Wisconsin Medicaid Informational Series

How Medicaid Changes in the American Health Care Act Affect Wisconsin's Disability and Aging Communities

Agenda

June 28, 2017
300 NE, State Capitol
11:30 a.m.

Introduction: Assembly Aging and Long Term Care Committee Chair Representative Tom Weatherston.

I. Overview of Wisconsin Medicaid and the AHCA: Lisa Pugh, The Arc Wisconsin, and Lynn Breedlove, the Wisconsin Long Term Care Coalition

- Overview of Wisconsin Medicaid.
- Overview of Medicaid Changes Proposed by Congress and Implications for Wisconsin

II. Facilitated Discussion with Program Participants with Disabilities: Ginger Beuk, Family Care Participant, Oshkosh, WI, and Katy Morgan Davies, mother of child enrolled in the Children's Long Term Support Program, Middleton, WI.

- Discussion of Medicaid's role in supporting people with disabilities and their families

III. Facilitated Conversation with Wisconsin Provider: David Boelter, Executive Director of The Arc Fond du Lac.

- Discussion of Medicaid's role in supporting Wisconsin businesses and their employees

IV. How Medicaid Changes in the AHCA Affect Older Adults and Access to Care:
Janet Zander, Greater Wisconsin Agency on Aging Resources

- Overview of older adult enrollment in Medicaid
- Implications of Medicaid Changes for Wisconsin's Aging and Disability Resource Centers (ADRCs) and the State's Ability to Respond to Wisconsin's Aging Population

V. Time for Questions and Answers

VI. Adjourn

THE HENRY J. KAISER FAMILY FOUNDATION

MEDICAID IN WISCONSIN

June 2017

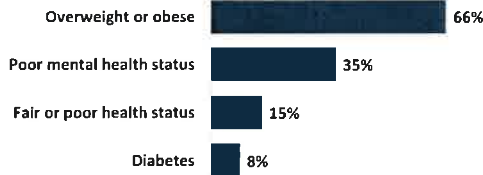
Medicaid and the Children's Health Insurance Program (CHIP) provide health and long-term care coverage to more than 1.0 million low-income children, pregnant women, adults, seniors, and people with disabilities in Wisconsin. Medicaid is a major source of funding for safety-net hospitals and nursing homes. The American Health Care Act (AHCA) would fundamentally change the scope of the program and end the guarantee of federal matching funds.

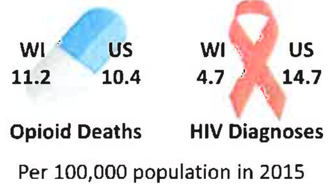
Snapshot of Wisconsin's population

29% of WI's population is low-income

Low-income: <200% FPL or $40,840 for a family of 3 in 2017

Adults in WI reporting:



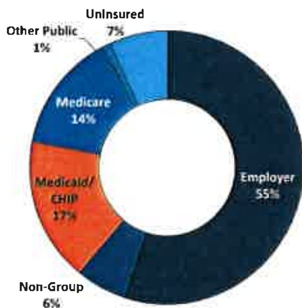


Opioid Deaths | HIV Diagnoses

Per 100,000 population in 2015

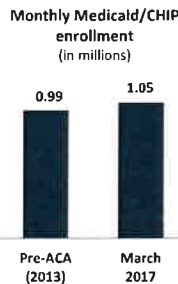
How has Medicaid affected coverage and access?

In 2015, 17% of people in WI were covered by Medicaid/CHIP.



Since implementation of the Affordable Care Act (ACA), Medicaid/CHIP enrollment has increased in WI.

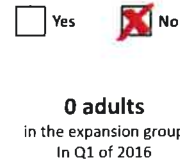
Monthly Medicaid/CHIP enrollment (in millions)



Did WI expand Medicaid through the ACA?

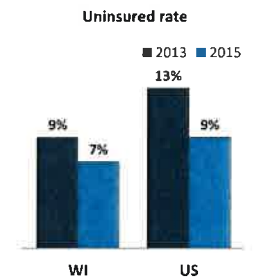
Yes No

0 adults
in the expansion group
in Q1 of 2016

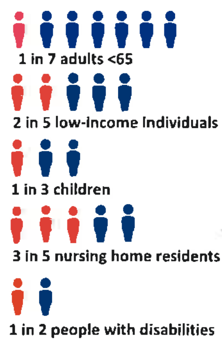


The uninsured rate in WI has decreased.

