2017 POST-ELECTION INSIGHTS AND LEGISLATIVE UPDATE

Chad Mulvany, FHFMA
Director, Healthcare Finance Policy, Strategy and Development
HFMA
Caveats

- The transitional period and early months of a new administration are periods of significant uncertainty.
- This document attempts to project what Republicans will do based on previously published whitepapers and released legislative concept documents.
- The actual trajectory of legislative and regulatory changes will be impacted by a number of factors that at this juncture are impossible to predict. They include but are not limited to:
  - Dynamics within the House Republican caucus and between the legislative branches.
  - Other competing policy priorities (e.g., tax reform)
  - What is ruled germane to using “budget reconciliation” to pass legislation in the Senate without a super majority.
- It is equally difficult to predict the timing of any legislative efforts to significantly change the ACA. However, it is anticipated that a repeal will not be passed prior to late in the first quarter or early in the second quarter of 2017 at the earliest.
- If and when a package is passed, it will take several years to implement. Any legislative ACA “repeal and replace” package will likely include a transition period to shelter those who gained coverage from an abrupt termination of coverage.
Agenda

• The Politics Are Complicated
  • Repeal, Transition, and Replace?
  • The Continuing Transition to Value
  • Fiscal Issues
Deep Impact

Repeal without Replacement Would Significantly Increase the Number of Uninsured at the National and State Level

# of Uninsured in 2021 – Nationally

\[ \Delta + 81\% \]

\( \text{With ACA} \)
\( \text{Without ACA} \)

# of Uninsured in 2021 – California

\[ \Delta + 122\% \]

\( \text{With ACA} \)
\( \text{Without ACA} \)

Mixed Feelings

Approximately Half of Americans Want the ACA Implemented or Expanded, While Half Want It Repealed or Scaled Back

*Polling Question:* What Would You Like to See President-elect Trump and Congress Do with the ACA?
The 2018 “Election Map” Increases the Likelihood of Compromise…and Unexpected Outcomes

# of Senate Democratic Seats for Re-Election in States President Trump Carried

President Trump: 15
Secretary Clinton: 10

# of House Republican Seats for Re-Election in Expansion States

Expansion: 124
Non-Expansion: 123

Sources:
1) http://www.slate.com/blogs/the_slatest/2016/11/14/democrats_unlikely_to_take_the_senate_in_2018_midterms.html
2) HFMA analysis
3) http://fivethirtyeight.com/features/obamacare-has-increased-insurance-coverage-everywhere/
Senators and Representatives Will Approach Repeal and Replace Based on Their Specific Situations

Example: Potential ACA Impact on 2018 Senate Races in Nevada and Ohio

<table>
<thead>
<tr>
<th>Carried By w/ # of Votes:</th>
<th>Nevada</th>
<th>Ohio</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018 Senator for Re-Election:</td>
<td>Clinton - 26k Votes Heller (R) Yes</td>
<td>Trump - 454k Votes Brown (D) Yes</td>
</tr>
<tr>
<td>Expansion State:</td>
<td>-8.1% -219k</td>
<td>-4.5% -511k</td>
</tr>
<tr>
<td>Total Decrease in Uninsured (%/#):</td>
<td>-7.6% -161k</td>
<td>-4.3% -361k</td>
</tr>
<tr>
<td>R Districts: Avg. UI Decrease:</td>
<td>-9.4% -58k</td>
<td>-5.4% -150k</td>
</tr>
<tr>
<td>D Districts - Avg. UI Decrease:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Nevada
Ohio

Clinton - 26k Votes
Yes
Trump - 454k Votes
Brown (D)
Yes

R Districts: Avg. UI Decrease:
D Districts - Avg. UI Decrease:

Sources:
1) http://www.cnn.com/election
2) http://fivethirtyeight.com/features/obamacare-has-increased-insurance-coverage-everywhere/
3) HFMA analysis
One of the first issues Matt Bevin will confront as the new governor of Kentucky is how far to take his pledge to roll back parts of the state's Medicaid expansion under the Affordable Care Act.

