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DIRECTORS ALERT BULLETIN

National Association of State Directors of Developmental Disabilities Services

The Better Care Reconciliation Act:
An Overview for State I/DD Agencies

Senate Republicans last week unveiled the Better Care Reconciliation Act (BCRA), their version of legislation to "repeal and replace" the Affordable Care Act (ACA). Although a vote was originally scheduled for Thursday of this week, the intervening days have seen enough resistance from both the moderate and conservative edges of the Republican Caucus that Majority Leader Mitch McConnell (R-KY) has been forced to cancel the vote and continue negotiations on the bill, setting the expectation of a vote shortly after the Senate returns from its July 4th recess.

While the bill does make changes to the statutory provisions created by the ACA, possibly the most dramatic policy change in the bill involves changing the funding structure of Medicaid — not just the ACA-created Medicaid expansion, but also the traditional program as it has existed since 1965. The proposal to change Federal Financial Participation (FFP) from an open-ended entitlement to a per capita cap has significant policy implications for state I/DD systems. While the ACA repeal legislation that has already passed the House, the American Health Care Act (AHCA), also contained a per capita cap proposal, there are several important changes to the capping approach to be found in the BCRA. Below is a summary of the Medicaid provisions of the BCRA, followed by a look at the implications of the legislation.

Medicaid Provisions

Per Capita Caps: This legislation, like the AHCA, would put a per capita cap on federal Medicaid spending, although some of the details are different:

- **Under the BCRA, the caps kick in in 2020.**
  - Different caps would be set in five specified categories: the elderly, blind and disabled adults, nondisabled children, adults made eligible for Medicaid by the ACA, and all other adults. As in the AHCA, there is no specificity as to the eligibility criteria for several of the categories, including blind and disabled adults, where one might expect people with I/DD to fall. As a result, it is unclear whether this category would be determined by eligibility pathway, or some other measure, and therefore difficult to predict exactly who would be included — and who left out.
  - Blind and disabled children under 19 years of age would be excluded from the per capita caps and covered as under current law; again, however, there is no specific definition of blind and disabled children, so it is impossible to fully determine who would be included in this carve out.
  - This bill, similar to the AHCA, does not give explicit relief or flexibility regarding the underlying Medicaid statute.

- As with the AHCA, there are no guard rails on spending — that is, once the final limit has been determined, states may distribute that spending among the five categories in any way they choose (as long as consistent with the underlying Medicaid statute).

- **Calculating the Caps:**
  - The House bill designated 2016 as the base year for calculating the caps, but under the BCRA states would be able to choose any eight consecutive quarters between the first quarter of federal fiscal year 2014 and the third quarter of 2017.
  - The final limit on federal reimbursement for each state starting in 2020 would be the average cost per enrollee for the five specified groups of enrollees, reflecting growth from the base period in the relevant inflation factors multiplied by the number of enrollees in each category.
  - Each year through 2024, the inflation factor for the caps for most nondisabled children and nondisabled adults would be the Consumer Price Index for Medical expenditures (CPI-M), and for most enrollees who are disabled adults or age 65 or older, the CPI-M plus 1 percentage point.
  - Beginning in 2025, the inflation factor for all groups would be the consumer price index for all urban consumers (CPI-U).
  - If a state spent more than the amount eligible for federal reimbursement, the federal government would provide no reimbursement for spending over the limit.
  - Per capita caps may be retroactively adjusted to account for data errors, but these adjustments cannot result in an increase in the cap of greater than 2%.
  - If a state fails to adequately report spending and enrollment data for a given enrollment category or categories, the inflation factor for those categories will be reduced by one percentage point.
  - The legislation gives broad authority to the Secretary of Health and Human Services (HHS) to adjust data submitted by the state.
  - States which overspend their per-capita cap allotments in a given fiscal year will have the subsequent fiscal year's allotment reduced by the overspend amount, applied on a quarterly basis.

- **Twenty-Five Percent Rule:**
  - Starting in FY 2020, the per capita caps will be adjusted for states whose spending for a given population is above or below the national average by 25% or more.
  - For states 25% or more above the average, caps will be reduced by between 0.5 – 2%, at the Secretary of HHS's discretion. For states 25% or more below the average, caps will be increased by between 0.5 – 2%, at the Secretary's discretion.
  - Any such adjustments must be budget neutral.
  - Adjustments will not be made for states that have population densities of less than 15 people per square mile, based on the most recent Census data — this means Alaska, the Dakotas, Montana, and Wyoming.
  - In FY 2020 and 2021, these adjustments will take place by aggregating all enrollee categories.
  - For FY 2022 and beyond, adjustments will occur based on the distinct enrollee categories, including the blind and disabled category.

- **Community First Choice Option:**
  - The BCRA undoes the Federal Medical Assistance Percentage (FMAP) enhancement of 6%

for 1915(k), the Community First Choice Option.
  - However, the bill does not remove the authority altogether, meaning that states who currently have 1915(k) programs will need to determine whether they intend to continue without the enhanced match, or file a State Plan Amendment (SPA) to discontinue it.