Uninsured rate



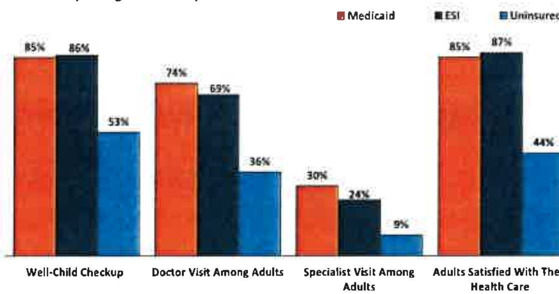
In WI, Medicaid covers:



80%
of adult and child Medicaid enrollees in WI are in families with a worker.

Nationally, Medicaid is comparable to private insurance for access and satisfaction – the uninsured fare far less well.

Percent reporting in the last year:



Medicaid coverage contributes to positive outcomes:

- Declines in infant and child mortality rates
- Long-term health and educational gains for children
- Improvements in health and financial security

And...

>85%
of the public would enroll themselves or a child in Medicaid if uninsured.

How does Medicaid work and who is eligible?

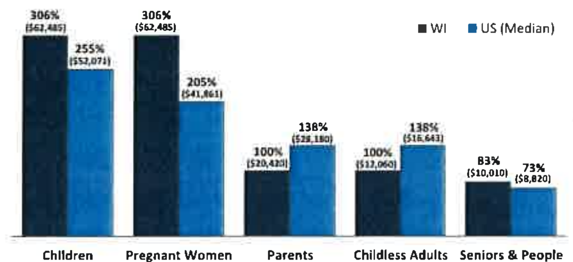
Each Medicaid program is unique:

Federal government sets core requirements, but states have flexibility regarding:

- **Eligibility** – All states have taken up options to expand coverage for children; many have opted to expand coverage for other groups.
- **Benefits** – All states offer optional benefits, including prescription drugs and long-term care in the community.
- **Delivery system & provider payment** – States choose what type of delivery system to use and how they will pay providers; many are testing new payment models to better integrate and coordinate care to improve health outcomes.
- **Long-term care** – States have expanded eligibility for people who need long-term care and are increasingly shifting spending away from institutions and towards community-based care.
- **State health priorities** – States can use Medicaid to address issues such as the opioid epidemic, HIV, Zika, autism, dementia, environmental health emergencies, etc.

Eligibility levels are highest for children and pregnant women.

Eligibility Level as a Percent of FPL, as of January 1, 2017



Eligibility levels are based on the FPL for a family of three for children, pregnant women, and parents, and for an individual for childless adults and seniors & people w/ disabilities. Seniors & people w/ disabilities eligibility may include an asset limit.

How are Medicaid funds spent and how is the program financed?

Medicaid plays a key role in the U.S. health care system, accounting for:

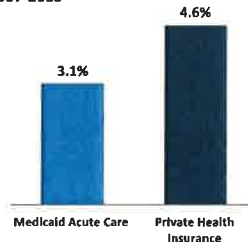
$1 in $6 dollars spent overall in the health care system

More than $1 in $3 dollars provided to safety-net hospitals and health centers

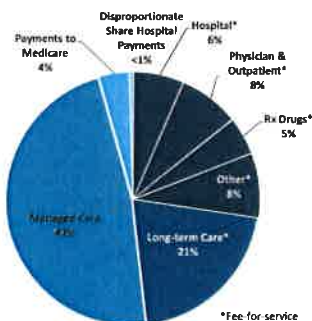
$1 in $2 dollars spent on long-term care

On a per enrollee basis, Medicaid spending growth is slower than private health care spending, in part due to lower provider payments.

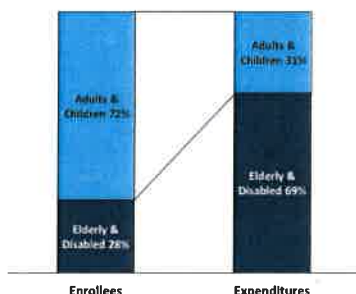
Per enrollee spending growth in the US, 2007-2013



In FY 2016, Medicaid spending in WI was $7.7 billion.