The effects could be particularly dramatic in places such as Jackson County, one of the poorest counties in Kentucky. Half of the population of 13,000 is on Medicaid, the state and national program that provides health care insurance to low-income Americans. According to Census figures, 34 percent of Jackson County's residents live below the poverty line....
In Office He Is Pursuing Additional Medicaid Waivers Instead of Repealing the Expansion

Gov. Matt Bevin on Wednesday submitted his Medicaid waiver proposal to the federal government, hoping to reshape the program that provides health insurance for 1.32 million Kentuckians.

The revised plan Bevin sent to the U.S. Department of Health and Human Services — which he calls Kentucky HEALTH — had a handful of changes that he said are a response to public criticism of the original waiver proposal he unveiled in June. Over the next five years, it could shave $2.2 billion off the expected $37.2 billion expense of Kentucky’s Medicaid program, according to the waiver application.

Agenda

- The Politics Are Complicated
- Repeal, Transition, and Replace?
- The Continuing Transition to Value
- Fiscal Issues
Reconciliation Primer

Reconciliation Is a Procedural Maneuver That Allows Legislation to Pass the Senate with A Simple Majority Instead of 60 Votes

House and Senate Pass Budget with “Reconciliation Directives”

Specified House and Senate Committees Report Legislation Achieving Directed Goals

Provisions of Reported Legislation Must Adhere to “Byrd Rule”

Source: http://www.cbpp.org/research/federal-budget/introduction-to-budget-reconciliation
"Repeal Bill" Advanced to President Obama’s Desk Overturned Many Key ACA Provisions...

Key Elements of Senate Amendment to H.R. 3762: Restoring America’s Healthcare Freedom Reconciliation Act

| Coverage                          | • Eliminated Medicaid Expansion Funding and Exchange Subsidies  
|                                  | • Reduced Employer and Individual Mandate Penalty to $0        |
| Marketplace                      | • Eliminated Reinsurance, Risk Corridor, and Risk Adjustment Programs  
|                                  | • Eliminated Cost-Sharing Subsidies                          |
| Payment Cuts                     | • Eliminated Medicaid DSH Cuts                              |

Source: https://fas.org/sgp/crs/misc/R44300.pdf
ACA’s Remnants

However, the “Repeal Bill” Left Many ACA Provisions Impacting Hospitals, Physicians, and PAC Settings Standing

Key Elements Remaining After Senate Amendment to H.R. 3762:
Restoring America’s Healthcare Freedom Reconciliation Act

<table>
<thead>
<tr>
<th>Insurance Reform</th>
<th>Payment Cuts</th>
<th>Transition to Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Individual &amp; Employer Mandates</td>
<td>• Medicare Market Basket Update Reductions</td>
<td>• Hospital Value-Based Purchasing</td>
</tr>
<tr>
<td>• Guaranteed Issue/Renewability</td>
<td>• Medicare DSH Cuts</td>
<td>• Readmissions Penalty</td>
</tr>
<tr>
<td>• Mandated Benefits</td>
<td></td>
<td>• HAC Penalty</td>
</tr>
<tr>
<td>• Dependents Remain on Parents’ Policy to Age 26</td>
<td></td>
<td>• ACOs/Bundle Pmt. Pilots</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CMMI</td>
</tr>
</tbody>
</table>
Delicate Transition

Republicans Must Address Existing Issues in the Individual Market While Also Clearly Defining the New Rules

1. **Anchor Markets:**
   - Fund Premium Support Subsidies
   - Reduce “Gaming” via Special Enrollments

2. **Improve Risk Pool Balance:**
   - Fund and Extend Risk Adjustment Programs
   - Increase Enrollment
Current Republican Plans to Replace the ACA Would Require 60 Votes and a Compromise in the Senate