- **Block Grants:** The BCRA also includes a block grant option for states:
  - Starting in 2020, states would have the option to receive federal aid for providing medical assistance to nondisabled adults (excluding adults made eligible for Medicaid by the ACA) in the form of a block grant rather than under a per-enrollee cap.
  - A state's initial block grant would be determined by multiplying the amount of the per capita cap, as estimated by the Secretary of HHS, for the state's nondisabled adult population by the state's total number of nondisabled adult enrollees in the year before the preceding fiscal year, adjusted for population growth plus 3 percentage points.
  - In subsequent years, the block grant amount would grow at the rate of the CPI-U.
  - A state would be required to contribute, at a minimum, an amount calculated using its matching rate for enrollees under the Children's Health Insurance Program (CHIP), not including the 23 percentage-point decrease for such rates established under the ACA.
  - Unspent block grant funds may be rolled over into subsequent block grant fiscal years.
  - HHS will promulgate quality standards for state use of block grant funds by January 1, 2020.
  - The bill contains Maintenance of Effort (MOE) provisions, and block grants must cover mandatory Medicaid populations and benefits as defined in current statute.

- **Medicaid Expansion:** The bill winds down the enhanced matching rate for the Medicaid expansion:
  - Under the BCRA, the ACA's Medicaid expansion enhanced match remains at 90% through 2020 but then reduces 5% each year for 3 years (85% in 2021, 80% in 2022, and 75% in 2023). In 2024, a state would only receive its regular FMAP if it wanted to continue covering these enrollees.
  - It also requires those in the Medicaid expansion population to submit eligibility renewal paperwork every six months to stay on Medicaid, beginning October 1, 2017.
  - If states that have not yet expanded want to expand, they would only get the state's "regular" FMAP even while other states that have expanded could get a higher match through 2023.

- **Medicaid Waivers:**
  - BCRA contains language that requires the Secretary to implement procedures to encourage states to adopt or extend HCBS waivers, if the state determines that such waivers would improve patient access to services, but does not offer any incentives or requirements on the part of the state to do so.
  - The legislation allows managed care waivers to be grandfathered into permanency, if the waiver was approved under 1915(b), 1932, or 1115 authority as of January 1, 2017; and has been renewed at least one time. Waiver terms and conditions may not be modified under this grandfathering process.

- **CMS Interaction with States:**
  - Effective January 1, 2018, the Secretary must establish a process for consulting with state Medicaid Directors prior to issuing proposed rules, plan amendments, waiver requests, or project proposals.

- The Secretary must accept and consider comments from an organization representing state Medicaid Directors and incorporate in response to comments any input received from this process, as well as the Secretary's response.

- **State Data Reporting:** The BCRA contains some new reporting requirements for states:
  - Sixty days after passage of the BCRA, HHS must modify the CMS-64 to allow state reporting of expenditures in qualified inpatient psychiatric hospital settings.
  - Beginning October 1, 2018, states must report on the CMS-64 spending and enrollment data for all per capita cap categories.
  - By January 1, 2020, states must report on the CMS-64 data for medically complex children, defined as:
    - Under 21 years old;
    - Have a chronic condition affecting two or more body systems; affects cognitive or physical functioning; and either requires complex interventions or meets medical complexity criteria under existing risk adjustment methodologies.

- **New Funding for Reporting:** The bill also provides limited new funding for these activities. For states choosing the most recent eight consecutive quarters for their per capita cap base period, FMAP from October 1, 2017, to October 1, 2019, for activities related to new CMS-64 reporting requirements will be enhanced on the following basis:
  - Increased 10 percentage points, to 100%, for system design, development, and installation;
  - Increased 25 percentage points, to 100%, for systems operation;
  - Increased 10 percentage points, to 60%, for program administration.

- **Changes to Eligibility:**
  - Effective October 1, 2017, the bill ends the three-month Medicaid retroactive eligibility period.
  - The Senate bill also repeals the ACA's increase in Medicaid eligibility to 138% FPL for children ages 6-19 as of December 31, 2019. The minimum federal income eligibility limit for these children will revert to 100% FPL.

Prognosis

CBO Score: The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) on Monday released their "score" of the Better Care Reconciliation Act of 2017, an estimate of the direct spending and revenue effects of the bill, and estimate that enacting this legislation would reduce the cumulative federal deficit over the 2017-2026 period by $321 billion, $202 billion more than the estimated net savings for the version of H.R. 1628 that was passed by the House of Representatives. The Senate bill would increase the number of people who are uninsured by 22 million in 2026 relative to the number under current law, slightly fewer than the increase in the number of uninsured estimated for the House-passed legislation. By 2026, an estimated 49 million people would be uninsured, compared with 28 million who would lack insurance that year under current law.

CBO projects that the largest savings would come from a reduction of $772 billion in federal outlays for Medicaid — spending on the program would decline in 2026 by 26% in comparison with what CBO projects under current law. Enrollment in Medicaid would be lower throughout the coming

decade, with 15 million fewer Medicaid enrollees by 2026 than projected under current law in CBO's March 2016 baseline. Some of that decline would be among people who are currently eligible for Medicaid benefits, and some would be among people who CBO projects would, under current law, become eligible in the future as additional states adopted the ACA's option to expand eligibility.