In 2014, most Medicaid beneficiaries in WI were children and adults, but most spending was for the elderly and people with disabilities.



Federal matching funding to states is guaranteed with no cap and rises depending on program needs.

In WI the federal share (FMAP) is 58.5%. For every **$1** spent by the state, the Federal government matches **$1.41**.

Expansion states receive an increased FMAP for the expansion population. WI did not expand Medicaid and did not receive additional federal funds.

0.71
is the Medicaid-to-Medicare physician fee ratio in WI.

65%
of long-term care spending in WI is for home and community-based care.

67%
of beneficiaries in WI are in managed care plans.

168,300
Medicare beneficiaries (18%) in WI **rely on Medicaid** for assistance with Medicare premiums and cost-sharing and services not covered by Medicare, particularly long-term care.

49%
of Medicaid spending in WI is for Medicare beneficiaries.

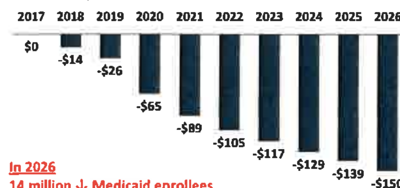
17%
of state general fund spending in WI is for Medicaid.

45%
of all federal funds received by WI is for Medicaid.

What are the implications of reduced federal financing in a Medicaid block grant or a per capita cap?

The American Health Care Act (AHCA) would reduce federal Medicaid funding through ACA repeal and federal caps.

The CBO estimates that the AHCA would reduce federal Medicaid spending by **$834 billion** nationally over the 2017-2026 period.



In 2026
14 million ↓ Medicaid enrollees
24% ↓ in federal funds
23 million ↑ in uninsured → 51 million uninsured

However, **71%** of Americans think Medicaid should continue as it is today

Reducing federal funds through a per capita cap or block grant:

Shifts costs and risks to states, beneficiaries, and provider payment if states restrict eligibility, benefits, and provider payment.

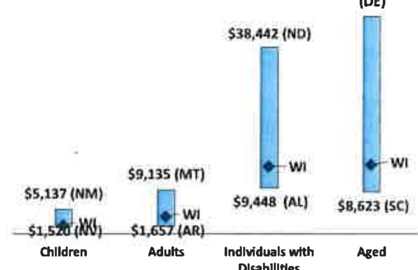
Locks in historic spending patterns and have an even greater impact on states that expanded Medicaid.

Limits states' ability to respond to rising health costs, increases in enrollment due to a recession, or a public health emergency such as the opioid epidemic, HIV, Zika, etc.

Leads to more low income uninsured Americans.

A per capita cap would lock in state spending patterns and limit states' ability to respond to changing program needs.

Per capita spending by enrollment group



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Filling the need for trusted information on national health issues, the Kaiser Family Foundation is a nonprofit organization based in Menlo Park, California.

STATEMENT

FOR IMMEDIATE RELEASE
June 26, 2017 Contact: matt.salo@medicaiddirectors.org

Consensus Statement from the National Association of Medicaid Directors (NAMD) Board of Directors on the Better Care Reconciliation Act of 2017

This statement represents the overwhelming consensus of the NAMD Board of Directors, but is not intended to communicate the unanimous position of all 56 members.

Washington, DC - Medicaid is a successful, efficient, and cost-effective federal-state partnership. It has a record of innovation and improvement of outcomes for the nation's most vulnerable citizens.

Medicaid plays a prominent role in the provision of long-term services and supports for the nation's elderly and disabled populations, as well as behavioral health services, including comprehensive and effective treatment for individuals struggling with opioid dependency.

Medicaid is complex and therefore demands thoughtful and deliberate discussion about how to improve it.

Medicaid Directors have long advocated for meaningful reform of the program. States continue to innovate with the tools they have, but federal changes are necessary to improve effectiveness and efficiency of the program. However, these changes must be made thoughtfully and deliberately to ensure the continued provision of quality, cost-effective care.

Medicaid Directors have asked for, and are appreciative of, improved working relationships with HHS and are working hard to streamline and improve the administration of the program. The Senate bill does formalize several critical administrative and regulatory improvements, such as giving Medicaid Directors a seat at the table in the development of regulations that impact how the program is run, and the pathway to permanency for certain waiver programs.