Current U.S. Senate Composition

52 Republicans
48 Democrats

Votes Required to Replace ACA

- Republican
- Dem Swing Votes
- Democrats

Source:
http://www.nytimes.com/elections/results/senate
Republican Replacement Plans Will Likely Draw Heavily from Speaker Ryan’s and Congressman Price’s Work

“A Better Way”

“Empowering Patients First”

Sources:
2) https://tomprice.house.gov/HR2300
The Price Plan Uses a Continuous Coverage Requirement Instead of an Individual Mandate to Minimize Adverse Selection Against Plans

Example of How a Continuous Coverage Requirement Works

*Individuals who lose coverage but qualify for “Special Enrollment Periods” are not subject to exclusions

Source:
1) https://tomprice.house.gov/HR2300
Refundable Tax Credits

Instead of Income-Based Tax Credits, Empowering Patients Provides Age-Based Credits

**Schedule of Age-Based Tax Credits to Purchase Coverage**

- **Dependents to 18**: $900
- **18 to 35 Y/O**: $1,200
- **35 to 50 Y/O**: $2,100
- **50 and Older**: $3,000

**Key Features**

- Credits available to purchase coverage on the individual market.
- Upon purchase, individuals have the option of receiving an advanceable credit.
- Individuals may opt out of federal programs to receive tax credit to purchase coverage.

Source: https://tomprice.house.gov/HR2300
Other Affordability Provisions

Republican Plans Include Additional Provisions to Improve Affordability

Elements Designed to Improve Affordability in Republican Replacement Plans

**Pricing Flexibility**
- Eliminate Minimum Essential Benefits Requirements for “Qualified Coverage”*
- Relaxes Age Rating Bands from 3:1 to 5:1**

**Insurance Market Reforms**
- Allow Cross-State Insurance Purchase*
- Provide Funding for State High Risk Pools*
- Allow Children Under 26 to Remain on Their Parent’s Coverage*

**Encourage Consumerism**
- Encourages Adoption/Use of HSAs*
- Creates State-Based Transparency Portals for Providing Info on Health Plans and Providers***

Sources:
1) [https://fas.org/sgp/crs/misc/R44300.pdf](https://fas.org/sgp/crs/misc/R44300.pdf)
While the Theory is Solid, Selling Insurance Across State Lines May Be Difficult to Execute

“Creating the network is not such a simple thing. You have to really worry about network adequacy.”

Dr. Kathleen Hittner
Rhode Island Health Insurance Commissioner

Sources:
Historically, High-Risk Pools in Many States Were Inadequate...

High-Risk Pool Challenges

- Insufficiently Funding:
  - Capped Enrollment
  - Exclusion Periods for Pre-Existing Conditions
- Policies with Lifetime and/or Annual Limits
- High Premiums Coupled with High Cost Sharing

Sources:
High-Risk Pools

...Applying Population Health Management Concepts to High-Risk Pools Could Produce Better Outcomes

UCLA Newsroom

HEALTH + BEHAVIOR

Disease-specific health plan appears to help keep diabetes care under control, UCLA study finds

Enrique Rivero | May 27, 2015

People with diabetes who enroll in a health insurance plan tailored to their medical condition are more likely to stick to their medication and actively take charge of their own health care, according to a UCLA study.

... According to Duru, this can be translated to about a 1 percent reduction in health care spending and 0.6 percent fewer visits to hospitals and emergency treatment centers.

Source:
Encouraging Consumerism

“Empowering Patients” Couples Tax Sheltered Out-of-Pocket Spending with Increased Transparency

Economic Incentives
- 1x $1,000 HSA Tax Credit
- Increases Allowable Contribution to IRA Level
- Expands Account Rollover to Decedent Survivors

Transparency
- States May Create Portals Providing Standardized Information on:
  - Health Plans Co-Payments, Covered Benefits
  - Providers Price and Quality

Source:
1) https://tomprice.house.gov/HR2300
HFMA’s Healthcare Dollars & Sense®

HFMA Has Developed A Suite of Tools to Help Navigate Consumerism

Tools and resources for developing a patient-centered approach to financial interactions with patients and other healthcare consumers

hfma.org/dollars
Agenda

• The Politics Are Complicated
• Repeal, Transition, and Replace?
• The Continuing Transition to Value
• Fiscal Issues
MACRA Moves Forward

