Medicaid Financing Alternatives

ACHI
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Medicaid cost-saving and cost-containment strategies continue to be at the forefront of health reform discussions as policymakers consider options to modify the current Medicaid financing in anticipation of additional federal flexibility. Medicaid is one of the largest budget items for states, representing $5.2 billion in Arkansas state fiscal year 2016.[1] Tasked with recommending an alternative approach to Medicaid financing in the state, the Arkansas Health Reform Legislative Task Force examined the potential of "block grant" programs. The incoming federal administration has indicated its openness to block grants for Medicaid. This fact sheet looks at traditional Medicaid financing, finance reform approaches, and how they affect state funding.

INTRODUCTION

Medicaid financing has traditionally been a shared responsibility between states and the federal government, with the federal share based on a match rate—the federal medical assistance percentage (FMAP). The standard FMAP rate varies based on a state's average per capita income (50% minimum and 82% maximum), with lower income states such as Arkansas receiving greater federal assistance when compared to the national average.[2] (See Table 1.) The limit on federal contributions under the FMAP approach is the amount of funds a state is willing to contribute towards its share in covering eligible individuals.

Shared contribution allows the federal government to set minimum standards while allowing for some state flexibility and innovation. Recently, states have explored proposals to gain greater flexibility to administer Medicaid in exchange for assuming greater financial risk of future cost growth through block grants.

Table 1: Arkansas Match Rates for Fiscal Year 2017 [2]

	Federal Share	State Share
Standard Medicaid FMAP	69.69%	30.31%
Children's Health Insurance Program	100%	0%
Arkansas Works	95%	5%
Administrative Services	50%	50%

FIXED LUMP SUM OPTION

Under a fixed amount, lump sum finance approach, states would receive a fixed allotment based historical spending levels in exchange for increased flexibility on program management.[3] The allotment would be adjusted annually at a predetermined, formula-driven rate.[4] States would be responsible for all costs that exceed the federal allotment.

The existing FMAP approach is countercyclical, offering increased financial protection for states during periods of economic recession when they may experience greater numbers of potential enrollees. Under a fixed lump sum approach, federal funding would be capped and additional program expenses during economic downturn would be the states' responsibility. If the strategy utilized to determine the fixed federal allotment does not anticipate state and national economic cycles in such circumstances, states would be forced to decide whether to increase state funding or make program cuts, which may include changes to eligibility, benefits, and provider payment.

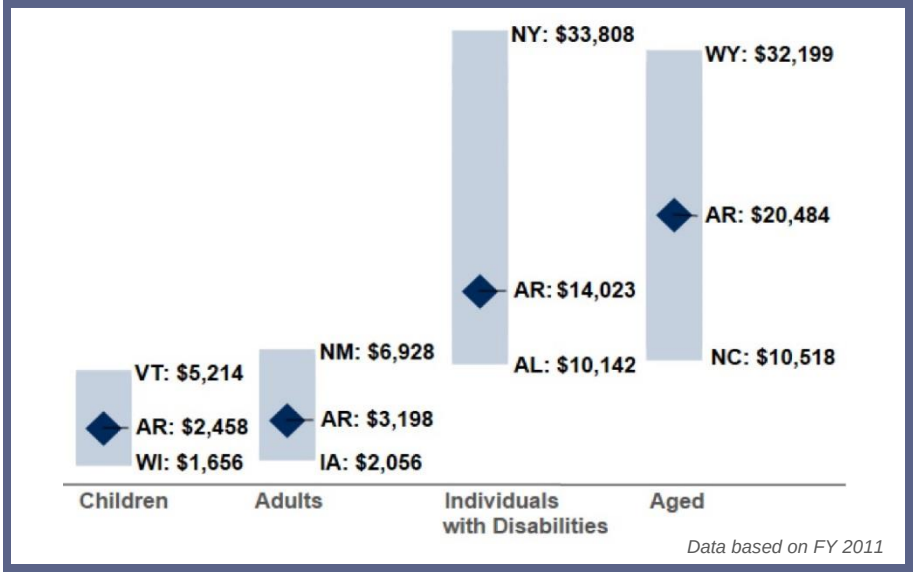
As proposed, in exchange for fixed federal financial exposure, states would gain program flexibility and avoid existing federal requirements. States would still be likely to be subject to some level of federal oversight. Although the U.S. Department of Health and Human Services (HHS) has wide-ranging authority through Section 1115 waivers to offer state flexibility, HHS does not have the authority under current federal law to waive the FMAP formula, which would be required to allow for this type of financing structure to enable complete state flexibility.

FIXED AMOUNT PER ENROLLEE OPTION

Another approach to Medicaid financing would be to provide states a fixed amount per enrollee, or "per capita caps," instead of a fixed lump sum. Per capita caps would set a limit on federal spending per enrollee, either for all beneficiaries or by eligibility groups.[3] Similar to fixed lump sum proposals, the per capita growth rate would be set below the projected growth in an effort to achieve federal savings. Unlike the fixed lump sum approach, however, per capita caps may protect against unexpected enrollment increases due to changes in the economic environment or natural disasters maintaining the countercyclical protections of state budgets. U.S. Congressional Republicans proposed this approach, described as a "per capita allotment," in their plan released on June 22, 2016.[5]

Many comprehensive Section 1115 waivers that include beneficiaries from different eligibility categories have relied on this financing approach. Per capita caps (see Figure 1 on next page, adapted from source)[6] and fixed lump sums may lock in historical funding levels, which vary significantly by state.

Figure 1. Differences in Per Capita Spending by Enrollment Group



Data based on FY 2011

CAPPED FEDERAL MATCH

Unlike block grants, which require federal legislation to implement, HHS has the authority to place a "global cap" on a state's federal match funds via a Section 1115 demonstration waiver. Under this approach, a state still receives matching funds based on services billed by providers, but the total amount of federal reimbursement based on the match rate is capped. Perhaps one of the most referenced demonstrations of a global cap is the Rhode Island Global Consumer Choice Compact Medicaid Waiver, described in more detail in the case study (see text box, right).

CONCLUSION

Medicaid program financing is complex. Due to innovative approaches to care delivery such as Arkansas's premium assistance model and the need for states to more readily project and control budget expenditures, there has been significant state and national pressure to seek alternative finance models. Fixed federal funding may result in less federal spending, shifting risk to the states either to cover funding amounts in excess of the set federal limit (which could adversely affect states with lower income levels) or to cut services, enrollment, or provider payment. Countercyclical protections should be a component of future alternative financing strategies.

Case study: Rhode Island Global Consumer Choice Compact Medicaid Waiver ("Global Waiver")

In 2006, Medicaid was one quarter of Rhode Island's budget.[7] The state originally asked for a fixed, upfront lump sum, which would terminate the state match, but instead the HHS agreed to an aggregate budget ceiling of $12.075 billion dollars over a five year demonstration period, and the state had to spend the first dollar. In exchange, the state had the ability to make certain program changes including rebalancing long-term care and updating its provider payment methodology. The waiver's budget ceiling was higher than projected, making it more generous and safer for the state than a typical block grant proposal. In addition, HHS granted the state the authority to obtain up to $22 million in federal matching funds annually for services previously covered only by the state, called Costs Not Otherwise Matchable (CNOM). Between the American Recovery and Reinvestment Act (ARRA) of 2009 that provided states with enhanced federal fiscal support, CNOM dollars, and a generous global cap, the federal government actually spent more money. Moreover, the state did not receive significantly more discretion to administer its Medicaid program and was required to request permission from HHS to make additional changes throughout the waiver.[8]

REFERENCES

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