FIRST FOCUS
MAKING CHILDREN & FAMILIES THE PRIORITY

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The Honorable Fred Upton
Chairman
House Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Frank Pallone
Ranking Member
House Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Joseph Pitts
Chairman
Health Subcommittee, Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Gene Green
Ranking Member
Health Subcommittee, Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairmen Upton and Pitts and Ranking Members Pallone and Green:

On behalf of First Focus, I would like to thank you for holding the hearing entitled "Examining Medicaid and CHIP's Federal Medical Assistance Percentage." In thinking about the impact and incentives created by the Federal Medical Assistance Percentage (FMAP) on our nation's most vulnerable children, we would make the following observations for your consideration.

The FMAP Formula Is Outdated and Should Be Revised Over Time

The Federal Medical Assistance Percentage (FMAP) that is used to calculate the federal-state matching rate for programs, including Medicaid, the Children's Health Insurance Program (CHIP), and Title IV-E of the Social Security Act is outdated and should be updated.

Under the present formula, as noted in the House Energy and Commerce Majority Staff memo, "Per capita income is used as a proxy for both State resources and the low-income population in need of Medicaid services in each State."

The memo explains:

> *It is well known that per capita income – the key data source for calculating a State's FMAP – does not accurately represent States' populations in need of Medicaid services or States' ability to finance services, and does not account for geographic cost difference among States.*

At First Focus, we support efforts by the Government Accountability Office (GAO) to develop better measures to determine the "demand for Medicaid services, geographic cost differences, and state resources." For example, per capita income is a very poor proxy for need when we now have readily available state poverty data. Therefore, we agree with the GAO that such adjustments "could be combined to provide a basis for allocating funds more equitably among states than the current FMAP."

The FMAP Should Be Further Adjusted During Economic Recessions

A critically important strength of the current Medicaid financing structure is that it automatically adjusts for need. Therefore, when there is a recession, a natural disaster, a health care crisis, or even a State's need to increase provider payment rates to improve access to care, the financing structure automatically adjusts for a State's growth in beneficiaries or costs with increased federal support. This is important because, during such crises, states are witnessing increased Medicaid demand while simultaneously dealing with declining state resources.

At First Focus, we strongly support FMAP increases enacted by Congress during past recessions, as they have been critical to helping states address such situations where Medicaid enrollment and costs rise but state economies are weaker. We also agree with GAO's assessment that temporary increases in the FMAP could be made more "timely or responsive" and urge the Committee's continued exploration and consideration for creating automatic adjusters or a trigger to the FMAP using "readily available economic data."

As the GAO points out:

> *Improving the responsiveness of federal assistance to states during economic downturns would facilitate state budget planning, provide states with greater fiscal stability, and better align federal assistance with the magnitude of the economic downturn's effects on individual states.*

We agree and believe making a responsive financing mechanism even more responsive than it already is would be beneficial to the states and the millions of low-income elderly, disabled, adults, and children served by Medicaid.

Block Grants Should Be Rejected, Including the One Imposed on Puerto Rico

It is important to note that other alternatives to the Medicaid financing structure, such as converting Medicaid into a block grant, are unresponsive to changing state needs. In fact, due to the fact that block grants are arbitrary capped allotments, there is no adjustment whatsoever to any crisis. Therefore, a Medicaid block grant would leave states with 100 percent of the burden for any increase in costs that would be associated with any economic or natural disaster, epidemic, or other increases in costs.

In sharp contrast, Medicaid's current financing structure adjusts to align with a state's changing needs during a time of economic recession, natural disaster, or epidemic. With block grants, the funding remains stagnant irrespective of changing needs.

Puerto Rico's economic and related healthcare crisis highlights how harmful Medicaid block grants can be. Since the Commonwealth relies on a block grant to support its Medicaid program ("Mi Salud") and it fails to adjust for need, Puerto Rico is only receiving a reported 15 to 20 percent of its Medicaid costs from the federal government, despite being immersed in a major financial crisis. According to David Thomsen at the National Council of La Raza:

> *In 2010, prior to passage of the Affordable Care Act (ACA), the federal government's contribution to Mi Salud was $364 million. Comparatively, Oklahoma, with a population of 3.9 million, receives $3.5 billion for its Medicaid program.*

The effects on Puerto Rico's children have been devastating. Doctors are fleeing to the mainland or refusing to accept patients on Medicaid, leaving children without access to pediatric and preventive care. Consequently, children are more likely to have preventable hospitalizations and use overwhelmed hospital emergency departments for illnesses that should be treated by primary care physicians. Furthermore, the lack of access to specialists leaves children at risk of developing preventable chronic diseases.

As highlighted by the health and economic crisis in Puerto Rico, block grants could threaten the well-being of our nation's most vulnerable citizens, including children. Congress should recognize the role the Medicaid block grant funding cap has played in both Puerto Rico's health and fiscal crises and eliminate the block grant for the Commonwealth.

In addition, the Committee and our nation's governors should learn from Puerto Rico's experience and reject policy proposals to block grant or impose other arbitrary limits on the Medicaid program such as per capita caps. Just as the block grant has been a disaster for Puerto Rico, it would be for the rest of our nation as well.