While the Pace of Implementation May Slow, the Direction Likely Will Not

- **2016 -- 2019**: + 0.5%
- **2020 -- 2025**: 0%
- **2026 & Beyond**: + 0.25% for MIPS Path

- **Up to $500M Annually for MIPS High Performers**
- **5% Per Year Lump Sum APM Bonus**
- **+ 0.75 % for APM Path**
Pick Your Pace

In Response to Provider Feedback, CMS Is Providing Physicians with Options for Participating in MACRA’s Quality Payment Program

2017 Participation Options

- Option 1: Test the Quality Payment Program
- Option 2: Participate for Part of the Calendar Year
- Option 3: Participate for the Full Calendar Year
- Option 4: Participate in an Advanced APM Model

Source: https://blog.cms.gov/2016/09/08/qualitypaymentprogram-pickyourpace/
Medicare APM Nominal Risk

CMS Finalized Two Ways that a Non-Medical Home APM Can Meet the Advanced APM Nominal Risk Standard

1) **Revenue Standard: 8% or more** of the APM Entity’s average Parts A and B revenue must be at risk in performance years 2017 and 2018.

Example: *The providers have $1M in Medicare allowable payments. They must be at risk of paying back losses of at least $80K.*

2) **Benchmark Standard: 3% or more** of the expected expenditures for which an APM entity is responsible. Applies to all performance periods.

Example: *A joint replacement episode target price is $20K. The orthopedic surgeon must be at risk of paying back losses of at least $600.*
Limited AAPM Options

Few Currently Available Medicare Models Qualify as AAPMs

APMs Meeting CMS’s Risk Criteria in 2017 and 2018

- Comprehensive Primary Care Plus*
- MSSP Tracks 2 and 3
- Next Generation ACO Model
- Comprehensive ESRD Care
- Oncology Care Model**
- CJR (2018)
- ACO Track 1+ (2018)***
- New Voluntary Bundled Payment Model (2018)***

*Practices of No More than 50 Providers Under the Corporate Umbrella After 2017
**Two-sided Risk Only
***Details TBD
HFMA’s Physician Resources

HFMA Has Created A Site for All of Its MACRA Resources

Physician Practice Resources

Updated MACRA Resources
Below are current items to help in the transition

Two Web Discussions

• Making Sense of the Final CMS MACRA Rule
• Strategies for Physician Groups to Prepare for MACRA Implementation

Three Articles:

• Preparing for MACRA, Part I: How to Succeed Under MIPS
• Preparing for MACRA, Part II: Applying Change Management
• Preparing for MACRA, Part III: Breaking Down MIPS Requirements

hfma.org/physician
Bundles - BPCI

Hospital-Initiated Lower Joint Replacement Episodes Show Promise…

90 Day LEJR Episode Spending Pre and Post Intervention
_BPCI Hospital Compared to Control Hospital_

<table>
<thead>
<tr>
<th></th>
<th>BPCI LEJR Model 2</th>
<th>Control LEJR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Episode Cost</td>
<td>$30,239</td>
<td>$29,814</td>
</tr>
<tr>
<td>Intervention Episode Cost</td>
<td>$28,232</td>
<td>$28,670</td>
</tr>
</tbody>
</table>

Key Findings

- Episodes at BPCI hospitals cost $864 less
- BPCI participants reduced SNF LOS by 1.3 days
- 3-day waiver associated with lower spending
- Hospitals with gainsharing waivers achieved greater savings

Sources:
1) [https://innovation.cms.gov/Files/reports/bpci-models2-4-yr2evalrpt.pdf](https://innovation.cms.gov/Files/reports/bpci-models2-4-yr2evalrpt.pdf)
2) [http://www.hfma.org/Content.aspx?id=50528](http://www.hfma.org/Content.aspx?id=50528)
Bundles - BPCI