However, no amount of administrative or regulatory flexibility can compensate for the federal spending reductions that would occur as a result of this bill.

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.

Medicaid - or other forms of comprehensive, accessible and affordable health coverage - in coordination with public health and law enforcement entities, is the most comprehensive and effective way address the opioid epidemic in this country. Earmarking funding for grants for the exclusive purpose of treating addiction, in the absence of preventative medical and behavioral health coverage, is likely to be ineffective in solving the problem and would divert critical resources away from what we know is working today.

Medicaid Directors recommend prioritizing the stabilization of marketplace coverage. Medicaid reform should be undertaken when it can be accomplished thoughtfully and deliberately.

# # #

The National Association of Medicaid Directors (NAMD) is a bipartisan, nonprofit, professional organization representing leaders of state Medicaid agencies across the country. NAMD members drive major innovations in health care while overseeing Medicaid, the nation's most important health care program. NAMD serves as the voice for state Medicaid directors in national policy discussions, supports state-driven policies and practices that strengthen the efficiency and effectiveness of Medicaid and actively monitors emerging issues in Medicaid and health care policy. Learn more at http://www.medicaiddirectors.org *and follow NAMD on Twitter @statemedicaid.*

WISCONSIN LEGISLATURE
P.O. BOX 8952 • MADISON, WI 53708

February 24, 2017

Wisconsin Congressional Delegation
United States Capitol
Washington, DC 20004

The Honorable Members of the Wisconsin Congressional Delegation,

In Wisconsin, we are proud of our innovative healthcare system. Not only is our state known for its high quality of care, but we are known for our unyielding commitment to providing care to all of Wisconsin's citizens. In fact, prior to the passage of Obamacare, Wisconsin had one of the lowest uninsured rates in the country and provided Medicaid coverage to over 1 million Wisconsin residents. However, under the policies of the Obama Administration, our innovative, Wisconsin-focused approach to expanding coverage was penalized.

In 2012, President Obama presented Wisconsin with the false choice of either expanding Medicaid or forgoing roughly $280 million per year. We co-chaired the state's budget committee when Governor Walker proposed striking our own path and making Wisconsin's Medicaid program a safety net for those in greatest need. We expanded access to all citizens living "in poverty" by lifting a 2009 Medicaid enrollment cap on individuals earning below 100% of the FPL.

Our innovative approach has worked. Today, we have the seventh lowest uninsured rate in the country and a lower uninsured rate than 25 of the 31 states that took Obamacare Medicaid expansion. We expanded our Medicaid safety net to cover all those living in poverty and provided coverage to more people than nine states that took the expansion.

Wisconsin's innovative approach was not rewarded by the Obama Administration. Despite adding approximately 130,000 individuals in poverty to Medicaid, Wisconsin's approach was classified as a "partial expansion." While other states receive full federal funding for their Medicaid expansion, Wisconsin receives no additional funding. In fact, Wisconsin taxpayers had already paid to support our state's Medicaid fund, and during the Obama Administration, they were asked to pay for the expansion in other states.

You have an opportunity to correct this flawed decision by the Obama Administration. As you begin to discuss Medicaid block grants and per-capita limits, we ask that you take a serious look at the inequity in Medicaid funding. We are asking that you once again stand up for Wisconsin and insist that we are treated fairly by receiving the same level of Medicaid funding that other expansion states receive going forward. This inequity should be addressed immediately, not phased in over years. While we very much support greater flexibility for states in designing and administering their Medicaid programs, more flexibility is not a substitute for funding equity.

We agree with Governor Walker's spokesperson who stated in the *Milwaukee Journal Sentinel* that the Governor, "...wants to ensure that the states that were fiscally responsible won't be punished for going that route." Wisconsin taxpayers should no longer be penalized for choosing the responsible path and assuring that all those in poverty have access to healthcare. We have done our part in Madison; now we need you to be our advocates in Washington, D.C. We appreciate your continued partnership on Medicaid reform and look forward to working with you to achieve this principled policy during the 115th United States Congress.

