NAMD
National Association of Medicaid Directors

The Graham-Cassidy ACA Repeal and Replace Bill: Key Provisions

On September 13, Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA) publicly released their own comprehensive health reform package. The most significant change from the Senate's previous comprehensive package, the Better Care Reconciliation Act (BCRA), is the conversion of ACA-related funds, including Medicaid expansion dollars, into a block grant to be distributed to the states. The package retains the majority of BCRA's Medicaid provisions, including the per capita cap financing system, though some policies differ.

This document provides a summary of key provisions of the legislation, organized by topic.

MEDICAID PROVISIONS

Medicaid Per Capita Caps

- Effective January 1, 2020, converts federal Medicaid financing to a per capita cap system.
    - 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.
    - Caps will be set for elderly; blind and disabled; children; expansion enrollees; and other non-elderly, nondisabled, non-expansion adults.
- The following populations are exempt from per capita caps:
    - CHIP enrollees;
    - IHS medical assistance recipients;
    - Breast and cervical cancer services-eligible individuals;
    - Partial benefit enrollees (including resident aliens, duals receiving Medicaid cost-sharing, and individuals receiving Medicaid subsidies for employer-sponsored insurance);
    - Blind and disabled children under 19 years of age.
- States may select any eight consecutive fiscal quarters from Q1 FY 2014 – to Q3 FY 2017 to serve as the base period.
    - Non-DSH supplemental payments will be treated as medical assistance expenditures for purposes of per capita cap calculations.

  - DSH payments, Medicare cost-sharing, and any safety net provider payment adjustments in non-expansion states are excluded from per capita cap calculations.
  - Each chosen quarter must have appropriate data to support per capita cap calculations, and may be adjusted by the Secretary if data quality concerns arise.
  - Allowable and excluded expenditures in the base period will be adjusted by dividing both expenditures by 2.
- Per capita cap structure:
  - For FY 2020 caps, the base period will be trended forward by applying CPI-medical to all applicable population categories, except for blind/disabled population, whose adjustment factor is CPI-medical plus one percentage point. This will produce a provisional FY 2019 target, which will again be trended forward by the relevant inflation factor.
  - For FY 2020 – 2024, the inflation factor will continue to be CPI-medical for non-blind/disabled populations and CPI-medical plus one percentage point for blind/disabled.
  - For FY 2025 and beyond, the inflation factor will be CPI-urban for children and non-elderly, non-disabled adults. For the elderly and the blind/disabled, the inflation factor will be CPI-medical.
- Starting in FY 2020, 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's discretion.
  - For states 25% or more below the average, caps will be increased by between 0.5 – 3%, at the Secretary's discretion.
  - Any such adjustments must be budget neutral. If budget neutrality cannot be achieved, no adjustments will be made for that fiscal year.
  - 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.
  - In FY 2020 and 2021, this adjustment will take place by aggregating all enrollee categories. For FY 2022 and beyond, adjustments will occur based on the distinct enrollee categories.
- States failing 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.
- 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%.

- From January 1, 2020 to December 31, 2024, state expenditures may be excluded under the per capita cap if the HHS Secretary declares a public health emergency.
    - Exempted spending cannot exceed the previous year's non-emergency spending, nor can it exceed $5 billion over the lifetime of the public health emergency exemption program.

Medicaid Expansion

- Effective December 31, 2019, sunsets the Medicaid expansion for states that expanded prior to July 1, 2016. For states expanding after July 1, 2016, Medicaid expansion ends on September 1, 2017.
    - Unlike BCRA, there is no gradual phase-down of the expansion's enhanced FMAP.
- Native Americans and Alaska Natives enrolled in a Medicaid expansion as of December 31, 2019 will be grandfathered into the program and retain eligibility for Medicaid.
- Effective December 31, 2019, sunsets Essential Health Benefits requirement for Alternative Benefit Packages.

IMD Exclusion Modification

- Effective October 1, 2018, states have the option to provide qualified inpatient hospital services to individuals between the ages of 21 – 65.
    - The covered period cannot exceed 30 consecutive days or 90 days in a calendar year.
- 50% FMAP is available for these services, unless the state already has a waiver in place to provide these services at a higher match.
- Maintenance of effort requirements around the number of state-operated/contracted inpatient psychiatric beds and spending on outpatient psychiatric care must be met to use this option.