...However, the Other Episodes Didn’t Have Sufficient Volume to Determine Results

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td># of Episode Initiated Q4 2013 - Q3 2014</td>
<td>18,936</td>
<td>4,225</td>
<td>1,109</td>
<td>5,805</td>
<td>6,661</td>
<td>1,464</td>
<td>2,859</td>
<td>966</td>
</tr>
</tbody>
</table>

Sources:
1) [https://innovation.cms.gov/Files/reports/bpci-modelb2-4-y2evalrpt.pdf](https://innovation.cms.gov/Files/reports/bpci-modelb2-4-y2evalrpt.pdf)
2) [http://www.hfma.org/Content.aspx?id=50528](http://www.hfma.org/Content.aspx?id=50528)
### Bundles – Mandatory Models

CMS Has One Mandatory Model in the Field... Another Is Scheduled to Start Later This Year

<table>
<thead>
<tr>
<th>What</th>
<th>CIR</th>
<th>EPM</th>
</tr>
</thead>
</table>
| Length:       | 90 Day Episode of Care that includes all Part A and B services (limited exclusions) | - AMI: 280 – 282
                |                                                                    | - PCI: 246 – 251, with AMI ICD-CM dx code                          |
|               |                                                                    | - CABG: 231 – 236                                                   |
|               |                                                                    | - SHFFT: 480 – 482                                                  |
| MS-DRGS:      | LEJR: 469 - 470                                                      | **Note:** All providers continue to receive FFS payments            |
| Payment:      | **Note:** Episodes reconciled to a target price. The episode initiating hospital is responsible excess savings or spending (start of 2nd year) | **Note:** Episodes reconciled to a target price. The episode initiating hospital is responsible excess savings or spending (start of 3rd year) |
| Reconciliation| **Note:** 3 years of historical blended hospital specific and regional payment data grouped into episodes |                                                                       |
| Target Price: | **Note:** 3 years of historical blended hospital specific and regional payment data grouped into episodes |                                                                       |
| Date:         | **Note:** April 1, 2016 - Dec 31, 2020                              | **Note:** July 1, 2017 - Dec 31, 2021                               |
| Markets:      | 67 selected MSAs                                                     | **Note:** Cardio: 98 selected MSAs                                 |
|               |                                                                    | **Note:** SHFFT: 67 CIR markets                                    |
Based on Congressman Price’s Previous Statements, It’s Unlikely CMMI Will Introduce Additional Mandatory Models

...CMMI has exceeded its authority, failed to engage stakeholders, and upset the balance of power between branches....We ask that you cease all current and future planned mandatory initiatives under CMMI.
ACO Growth

The Number of ACOs and ACO Covered Lives Continues to Grow

# of ACOs Over Time

# of ACO Covered Lives Over Time

ACOs: More Commercial Lives

Commercial Plans View ACOs as an Important Contracting Vehicle

ACOs: Region Matters

ACO Penetration Varies Significantly by Market

Estimated ACO Penetration by Hospital Referral Region

Relative to the Benchmark, the MSSP Results in Net Losses to Medicare After “Shared Savings” Payments to ACOs

MSSP Results FY 2013 - 2015

<table>
<thead>
<tr>
<th>Year</th>
<th>MSSP Gross Savings</th>
<th>Shared Savings Paid Net of Repayments</th>
<th>Net Loss to Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2013</td>
<td>$400,000</td>
<td>$200,000</td>
<td>$(200,000)</td>
</tr>
<tr>
<td>FY 2014</td>
<td>$400,000</td>
<td>$200,000</td>
<td>$(200,000)</td>
</tr>
<tr>
<td>FY 2015</td>
<td>$400,000</td>
<td>$200,000</td>
<td>$(200,000)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>N</th>
<th>% Generating Savings to Benchmark</th>
<th>% Losing Relative to Benchmark</th>
<th>% Sharing Savings</th>
<th>Median Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>220</td>
<td>54%</td>
<td>46%</td>
<td>24%</td>
<td>$4,867,501</td>
</tr>
<tr>
<td>333</td>
<td>54%</td>
<td>46%</td>
<td>26%</td>
<td>$3,064,039</td>
</tr>
<tr>
<td>392</td>
<td>52%</td>
<td>48%</td>
<td>30%</td>
<td>$3,644,035</td>
</tr>
</tbody>
</table>

Sources:
2) HFMA analysis
Physician-Led Savings

Early Results Suggest MD-Led ACOs Generate More Savings...

