The Future of Medicaid Funding:

The Local Impact of Proposed Changes to Medicaid Financing

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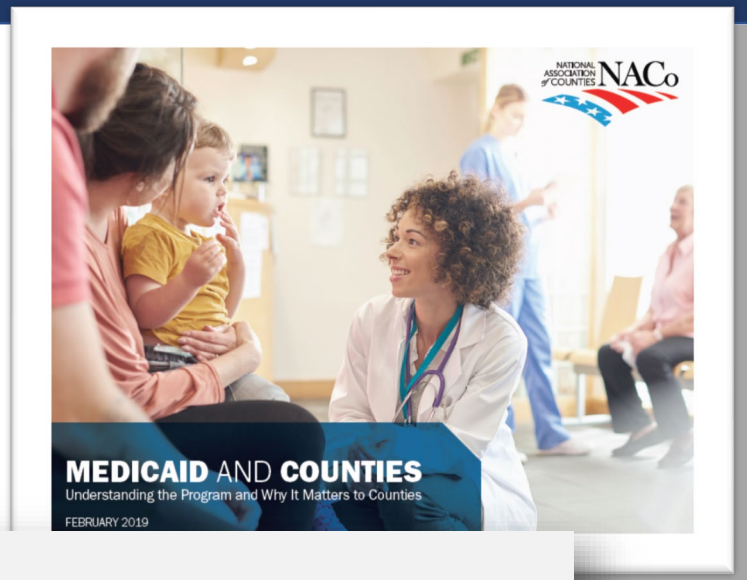
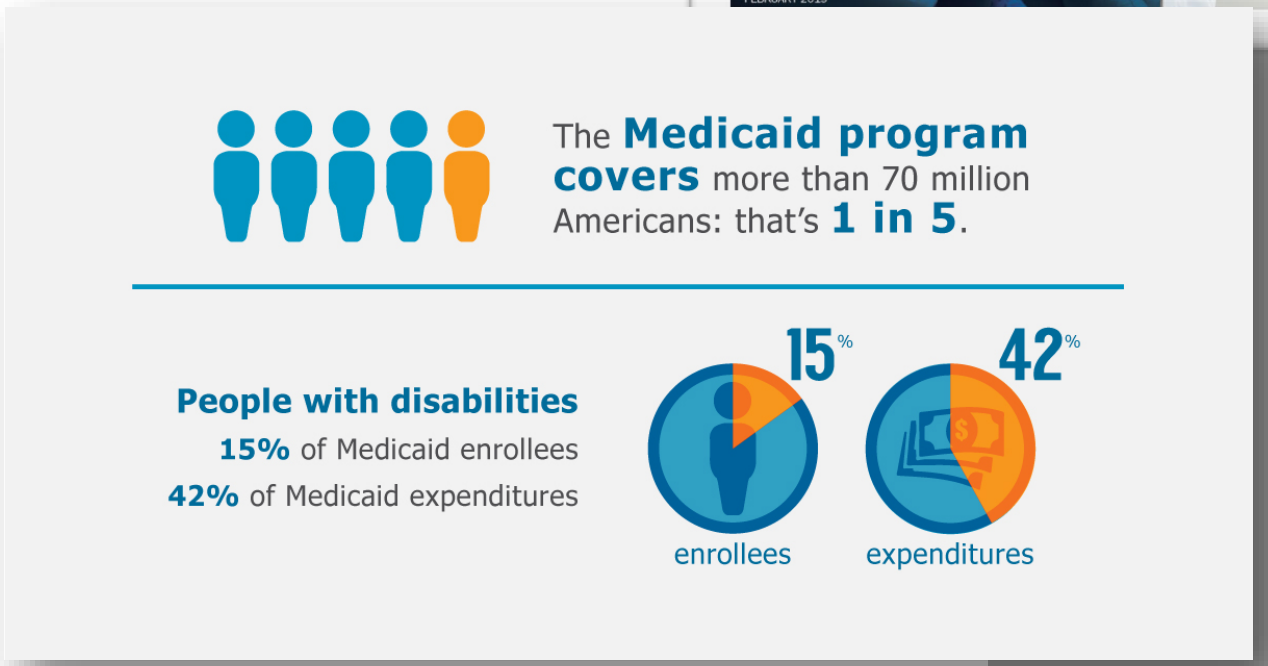
MEDICAID 101