DSH Payments

- All ACA DSH reductions remain in place.
- For years after 2020, DSH cuts will not be applied in any state whose allotment under the Market-Based Grant Program (described below) in that year is below the state's 2020 base amount inflated by CPI-M.
    - The DSH amount received by the state is subject to state match requirements. The DSH amount, when added to the state's total grant allotment, cannot exceed the amount the state would have received by applying the 2020 base amount inflated by CPI-M.

Eligibility Redeterminations

- States have the option to conduct eligibility redeterminations every 6 months (or more frequently) for individuals enrolled in a Medicaid expansion or otherwise have income above 133% FPL.
- From October 1, 2017 – December 31, 2019, FMAP for these redetermination activities will be enhanced by 5 percentage points.

CMS-64 Reporting Adjustments

- Beginning October 1, 2018, states must report on the CMS-64 spending and enrollment data for all per capita cap categories.
- 60 days after passage, HHS must modify the CMS-64 to allow state reporting of expenditures in qualified inpatient psychiatric hospital settings.
- 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.
- For states choosing the most recent 8 consecutive quarters for their per capita cap base period, FMAP from October 1, 2017 – 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.

Optional Work Requirement

- Effective October 1, 2017, states may impose work requirements on nondisabled, non-elderly, non-pregnant individuals.
- The following populations are exempt from work requirements:
    - Women during pregnancy through the end of the month following 60 days post-delivery;
    - Children under 19 years old;
    - Individuals who are the only parent or caretaker relative of a child younger than 6 or a child with disabilities;

    - Married individuals under 20 years old who are in secondary school or in an educational program directly related to employment
- Administrative FMAP will be increased by 5 percentage points for quarters in which states are implementing work requirements.

Block Grant Option

- Beginning FY 2020, states may choose to receive a Medicaid Flexibility Program block grant to provide health assistance to program enrollees.
    - The program period for a block grant is 5 consecutive fiscal years.
- States must apply for the block grant and include several elements in their applications.
- Block grant funding will be calculated on the following basis:
    - The initial fiscal year will be the product of the target per capita cap for each enrollee category multiplied by the number of enrollees in each category in the preceding fiscal year, trended forward by overall state population growth per Census estimates.
        - The population element of the calculation cannot exceed the per capita cap base period's non-expansion enrollees.
    - For subsequent years, the initial calculated block grant amount will be trended forward by CPI-urban.
- 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.
- Block grants must cover mandatory Medicaid populations and benefits as defined in current statute.
- Block grants must meet mental health parity requirements and operate under the Medicaid drug rebate program's rules if prescription drug coverage is provided.

Medicaid Quality Bonus Payments

- From FY 2023 – 2026, states may receive enhanced FMAPs for meeting quality targets and lower than expected aggregate spending within a fiscal year.
- HHS will determine relevant quality measures and lower than expected aggregate spending targets.
- FMAP enhancements for all states from FY 2023 - 2026 under this bonus program cannot exceed $8 billion.
- States must spend any funds received under this program on quality improvement activities.

HCBS Access Demonstration; Low Population Density State Adjustment Option

- Creates an $8 billion demonstration lasting from January 1, 2020 – December 31, 2023 under which participating states may make HCBS payment adjustments for the purposes of continuing to provide HCBS and improving quality of services.
    - Priority for selection in the demo must be given to any one of the 15 states with the lowest population density, based on census data.
    - Payments made under the demo receive 100% FMAP, up to the participating state's demo allotment.

Enhanced FMAP for Tribal Populations

- Sets FMAP at 100% for Medicaid services received by a Medicaid-eligible member of an Indian tribe.

Community First Choice Enhanced FMAP Reduction

- Effective January 1, 2020, repeals the enhanced FMAP for the 1915(k) Community First Choice option.

Provider Taxes

- Allowable provider taxes will be reduced from FY 2021 – 2025 and beyond, on the following basis:
    - Maximum of 5.6% in FY 2021;
    - Maximum of 5.2% in FY 2022;
    - Maximum of 4.8% in FY 2023;
    - Maximum of 4.4% in FY 2024;
    - Maximum of 4% in FY 2025 and beyond

Hospital Presumptive Eligibility

- Effective January 1, 2020, sunsets ability for hospitals to conduct presumptive eligibility determinations.

Retroactive Eligibility

- Effective October 1, 2017, ends the three-month Medicaid retroactive eligibility period for all Medicaid populations except the aged, blind, and disabled.

INDIVIDUAL MARKET REFORMS

Individual and Employer Mandates

- Retroactively repeals both the individual and employer mandates, effective December 31, 2015.