... Focus on Utilization and Referrals Have Been a Key Strategy

% MSSP Participants with Expenditures Below the Benchmark

Example: Palm Beach ACO

2013 Gross Savings: $39M
2014 Gross Savings: $32M

Key Strategies:
- Provide feedback to MDs on use patterns
- Improve care transitions
- Partnered with post-acute providers
- Invested in patient outreach

Sources:
2. Email communication with David Muhlestein, Leavitt Partners, 1/4/15
3. HFMA analysis of CMS MSSP financial data PUF files
Another View of ACOs

Compared to Similar Markets, Pioneer ACOs Reduced Expenditures in Years One and Two

Pioneer ACOs: PY 1 and 2 Performance Results

<table>
<thead>
<tr>
<th>Year</th>
<th># of Beneficiaries</th>
<th>PBPM Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>675,712</td>
<td>−$35.62</td>
</tr>
<tr>
<td>2013</td>
<td>806,258</td>
<td>−$11.18</td>
</tr>
</tbody>
</table>

Source: https://innovation.cms.gov/Files/reports/PioneerACOEvalRpt2.pdf
CMS Has Announced a Six-State ACO Pilot Focused On Duals

Medicare-Medicaid Accountable Care Organization (ACO) Model

On December 15, 2016, HHS announced a new model focused on improving care and reducing costs for beneficiaries who are dually eligible for Medicare and Medicaid (“Medicare-Medicaid enrollees”). Through the Medicare-Medicaid Accountable Care Organization (ACO) Model, the Centers for Medicare & Medicaid Services (CMS) intends to partner with interested states to offer ACOs in those states the opportunity to take on accountability for both Medicare and Medicaid costs and quality for their beneficiaries.

It’s Likely the New Administration Will Encourage States to Lead Innovation Efforts

CMS Round One State Innovation Model Awards

Sources:
1) https://innovation.cms.gov/initiatives/state-innovations/
HFMA’s Value Project

HFMA’s Research Provides Tools and Best Practices to Manage the Transition to Outcomes-Based Payment

hfma.org/valueproject/valuesourcebook
• The Politics Are Complicated
• Repeal, Transition, and Replace?
• The Continuing Transition to Value
• Fiscal Issues
Hitting the Ceiling

The Debt Limit Suspension Will End on March 15, 2017
Unsustainable Debt

Reducing Outstanding Federal Debt to the Historic Average Would Require $4 Trillion in Deficit Reduction

Source: https://www.cbo.gov/publication/51580/
The Most Recent Bowles-Simpson Plan Suggests $585 Billion in Healthcare Savings

Potential Federal Healthcare Savings: Bowles-Simpson Deficit

- **Post Acute:**
  - Reduce Market Basket Update
  - Site Neutral Payment Policy
  - Value-Based Purchasing
  - Post Acute Bundling
  - Savings: $70B

- **Beneﬁciaries:**
  - Reform Cost Sharing - $90B
  - Increase Eligibility Age - $65B
  - Income Relate Part B & D Deductible - $65B
  - Savings: $190B

- **Hospitals:**
  - Medicaid Provider Tax - $65B
  - Phase Out Bad Debts - $35B
  - Reduce IME/GME - $20
  - Reduce CAH - $10B
  - Savings: $130B

- **Delivery System:**
  - Penalties for HACs/Readmits
  - Payment Bundling
  - Increase Transparency
  - Strengthen IPAB
  - Savings: $60B

