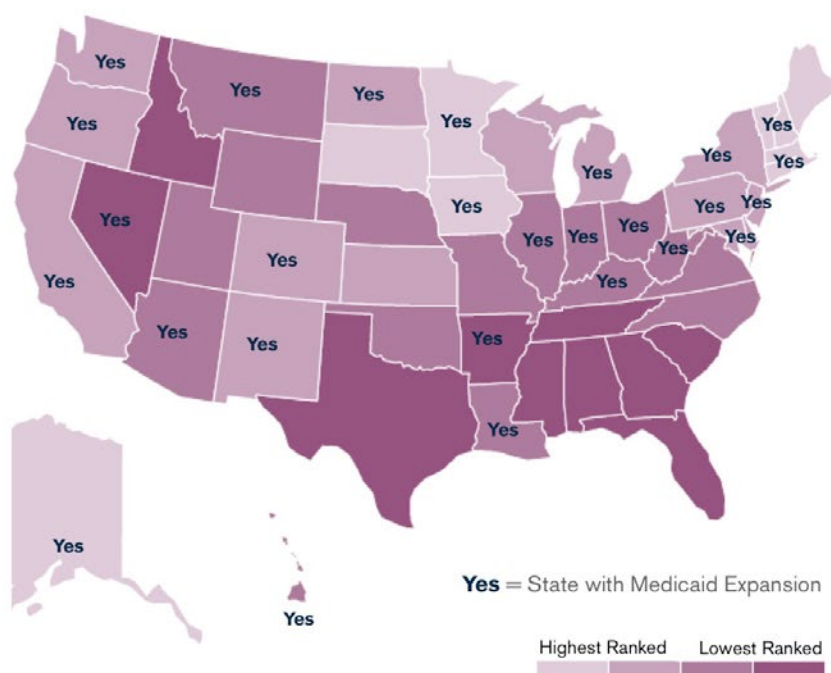
Co-morbid Depression and Medical Costs



Drug Overdose Deaths



ACCESS TO MENTAL HEALTHCARE BY STATE

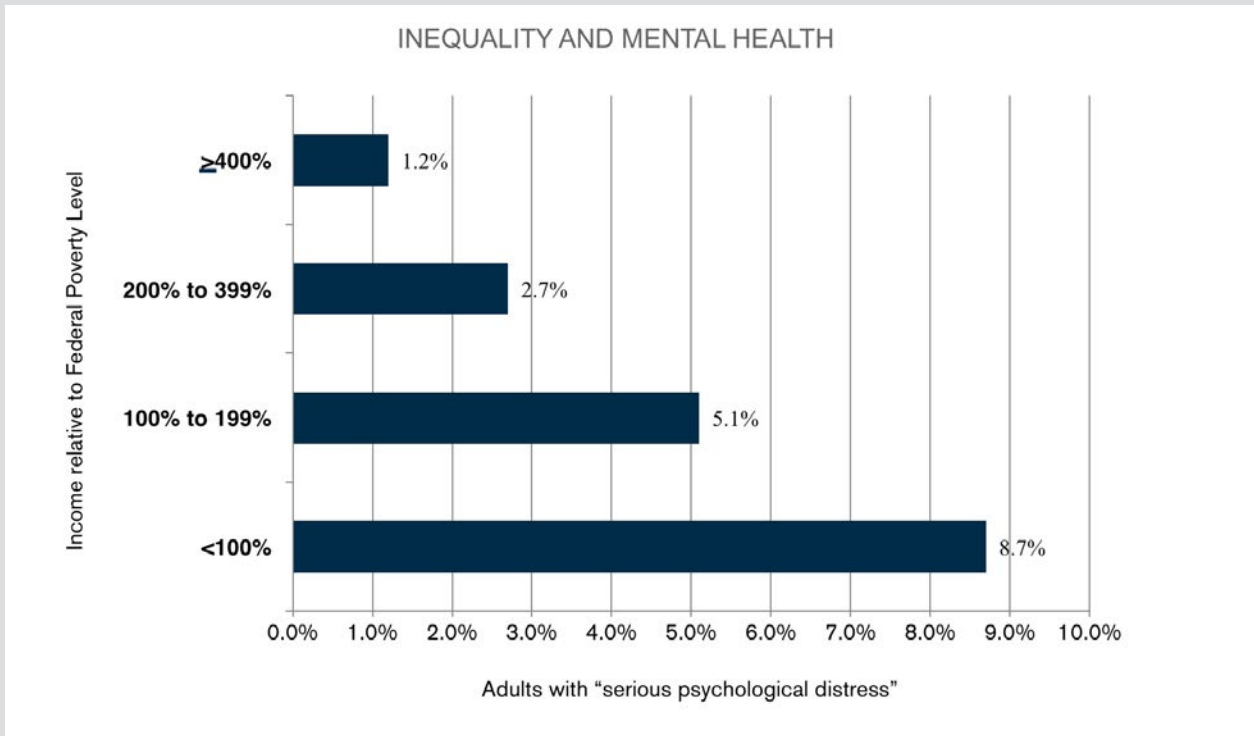


Source: <http://www.mentalhealthamerica.net/issues/mental-health-america-access-care-data>

The Centers for Disease Control and Prevention measured serious psychological distress in the adult population, defined as “mental health problems severe enough to cause moderate-to-serious impairment in social, occupational, or school functioning and to require treatment.”⁴¹ The Kessler Psychological Distress Scale (K6) was used to calculate a score based on the frequency of the following six questions: “During the past 30 days, how often did you feel ... (1) So sad that nothing could cheer you up, (2) Nervous, (3) Restless or fidgety, (4) Hopeless, (5) That everything was an effort and (6) Worthless?”⁴²

A key finding of the analysis highlighted that as income increased, the age-adjusted percentage of serious psychological distress declined. Those eligible for Medicaid, even in expansion states providing coverage for adults with income over 138 percent of the FPL, have a far higher burden of mental illness.

Financial, psychosocial and environmental pressures may contribute to serious psychological distress. Alternatively, having a mental illness such as schizophrenia, bipolar disease, PTSD or substance abuse may limit earnings capacity.



Sources: CDC/NCHS, National Health Interview Survey, 2009-13. Huffington Post http://www.huffingtonpost.com/2015/05/28/mental-health-coverage_n_7456106.html

Medicaid funding for behavioral health remains inadequate. Limited funding for ambulatory and community services often results in higher spending elsewhere (e.g., emergency rooms, hospitals, law enforcement and prisons) and may contribute to homelessness.

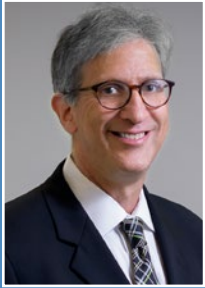
High-profile mass killings such as those in Columbine, Colorado (Eric Harris); Newtown, Connecticut (Adam Lanza); Aurora, Colorado (James Holmes); and Tucson, Arizona (Jared Loughner) may have been avoidable.⁴³

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“

America's health care system
is neither healthy, caring, nor
a system.

- WALTER CRONKITE

”

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