Premium Tax Credits

- Effective December 31, 2019, sunsets the premium tax credit.
- Effective December 31, 2017, premium tax credits cannot be used to purchase plans covering abortion services.

Qualified Health Plan Definition

- Effective December 31, 2017, excludes plans covering abortion (except abortions "necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest") from the definition of QHPs.

Small Business Tax Credit

- Effective December 31, 2019, sunsets the small business tax credit.
- Effective December 31, 2017, small business tax credits cannot be used to purchase plans covering abortion services.

MARKET-BASED GRANT PROGRAM

Short-Term Stability Measures

- Appropriates $10 billion in CY 2019 and $15 billion in CY 2020 CY 2018 – 2019 and $10 for CMS to fund arrangements with health insurance issuers to address urgent health care needs.

Market-Based Grant Program

- From January 1, 2020 – December 31, 2026, creates a Market-Based Grant Program which consolidates all ACA-related funding into a block grant for states to apply and receive.
    - Up to 20% of state grant funds may be used to provide Medicaid coverage.
- Funds are appropriated for each program year on the following basis:
    - 2020: $136 billion
    - 2021: $146 billion
    - 2022: $157 billion
    - 2023: $168 billion
    - 2024: $179 billion
    - 2025: $190 billion
    - 2026: $200 billion

- Only one application is necessary for state participation over the lifetime of the program.
- State allotments are determined on the following basis:
    - In 2020, states pick 4 consecutive quarters between FY 2014 – FY 2017. Federal spending for all state residents during those quarters, inclusive of Medicaid expansion, tax credits, cost-sharing reduction subsidies, and Basic Health Program spending, is summed to provide a 2017 base period.
    - Medicaid expansion spending will be inflated by MACAC estimation of Medicaid expansion cost inflation up to 2020, and all other spending will be inflated by CPI-M, to produce a 2020 baseline.
- The formula for allocation is:
    - Previous year's allotment + [2026 amount - 2020 baseline]/6
- A 2026 amount for the state is calculated by assessing the total number of eligible beneficiaries between 50 – 138% FPL nation-wide, adjusted by the percent of individuals in this range living in each state. This is the state percentage of beneficiaries.
    - The total amount of Federal 2026 funding is multiplied by the state percentage of beneficiaries to determine what the 2026 amount would be for the formula above. This will be recalculated annually to reflect changes in individuals within the 50 – 138% FPL range in the state.
- Beginning in 2024, state allotments will gradually shift from being based on percent of eligible individuals to being based on percentage of eligible individuals enrolled in credible coverage the previous year.
    - Credible coverage is coverage with actuarial value of at least the lowest CHIP actuarial value in the state. States providing coverage below this standard will have allotments adjusted accordingly.
- The adjustment to eligible individuals enrolled will occur on the following basis:
    - 2024: enrollment factor of 25%
    - 2025: enrollment factor of 50%
    - 2026: enrollment factor of 75%
- Beginning in 2021, a risk adjustment formula will be developed based on a population case mix index developed by the HHS Secretary. Risk adjustments will be applied in a budget neutral manner and ensure each state is within 10% of the mean per beneficiary amount in 2026, and introduced as follows:
    - 2020: no risk adjustment
    - 2021: 25%
    - 2022: 50%
    - 2023: 75%
    - 2024 – 2026: 100%

1332 WAIVERS

- Modifies 1332 waivers to not increase the federal deficit, as opposed to being budget neutral.
- Appropriates $2 billion in FY 2017 to provide grants to states for development of 1332 waivers. These funds will be available through FY 2019.
- States may use allotments from the Long-Term Stability and Innovation Fund to implement 1332 waiver plans.
- Waivers will be effective for 8 years (or shorter at state option), and may be renewed for another 8 years on an unlimited basis.

HEALTH SAVINGS ACCOUNTS

- Effective retroactively to distributions made after December 31, 2016, lowers the tax on distributions not used for qualified medical expenses for Health Savings Accounts from 20% to 10%; and for Archer medical savings accounts from 20% to 15%.
- Increases maximum annual contributions to HSAs to the annual deductible and out-of-pocket limitation.
- Allows spouses enrolled in a high-deductible health plan to make contributions to the same HSA.

OTHER PROVISIONS

Federal Payments to Planned Parenthood Temporarily Prohibited

- Maintains the House bill's language prohibiting Planned Parenthood from receiving federal dollars for one year. The legislative language does not call out this group by name, but its criteria are designed such that it is the only impacted entity.

FQHC Funding

- Appropriates $422 million in funding for federally qualified health centers.