Over Time, the FMAP Should Be Made Uniform for All Populations Below 138 Percent of Poverty

First Focus is also concerned about the incentives created by having much higher matching rates for low-income adults than for other populations, such as children, below 138 percent of poverty. While this makes sense in the short-term to help and encourage states to take up the option provided in the Affordable Care Act (ACA) to expand coverage to low-income adults, we would urge the Committee to consider moving to a budget-neutral, blended matching rate for low-income populations in the future.

The concern we have in the long-term is that, when states are looking to cut spending, they often look to cut Medicaid. If Medicaid services for children require a higher state match than childless adults, for example, we are concerned that this creates a financial incentive for states to look first at cutting pediatric services and provider payments. Consequently, pediatric services would constantly be more vulnerable to state budget cuts, particularly in times of economic crisis. Children and the providers that serve them should not disproportionately bear the burden of future Medicaid budget cuts.

In addition, creating a more uniform matching rate for all low-income populations over time should also reduce Medicaid administrative costs, as states now have to disaggregate costs and seek a lower matching rate for children than parents even though they may be enrolled in the same health plan.

CHIP Administrative Costs Should Have the Same FMAP as Medicaid

As the House Energy and Commerce Majority Staff memo notes:

> *…the Federal matching rate for Medicaid administrative services does not vary by State and is generally 50 percent, although certain administrative functions, such as the operation of certain information technology systems, have a higher Federal match rate.*

In contrast, CHIP has a higher matching rate than Medicaid and does not have differential or lower administrative match like Medicaid does. Fortunately, throughout its history, CHIP has been both a very efficient and incredibly effective program that is focused on the needs of children. At First Focus, we believe it is very important to retain the fiscal integrity of the program and to maintain the focus on maximizing health coverage to our nation's children rather than bureaucracy.

Therefore, as was raised by both Chairman Pitts and Representative Brooks at the hearing, we share the concern that the higher CHIP administrative match may create some future problems and urge the Committee to look at ways to retain the focus of the program's funding on children's health coverage and to maintain an efficient program.

First, since CHIP is a capped entitlement program, it is important to recognize that the higher CHIP administrative matching rate causes the federal CHIP allotments to states to be spent more rapidly than if the matching rate were lower, such as at the Medicaid administrative matching rate. This is problematic because dollars spent on administrative costs are no longer available to provide health coverage to children.

Second, now that the enhanced CHIP match is as high as 100 percent for a dozen states, there is less of an incentive for states to control administrative costs in their programs. Again, this diverts money away from children's health coverage.

Third, since states have the flexibility to use CHIP dollars to expand Medicaid, establish a separate state-based CHIP program, or use a combination approach, we are concerned that the differential matching rate for administrative costs between Medicaid and CHIP creates financial incentives to shift administrative costs from Medicaid to CHIP and to game the cost allocation methodology between the two programs to maximize federal funding to the states. The consequence of such actions would, once again, cause the CHIP allotments to be depleted more rapidly and take away funding from health coverage to children.

For these reasons, we urge the Committee to consider changing CHIP's administrative matching rate so that it is similar to or the same as that for Medicaid. Such a change would recreate incentives for states to be more judicious and efficient with their administration of CHIP. In addition, it would eliminate incentives for states to game the administrative matching rate differential between the two programs. Such savings would ensure that CHIP allotments remain dedicated to the health coverage of our nation's children rather than unnecessary administration, bureaucracy, and potential waste.

CHIP and the Maintenance of Effort Should Be Extended

Independent studies by Wakely Consulting Group, GAO, the Medicaid and CHIP Payment Access Commission (MACPAC), the Congressional Budget Office (CBO), and the Department of Health and Human Services (HHS), as required by Congress as part of the Affordable Care Act (ACA), all confirm that CHIP is vastly superior to coverage offered through the exchanges for children.

All the evidence shows that CHIP is pediatric-focused, more responsive, and less costly than coverage offered through marketplace or exchange plans. CHIP also offers better benefits, imposes less cost sharing, and offers more robust networks and access to care for children.

This is why the nation's governors and nearly 1,600 groups from across the country pushed to have CHIP's funding extended. According to estimates by the Urban Institute, over one million children would lose coverage entirely if CHIP were to be eliminated or allowed to expire. This is due to the fact that affordability test in the ACA limits the ability of dependent children to qualify for subsidized marketplace family coverage if their parent or guardian has an offer of affordable employee-only coverage. This has been referred to as the "kids' glitch" or "family glitch."

Moreover, the Urban Institute has found that, even if the "family glitch" was to be fixed and children were made eligible for exchange subsidies, nearly 500,000 children would become uninsured because coverage would still be unaffordable.

If addition, while it is estimated over two million currently enrolled children in separate state CHIP programs would be allowed to migrate to exchange coverage if CHIP were to expire, these children would still be left worse off because marketplace coverage is far more expensive than CHIP and offers fewer benefits. In short, millions of children would be left worse off if CHIP, which has been instrumental in cutting the uninsured rate by more than two-thirds since its inception, were allowed to expire.