- Largest source of health coverage in the united states
- Medicaid vs. Medicare
- Traditionally served the elderly, disabled, and families, children and pregnant women





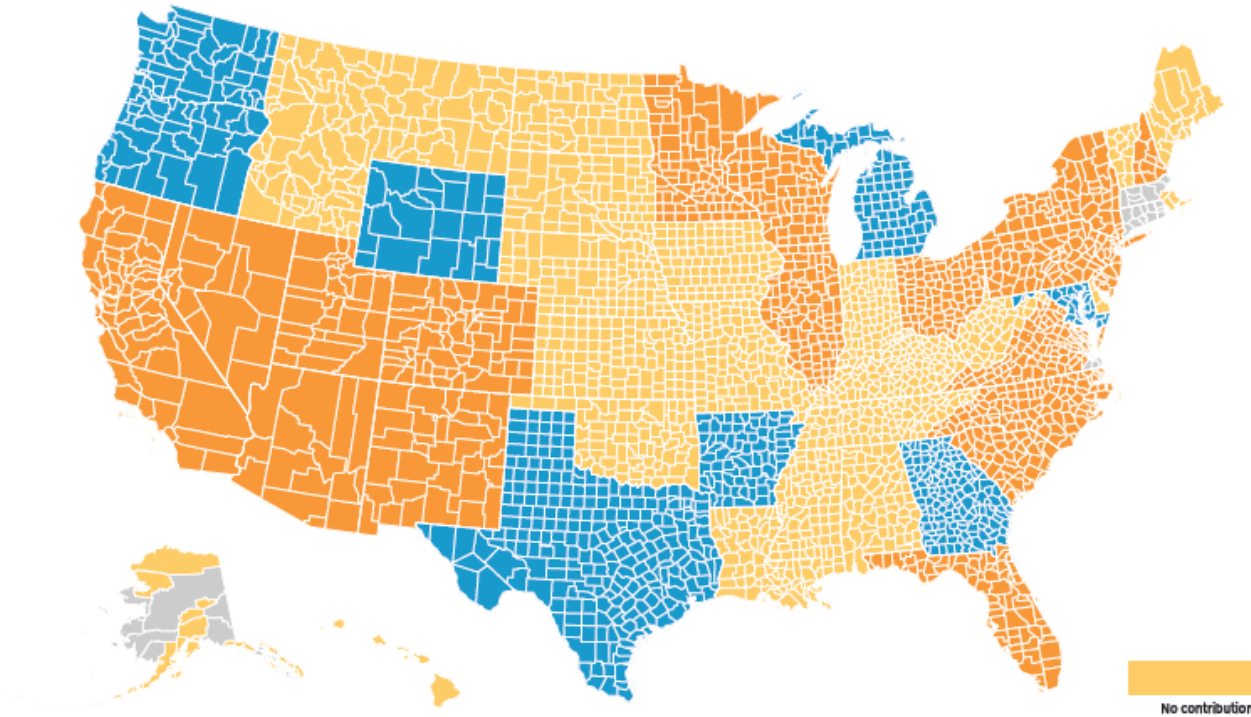
MEDICAID AND COUNTIES

- Operates as a joint federal-state-local partnership
- Helps counties provide a safety net for those who are unable to afford medical care
- Lessens the strain on county budgets

Medicaid Funding Structure

Counties contribute to Medicaid in 26 states. Of these states, **18 mandate** counties to contribute to the non-federal share of Medicaid costs and/or administrative, program, physical health and behavioral health costs. Mandated county contributions are the **highest in New York**. Counties in New York send nearly $7 billion per year – or $140 million per week – to the state for Medicaid costs.