Sincerely,

Senator Alberta Darling
Co-Chair, Joint Committee on Finance

Representative John Nygren
Co-Chair, Joint Committee on Finance

CC:

The Honorable Ron Johnson
The Honorable Tammy Baldwin
The Honorable Paul Ryan
The Honorable Mark Pocan
The Honorable Ron Kind
The Honorable Gwen Moore
The Honorable Jim Sensenbrenner
The Honorable Glenn Grothman
The Honorable Sean Duffy
The Honorable Mike Gallagher

The Valued Voice

June 9, 2017
Volume 61, Issue 23

- AHCA Medicaid Funding Disparity For Wisconsin: $36.9 Billion Less
- Budget Leaders Discuss Medicaid Waiver; Nygren says, "Wisconsin should be rewarded for what Wisconsin has done."
- WHA, Board Officers Meet With Speaker Ryan
- Wisconsin Hospitals State PAC & Conduit Approaches $150,000
- DHS Submits Waiver for Medicaid Childless Adults
- New Resource Connects Job Seekers with Health Careers
- Medicaid Coverage More Important in Rural Wisconsin than Metropolitan Areas
- WI BON Unanimously Favors Joining Enhanced Nurse Licensure Compact
- WHA To Participate in AHA Rural Hospital Policy Forum
- Call for Nominations: 2017 Global Vision Community Partnership Award
- HSHS appoints Johnson as new System VP and Chief Physician Executive
- Devine to Retire, Livingston Named New AboutHealth CEO

AHCA Medicaid Funding Disparity For Wisconsin: $36.9 Billion Less

New report shows nonexpansion states at significant funding disadvantage

A new report released this week documents significant funding disparities between Medicaid so-called "expansion" states when compared to "nonexpansion" states over the next decade under the current version of the American Health Care Act (AHCA). The 19 states that opted out of the Affordable Care Act's full expansion for Medicaid, including Wisconsin, will receive $680 billion less than expansion states. Wisconsin's portion of that total is estimated at almost $37 billion over 10 years.

"The report is eye-opening and should be of concern to anyone in a nonexpansion state," said Eric Borgerding, president/CEO, Wisconsin Hospital Association. "While the AHCA did attempt to provide a measure of relief to nonexpansion states like ours, clearly it is insufficient and must be addressed by the U.S. Senate during their deliberations."

The report released by the Missouri Hospital Association takes into account the various structural Medicaid funding provisions in the AHCA over the next decade—such as the move to per capita spending caps—and other provisions meant to lessen the disparity for nonexpansion states. The latter includes eliminating Medicaid Disproportionate Share Hospital payments cuts two years earlier for nonexpansion states than for expansion states as well as a $10 billion safety net fund.

The report details that even with all of these provisions in mind, expansion states will see an average of $1,936 per beneficiary compared to $1,158 per Medicaid beneficiary in nonexpansion states over the next 10 years. The disparity is a result of using 2016 as a base year when establishing the AHCA's per capita cap rates, which locks in the significantly enhanced federal Medicaid matching funds for expansion states. This means enhanced funding continues forward at those higher rates while nonexpansion states will not recover from their disadvantaged financial position.

"The unique Wisconsin model has worked to significantly reduce our uninsured rate, and we can be proud to say that everyone in poverty is covered under Medicaid," said Borgerding. "Unfortunately, this report shows that Medicaid funding disparities are baked into the AHCA and will place our state at a significant disadvantage long-term. Ironically, nonexpansion states are essentially being penalized for rejecting ObamaCare in a bill that is repealing ObamaCare."

Borgerding's comments are similar to those made by Sen. Alberta Darling and Rep. John Nygren, Co-Chairs state Legislature's Joint Committee on Finance, in a February 24, 2017 letter they penned to members of the Wisconsin Congressional delegation. And earlier this week, Rep. Nygren reiterated his concerns with unfair treatment nonexpansion states like Wisconsin are receiving in nation's capital.

"One of the frustrations I have had with the proposal coming out of Washington is that it didn't reward states like Wisconsin that did it the right way and basically continues to reward the states that went a different course," Nygren said this week at a Wisconsin Health News panel discussion (see related story below). "To me, that is continuing this inequity moving forward, rather than addressing the states that have everybody in poverty covered."

WHA continues to urge Wisconsin's two U.S. Senators, Ron Johnson and Tammy Baldwin, to fight for Wisconsin and ensure Medicaid funding equity under any proposals acted upon by the Senate.

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