By CBO's projections for the 2017-2024 period, the per capita caps would reduce outlays because Medicaid spending, on a per-enrollee basis, for nondisabled children and nondisabled adults under current law (after the changes to the Medicaid expansion population have been accounted for) would grow faster, at 4.9%, than the CPI-M, at 3.7%. However, for most enrollees who are disabled adults or age 65 or older, that rate is 3.3%, lower than the CPI-M plus 1 percentage point. The per capita cap would nonetheless "have a small effect on spending for those groups…because some shifting of costs among groups would probably occur, and spending for a particular group in a particular year could be affected." However, those impacts would become much larger for all groups in 2025 and beyond, as the differences between spending growth for Medicaid under current law and the growth rate of the per capita caps for all groups would be substantial — CBO projects the growth rate of the CPI-U in those years to be 2.4%.

NAMD Statement: Meanwhile, disability organizations, patient advocacy organizations, medical associations, and industry players such as the hospital associations have virtually unanimously announced their opposition to the legislation. Perhaps most significant for state DD directors is the stance that the bipartisan National Association of Medicaid Directors (NAMD) has taken. The statement "articulates the value of the Medicaid program, reiterates Medicaid Directors' commitment to targeted and effective reform of the program, notes the challenges with the financing reforms currently being debated, and calls for prioritizing the stabilization of the individual market before engaging in thoughtful and deliberative Medicaid reform." NAMD points out that "Medicaid is a successful, efficient, and cost-effective federal-state partnership" with "a record of innovation and improvement of outcomes for the nation's most vulnerable citizens." Pointing out, "Medicaid Directors have long advocated for meaningful reform of the program," but argues that "these changes must be made thoughtfully and deliberately to ensure the continued provision of quality, cost-effective care."

NAMD clearly articulates, "No amount of administrative or regulatory flexibility can compensate for the federal spending reductions that would occur as a result of this bill." The Medicaid Directors go on to say, "Changes in the federal responsibility for financing the program must be accompanied by clearly articulated statutory changes to Medicaid to enable states to operate effectively under a cap. The Senate bill does not accomplish that. It would be a transfer of risk, responsibility, and cost to the states of historic proportions. While NAMD does not have consensus on the mandatory conversion of Medicaid financing to a per capita cap or block grant, the per capita cap growth rates for Medicaid in the Senate bill are insufficient and unworkable."

Senate Outlook: Since Senate Republicans finally unveiled their legislation last week, several Republican Senators have suggested they are unlikely to vote yes on the bill. Nevada Senator Dean Heller, facing a tough re-election bid in a state that went to Clinton in 2016, announced last week that he could not support the bill without significant changes, seeming to take a position against per capita caps altogether in addition to calling for preserving the Medicaid expansion. Conservative Senators Rand Paul (KY), Mike Lee (UT) and Ted Cruz (TX) last week indicated that they felt the bill did not do enough to repeal Obamacare and therefore were not likely to support. Ron Johnson (WI)

was the most direct and forceful of several Senators who pushed back against the quick timeline for consideration, saying that the scheduled vote this Thursday did not give him enough time to think through the implications of the bill and get feedback from constituents. Monday's release of the CBO score seemed to make matters worse, as several other Senators seemed to waver and Susan Collins of Maine announced that she had become a firm no.

As a result of this turmoil, Senate Majority Leader Mitch McConnell yesterday announced that he would delay the vote until after the 4th of July recess. This constitutes a major setback for supporters of the legislation, as McConnell had previously expressed not only his firm commitment to a vote before the recess, but also his intention to move on to other issues after the recess, whether the Senate had passed a health care bill or not. However, the leader does not seem intent on dropping his efforts to get the bill passed. One of the few bright spots for Republicans in the CBO score was an unexpected $188 billion surplus in savings over expenditures. This gives McConnell funds to use to make additions to the bill that might bring specific wavering Senators to supporting the legislation, and it appears that the next few days, and possibly the 4th of July recess, will be spent in backroom negotiations to see if Republicans can get the 50 votes they need for passage.

Implications for State Directors

Given the current status of the bill, the likelihood is that if the Senate returns to consideration of health care reform in the coming days or weeks, there will be significant changes to the legislation. Coupled with the fact that final passage of the legislation is not assured, this means that there are no concrete legislative changes to which state I/DD directors can now respond.

However, should any legislation be signed into law, it will almost certainly contain provisions imposing a per capita cap on the Medicaid program. Therefore, there are important steps state directors can take during this period, including:

- Getting to the table: making certain that the governor and state Medicaid director are well-versed in the important role Medicaid plays in I/DD services, and explain the pivotal impact per capita caps could have on the I/DD system.
- Understanding the states' 'as is' data — this will help to prepare, model and understand the potential implications of any final legislation on the I/DD system in the state.

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