2016 FEDERAL MEDICAL BENEFITS: MEDICAID CONTRIBUTION MANDATE FOR COUNTIES



MANDATED COUNTY CONTRIBUTIONS ARE HIGHEST IN NEW YORK. COUNTIES IN NEW YORK SEND NEARLY $7 BILLION PER YEAR – $140 MILLION PER WEEK – TO THE STATE FOR MEDICAID COSTS

No contribution | State mandated contribution | Contribution, not state mandated

*county data is unavailable if the county is colored grey

Source: NACo County Explorer explorer.naco.org, NACo Research, 2016

Legislative and Administrative Action

- 2017 “repeal and replace” efforts
- Administration considering giving states ability to implement Medicaid block grants through 1115 Medicaid waivers (Healthy Adult Opportunity Guidance)
- Medicaid fiscal accountability rule (MFAR)

Medicaid Fiscal Accountability Proposed Rule

- On November 12, 2019, the centers for Medicare and Medicaid services (CMS) published the proposed rule Medicaid fiscal accountability

- Changes state reporting requirements regarding supplemental payments in the Medicaid program

- Includes structural and definitional changes that can decrease state flexibility in financing the state share of its Medicaid program

Provider-Level Reporting For States

- The proposed rule outlines provider-level reporting requirements for states regarding upper payment limit (UPL) demonstrations and supplemental payments

- Data elements include, but are not limited to:
  - Listing of each provider that received a supplemental payment under the state plan amendment (SPA) or demonstration authority
  - The specific amount of the supplemental payment made to the provider
  - Total disproportionate share hospital (DSH) payments
  - Total Medicaid base payments

Changes to Generating State Share of Financial Participation

- The proposed rule makes structural and definitional changes to:
  - Intergovernmental transfer (IGTs)
  - Certified public expenditures (CPEs)
  - Provider-related donations and healthcare-related taxes

Changes to Intergovernmental Transfers (IGTs)

- An IGT is a transfer of funds from another governmental entity to the Medicaid agency before a Medicaid payment is made
- The proposed rule requires that IGTs must be derived from state or local tax revenues
  - CMS believes that states are deriving IGTs from sources other than state or local tax revenue
- The proposed rule also prohibits non-bona fide provider-related donations as a source for IGTs

Changes to Certified Public Expenditures (CPEs)

- A CPE is an expenditure made by a governmental entity under the state's approved Medicaid state plan, making the expenditure eligible for federal match
- Rule is proposing that CPE payments can only be made to providers that are state government providers or non-state government providers
- Proposing that CPE payments be limited to reimbursement not in excess of the provider's actual, incurred cost of providing covered services to Medicaid beneficiaries

Changes to Provider-Related Donations and Health Care Taxes

- A bona fide donation must be truly voluntary and not part of a hold harmless arrangement that effectively repays the donation to the provider and CMS will examine the “net effect”