- **Post Acute:**
  - Reduce Market Basket Update
  - Site Neutral Payment Policy
  - Value-Based Purchasing
  - Post Acute Bundling
  - Savings: $70B

- **Beneﬁciaries:**
  - Reform Cost Sharing - $90B
  - Increase Eligibility Age - $65B
  - Income Relate Part B & D Deductible - $65B
  - Savings: $190B

- **Hospitals:**
  - Medicaid Provider Tax - $65B
  - Phase Out Bad Debts - $35B
  - Reduce IME/GME - $20
  - Reduce CAH - $10B
  - Savings: $130B

- **Delivery System:**
  - Penalties for HACs/Readmits
  - Payment Bundling
  - Increase Transparency
  - Strengthen IPAB
  - Savings: $60B

Fiscal Issues

On the Menu
Federal Medicaid Reform

“Capping” or “Block Granting” Medicaid Has Been Proposed to Reform the Program and Reduce Expenditures

Comparison of Traditional Medicaid to Caps or Block Grants

<table>
<thead>
<tr>
<th>Program Feature</th>
<th>Traditional Medicaid</th>
<th>Per Capita Allotment</th>
<th>Block Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Funding</td>
<td>The federal government “matches” state spending for qualifying services/ populations.</td>
<td>A per capita allotment is the product of the state’s per capita allotment for the four major beneficiary categories. Allotment is determined by a state’s average medical assistance and non-benefit expenditures per full-year-equivalent enrollee.</td>
<td>Funding is determined using a base year, assuming states transition expansion individuals into other coverage. Spending and benefit decisions for able-bodied adults and children rest solely with states.</td>
</tr>
<tr>
<td>ACA Expansion Population</td>
<td>Yes</td>
<td>Phased Out Starting in 2019</td>
<td>No</td>
</tr>
<tr>
<td>Inflation Adj</td>
<td>Yes</td>
<td>Less than healthcare cost growth</td>
<td>No</td>
</tr>
<tr>
<td>Population Adj</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
“Capping” or “Blocking” Will Reduce Federal Funding for Medicaid...

Comparison of 10-Year Savings from ACA Medicare Market Basket Reductions to a Medicaid Block Grant Proposal

<table>
<thead>
<tr>
<th>$, Billions</th>
<th>ACA Medicare Cuts</th>
<th>Medicaid Block Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>($100)</td>
<td>($732)</td>
</tr>
<tr>
<td>($100)</td>
<td>($200)</td>
<td>($732)</td>
</tr>
<tr>
<td>($200)</td>
<td>($300)</td>
<td>($732)</td>
</tr>
<tr>
<td>($300)</td>
<td>($400)</td>
<td>($732)</td>
</tr>
<tr>
<td>($400)</td>
<td>($500)</td>
<td>($732)</td>
</tr>
<tr>
<td>($500)</td>
<td>($600)</td>
<td>($732)</td>
</tr>
<tr>
<td>($600)</td>
<td>($700)</td>
<td>($732)</td>
</tr>
<tr>
<td>($700)</td>
<td>($800)</td>
<td>($732)</td>
</tr>
</tbody>
</table>

Sources:
1) https://fas.org/sgp/crs/misc/R40486.pdf
State Reaction

...Driving States to Pursue Strategies to Reduce Coverage and Payment

<table>
<thead>
<tr>
<th>Anticipated State Cost Management Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment</strong></td>
</tr>
<tr>
<td>Cut Rates to Providers</td>
</tr>
<tr>
<td>Increase Implementation of Alternative Payment Models Similar to Oregon, Vermont, Arkansas, Tennessee</td>
</tr>
<tr>
<td>Transition Children and &quot;Able-Bodied&quot; Adults to Managed Care (for the remaining states that have not done so)</td>
</tr>
<tr>
<td>Transition Elderly and Disabled Coverage Populations to Managed Care</td>
</tr>
<tr>
<td>Pursue Medicare/Medicaid &quot;Duals&quot; Demonstration Opportunities</td>
</tr>
<tr>
<td><strong>Coverage</strong></td>
</tr>
<tr>
<td>Phase Out Coverage of Expansion Population (if coverage expanded)</td>
</tr>
<tr>
<td>Use Waiting Lists or Enrollment Caps for Non-Mandatory Populations</td>
</tr>
<tr>
<td>Offer Reduced Benefit Packages</td>
</tr>
<tr>
<td>Charge Limited Premiums and Include Work/Education Requirements</td>
</tr>
</tbody>
</table>
Indiana’s HIP 2.0