Furthermore, as the Committee takes a closer look at the incentives that federal matching rates create, it is important to note that the maintenance of effort (MOE), which requires that states maintain eligibility and benefit standards for children in Medicaid and CHIP through 2019, has been critical in ensuring that the health coverage for children and the federal budget are protected. Since states have a financial matching requirement under CHIP (and Congress would be increasing that if you choose to change the administrative match), they would have a financial incentive to drop CHIP and dump those kids into the exchange plans if

the MOE were allowed to expire. According to the CBO, previous legislation to eliminate the MOE would result in at least half of the states to phase-out or eliminate their CHIP programs. This would cause millions of children, who were covered by CHIP plans to largely move into federal-only financed exchange plans or become uninsured.

In fact, this is exactly what happened in Arizona when the State froze enrollment in its KidsCare program just a few weeks before passage of the ACA and the MOE provision. Since the MOE did not apply to Arizona, the State has chosen to keep an enrollment freeze on its KidsCare program (although it did offer alternative coverage for some kids through a temporary KidsCare II plan through January 2014 to mitigate harm). Since then, a number of children have moved from KidsCare and KidsCare II into the ACA's marketplace plans but, as studies by the Georgetown Center for Children and Families, the Arizona Children's Alliance, and Wakely Consulting Group have demonstrated, children and families experienced significant increases in their cost sharing and found fewer benefits in the marketplace plans. Even worse, thousands of children lost coverage altogether due to the ACA's "family glitch."

We must avoid this from happening to children across the rest of the country. Therefore, just as Congress has created MOE provisions in dozens of other programs to prevent states from shifting their costs onto the federal government, we would strongly urge the continuation of the Medicaid and CHIP MOE to protect both the federal budget and, more importantly, the health care of millions of children.

The CHIP "Clawback" Should Be Eliminated

Finally, as part of the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA) by Congress last year, we very much appreciated the strong bipartisan effort in Congress to enact a two-year extension of CHIP coverage for the 8 million children receiving health insurance program through the program.

Unfortunately, in a last-minute addition to the bill, section 301 of MACRA removes one-third of all CHIP carryover funding to states in FY 2018 from their unspent FY 2017 state allotments and, instead, takes those funds away from the states and CHIP and returns those dollars to the Federal Treasury. The inclusion of this "clawback" provision in the law raids important CHIP dollars in FY 2018 that would otherwise be dedicated to children's health coverage and puts CHIP in a more precarious financial position in the future. In fact, the "clawback" will substantially reduce available state CHIP funds and creates a funding hole in FY 2018 that Congress will need to address if CHIP is to continue to be funded through the authorization period, which ends in FY 2019.

Furthermore, as a capped entitlement, the federal government has always allowed unspent allotment dollars to states to carryover into future years and this change marks a significant departure from that history. As some state officials have noted, it creates some uncertainly at the state-level about the protection and cushion these dollars provide from potential increases in caseload or costs. Even worse, it creates a disincentive for states to be as prudent and efficient with their federal allotments because the federal government will now "clawback" one-third of all dollars states saved for the purposes of carrying those dollars over into out-years.

Therefore, with respect to CHIP, we urge Congress to: (1) begin legislative action this year to create a separate CHIP administrative matching rate that is more aligned with Medicaid in order to improve the efficiency of both programs; (2) prioritize health coverage to children and eliminate the "clawback" in CHIP allotments that was established in section 301 of MACRA; and, most importantly, (3) begin to take steps to extend both CHIP and the MOE.

On the last point, as you consider the future of children's health, there are some that may push for another short two-year extension of CHIP. Given the state of marketplace coverage for children compared to CHIP, it is clear that health coverage for children is far superior in CHIP and will continue to be well into the future.

To achieve comparability and ensure no child would be left worse off by the elimination of CHIP, Congress would have to enact legislation to fix the "family glitch," improve benefits, reduce cost sharing, and expand provider networks in the ACA's marketplace plans. That is highly unlikely.

Therefore, CHIP must be extended in order to protect the health of over 8 million children. And certainly, if all else fails, we would support a two-year extension of CHIP. However, since Congress just eliminated the problem of having to constantly extend and pay for the "Medicare doc fix," it would seem wise to try and avoid that same trap of falling into a process that creates the need for repeated, short-term extensions for CHIP. Moreover, as directors of the state programs have pointed out, limiting CHIP to a series of short-term extensions is harmful to both the program and health coverage to children because it precludes states from partnering with the private sector on important long-term initiatives, such as efforts to improve health care quality and measurement, pay-for-performance, etc.

For these reasons, we would urge the Committee to take these three steps in an effort to protect and improve Medicaid and CHIP and ensure the continuation of health coverage to over 8 million of our nation's children. CHIP has proven to be an enormous success story over its nearly 19-year history. Congress must make it a priority to continue to make progress in covering kids while ensuring that no child is left worse off by any changes to their coverage in the future.

Thank you for your consideration of these important issues related to Medicaid and CHIP financing and the role they play in the delivery of health coverage to millions of our nation's children.

Sincerely,

Bruce Lesley
President

xc: Members of the House Energy and Commerce Committee