- Changing the definition of what qualifies as a health care related tax

MFAR Impact on Counites

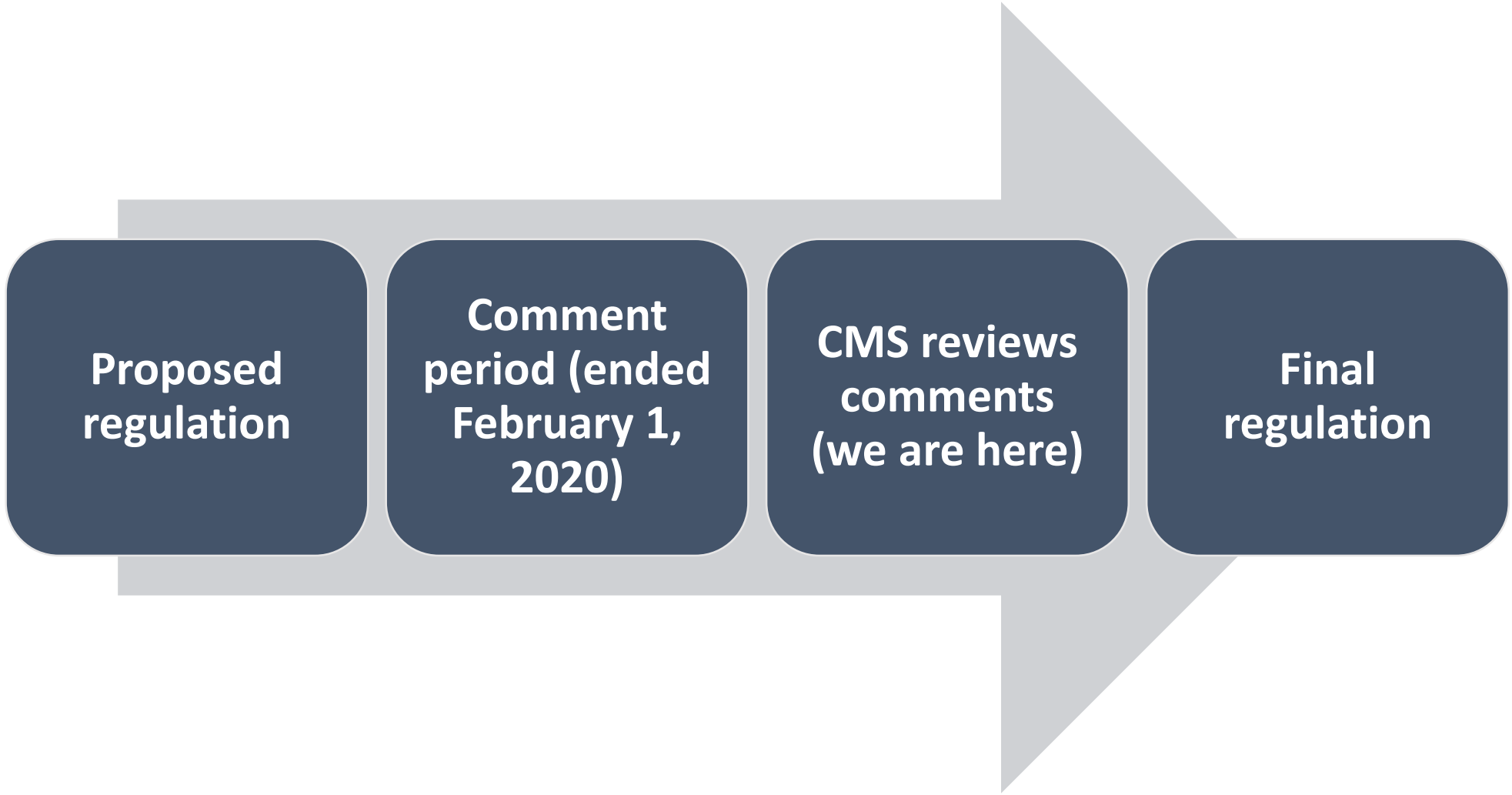
1. Reduced flexibility for financing the non-federal share of state Medicaid programs.

2. Diminished resources to support local health care systems.

3. Burdensome, unfunded reporting requirements.

4. Diminished confidence in the ability to meet federal requirements for financing state Medicaid plans as a result of unclear standards.

Federal Process



Strategic Approach

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New York State Medicaid Budget Proposals

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Medicaid State Budget Proposals

For the 2021 State Budget, Medicaid faces a multi-billion dollar spending and funding gap

- The Governor is counting on a new Medicaid Redesign Team (MRT) to find $2.5 billion in recurring savings to balance the Medicaid program going forward.
  - Any proposals submitted to the MRT must be sent by this Friday, February 21st by Noon
    https://www.surveymonkey.com/r/Medicaid_Redesign_II_Pulic_Proposal_Survey
- The Governor's budget also counts on increasing contributions from counties and New York City by $150 million per year to help fill part of the Medicaid gap

Medicaid State Budget Proposals

Medicaid - The Budget proposes three actions related to weakening the Local Medicaid Cost Caps.