Even if Medicaid Reform Isn’t Passed, CMS Will Likely Grant Waivers, Similar to “HIP 2.0,” That Change the Benefit Design

<table>
<thead>
<tr>
<th>Key Features of the Healthy Indiana Program (HIP) 2.0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Premium Payment</strong></td>
</tr>
</tbody>
</table>
| • Establishes premiums through contributions to HSAs for most newly eligible adults.  
  • For those between 101-138% Federal Poverty Level, premiums are a condition of eligibility. |
| **Cost Sharing**                                  |
| • Beneficiaries below 101% FPL who fail to pay premiums are required to pay copayments.  
  • Co-payments are required for non-emergent use of EDs. |
| **Employer Option**                               |
| • For beneficiaries with access to employer-sponsored insurance, Medicaid will provide a $4,000 HSA contribution to purchase coverage through the employer. |

Source: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-indiana/
HIP 2.0 Impact

Utilization Metrics for HIP 2.0 Members Appear Better...

**HIP 2.0 Member Utilization Compared to Members Who Do Not Contribute to Their HSA**

Utilization Per 1,000

<table>
<thead>
<tr>
<th>Service</th>
<th>% of HIP Members Making Co-Payments</th>
<th>Provider Responses</th>
<th>Weighted Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>&gt; 25%</td>
<td>38</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>25 - 49%</td>
<td>27</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>50 - 74%</td>
<td>41</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>75 - 99%</td>
<td>40</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>16</td>
<td>9%</td>
</tr>
<tr>
<td>ED Visits</td>
<td>Don't Know</td>
<td>26</td>
<td>14%</td>
</tr>
</tbody>
</table>

...Half of Providers Report at Least 50% of HIP Members Make Co-Payments

Percentage of HIP Members Making Their Co-Payments, as Reported by Surveyed Providers

Sources:
### Medicare Premium Support

Based on “A Better Way,” Starting in 2024 Medicare Would Move from a Defined Benefit Program to a Defined Contribution

#### Key Features of Premium Support from “A Better Way”

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beneficiaries Given a Flat Amount</strong></td>
<td>- Starting in 2024, beneficiaries would be given a defined contribution – similar to federal employees – to purchase either FFS or MA coverage in an exchange.</td>
</tr>
</tbody>
</table>
| **Health Status and Income Adjs** | - Sicker beneficiaries would receive higher payments  
- Low-income seniors receive additional assistance to help cover out-of-pocket costs. Wealthier seniors assume responsibility for a greater share of premiums. |
| **Inflation Adj**                | - “A Better Way” does not specify an inflation factor.  
- Prior versions of Ryan’s plan ranged from indexing payment growth to GDP + .5% to GDP + 1. |

Premium Support’s Impact

An Option Modeled By the Congressional Budget Office Reduced Medicare Parts A and B Expenditures by $80 Billion Over Six Years


Hospital with $60M of Net Medicare Revenue in 2017

Sources:
4) HFMA Analysis
HFMA’s Value Project

HFMA’s Research Provides Tools and Best Practices to Guide Delivery Systems as They Look to Sustainably Reduce Cost

hfma.org/valuereconfiguration
Questions?

Chad Mulvany
Director, Healthcare Finance Policy, Strategy and Development
HFMA

1825 K St NW
Suite 900
Washington, DC 20006
Office: 202.238.3453
Email: dmulvany@hfma.org