1. **Capping eFMAP Federal Fiscal Benefits to Counties**
   a) The Affordable Care Act (ACA) provides an enhanced federal match of up to 90% for states that choose to expand Medicaid eligibility.
   b) New York and a handful of states had already expanded Medicaid eligibility for some populations before the ACA was enacted. In recognition of these expansions and as a matter of fairness, the ACA provides a credit to these early adopter states to ensure they benefit from the new federal matching funds.
   c) As a payor, the counties of New York are entitled to receive these credits under the ACA.
   d) State Budget proposes to cap the federal credit that can flow to counties and redirects those credits to the state. The Budget language is not clear on whether this would be applied through a retroactive claw back of all savings provided, prospectively, or some combination. This provision is effective April 1, 2020, but no fiscal impact amount is provided in the budget for this proposal.
   e) As of SFY 2016-17, counties/NYC received about $500 million in annual federal savings. The state receives at least 4 times as much in federal savings from the provisions of the ACA. The federal savings are delivered to counties through reductions in each county's Medicaid weekly share payments based on the zero growth statutory caps for each county. The savings are reconciled annually, but the state is currently 3 years behind. Counties usually receive a credit as part of this reconciliation process. In prior years, these credits easily exceeded $100 million per year to counties/NYC. Had these reconciliations been completed, we estimate the federal credits would be about $700 million annually today.

Medicaid State Budget Proposals

2. Require Counties and New York City to Adhere to the 2 Percent Property Tax Cap or Lose the Benefits of the State Funded Local Medicaid Growth Cap

a) If a county fails to stay under the tax cap, or if New York City's property tax levy grows more than the county property tax cap allows, then the jurisdiction would lose the benefit of the incremental value of the state funded Medicaid caps in the year the cap is breached. NYSAC is seeking clarification on how this penalty is to be calculated, but it appears the county would be responsible for funding all growth in local Medicaid costs in the year they breach. No county exceeded the cap in 2020.

b) The penalty would permanently alter the weekly share base counties pay to the state. If the county stays under the cap in the following year, the cap benefits would be reinstated, but at a higher base cost. A county may seek a hardship waiver from the tax cap penalty. This provision is effective April 1, 2020.

c) The Mayor has said that New York City would be see a negative impact of $1.1 billion if this Medicaid proposal was in place for 2019.

Medicaid State Budget Proposals

3. Limit Local Medicaid Cost Increase to No More Than 3 Percent

a) NYSAC believes the state budget language would impose a penalty if a county's local Medicaid costs and associated savings grows more than 3% in any given year. If so, the county is required to pay for any local cost and savings growth over the 3% threshold. This provision is effective for state fiscal year 2021-22 and beyond.

b) Most counties will not be able to comply with this limit based on current trends. Mainly because counties have limited ability to control costs in this program. Counties are required to follow state and federal enrollment and eligibility rules so they must enroll all qualified applicants.

Medicaid State Budget Proposals

Estimated Impact on Counties from 3% Proposal

- 40 counties responded so far (all but 4 counties would pay a penalty), representing 78 percent of the ROS Medicaid local share spend. These counties estimated a negative impact of $95 million had the law been in place for 2019. Year-to-year changes swung considerably. Assuming these results would be consistent in the remaining counties:

  - The total impact for counties, outside New York City, would have been about $121 million for 2019.
  - Similar analysis for 2018 data produces a negative impact of $248 million.

Medicaid State Budget Proposals

Counties Have Limited Ability to Contain Costs

We remain concerned that even with additional tools in place counties will still not be able to keep the growth in their net savings under 3%. In the years when the state said Medicaid costs were under control (SFY 2014 and 2015, for example) counties for which data is available still saw their net local savings grow by far more than 3%. Counties just do not have enough control over the cost of inputs to the health system to keep costs growth below the proposed 3%, including:

- Reimbursement rates for health care providers;
- Prescription drug & durable medical equipment costs;
- County demographics – disability, aging and longevity;
- Rates of illness (incidence, prevalence and morbidity);
- Minimum wage increases;
- The timing of payments and billings as they are submitted by health care providers; and
- Benefit design and eligibility thresholds.

Q & A

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