Arkansas Medicaid Primer

ACHI
Arkansas Center for Health Improvement

FACT SHEET **● November 2017**

Congressional deliberations regarding modification or elimination of the Patient Protection and Affordable Care Act (ACA) of 2010 have included discussions about the scope and costs of the Medicaid program. Since 1965, Medicaid has been a publicly funded federal and state partnership that provides healthcare coverage to predominantly low-income populations. The ACA provided states an opportunity to expand Medicaid eligibility for adults with incomes up to 138 percent of the federal poverty level. Unlike many Southern states, Arkansas opted to expand coverage through an innovative premium assistance approach under a Medicaid waiver. A thorough understanding of Medicaid expansion in 2014 and the history of traditional Medicaid is critical, as various policy proposals are being considered in lieu of the ACA. This fact sheet looks at the role of Medicaid in Arkansas, including programmatic history, financing, covered populations and benefits, as well as key considerations.

HISTORY & ADMINISTRATION

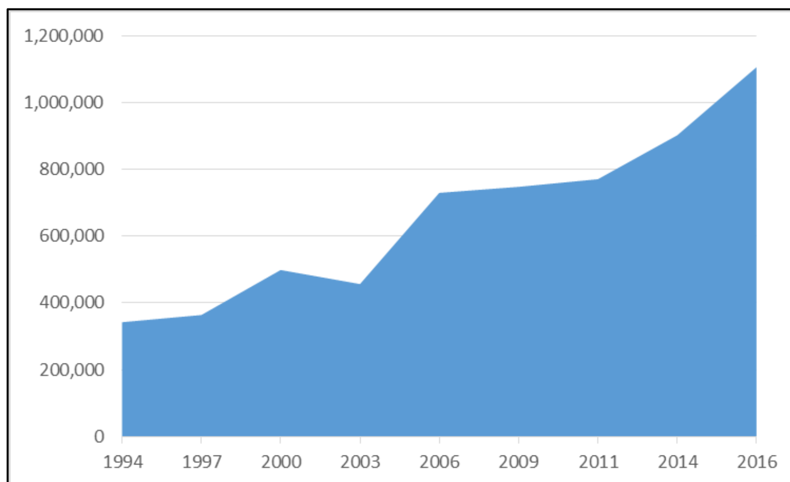
Medicaid is a jointly financed federal and state program which has historically provided healthcare coverage to the country's low-income children and their parents, pregnant women, individuals with disabilities, and low-income seniors. In 1965, President Lyndon B. Johnson signed legislation establishing Medicaid and another program, Medicare, which provides coverage to Americans ages 65 and over.[1] Established as Title XIX of the Social Security Act, Medicaid provisions provided states the opportunity to match state dollars with federal funding to establish medical assistance programs.[2]

Prior to the passage of Title XIX, Arkansas had established a limited program to provide medical care to indigent populations through Act 280 of 1939.[2] In 1970, Arkansas chose to participate in the federal option of Medicaid under the administration of Governor Winthrop Rockefeller, expanding the state's role in providing coverage to other low-income populations. The Arkansas Department of Human Services is the agency that oversees the state's Medicaid program.[2] Since the late 1970s, Arkansas Medicaid has undergone many revisions in order to meet the needs of changing populations and to capitalize on opportunities for state innovation.

ELIGIBILITY & ENROLLMENT

Arkansas has historically maintained some of the strictest income eligibility requirements for program enrollment. Eligibility is based on many factors, including income, state residency, and disability status. Unlike other states, Arkansas Medicaid did not cover low-income, non-caretaker adults unless a special condition was present (such as pregnancy) until Medicaid expansion in 2014.[3] Figure 1 shows Arkansas Medicaid enrollment trends since 1994.[4,5,6,7]

Figure 1: Arkansas Medicaid Enrollment (1994-2016)



The program functions as a safety net for the state's poorest residents and covers other diverse groups of enrollees with special medical needs. Medicaid recipients include children from low-income families (receiving coverage through the ARKids First program), individuals who have developmental disabilities and/or serious mental illnesses, the frail elderly with limited financial resources, and those who qualify as disabled and receive federal Supplemental Security Income (SSI).

In May 1997, Arkansas submitted its proposal for ARKids First, a section 1115 demonstration waiver which expanded coverage to children in low-income families with earnings up to 200 percent of the federal poverty level (FPL) who were not eligible for traditional Medicaid coverage. On a parallel track in 1997, Congress established the State Children's Health Insurance Program (CHIP) to extend healthcare coverage to children of low-income families. The differences in the two programs were later reconciled in 2000 under the ARKids First umbrella as ARKids A and B.[8]

Prior to the expansion of Medicaid to low-income adults in 2014, most Medicaid beneficiaries were children under the age of 21, comprising 66 percent of the Medicaid population and 14 percent of average claim payments per beneficiary. By comparison, seniors—who are often dually eligible for Medicaid and Medicare due to high health needs and low-income status—encompassed only 8 percent of the total Medicaid population, but represented 58 percent of average claim payments per beneficiary.[3] Although seniors represent a small percentage of overall enrollment in Medicaid, expenditures per elderly enrollee far exceed those of children and adults.

FINANCING

Medicaid financing traditionally has 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 (ranging from 50 to 90 percent), with lower-income states receiving greater federal assistance when compared to the national average.[3,9] Figure 2 shows changes in FMAP averages since 1996. The average standard FMAP rate between 1996 and 2016 for Arkansas has averaged approximately 73 percent, exceeding the national average of 60 percent during the same period (see Figure 2).[10] Notably, some Medicaid populations—including those covered through the 2014 expansion—receive enhanced FMAP rates. A 50-percent match rate is available to states for administrative expenses.

Figure 2: FMAP Rates in Arkansas vs. National Average (1996-2016)

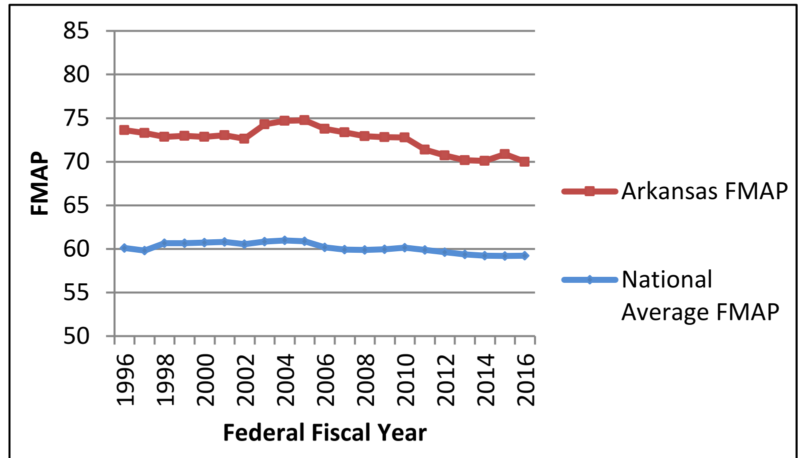
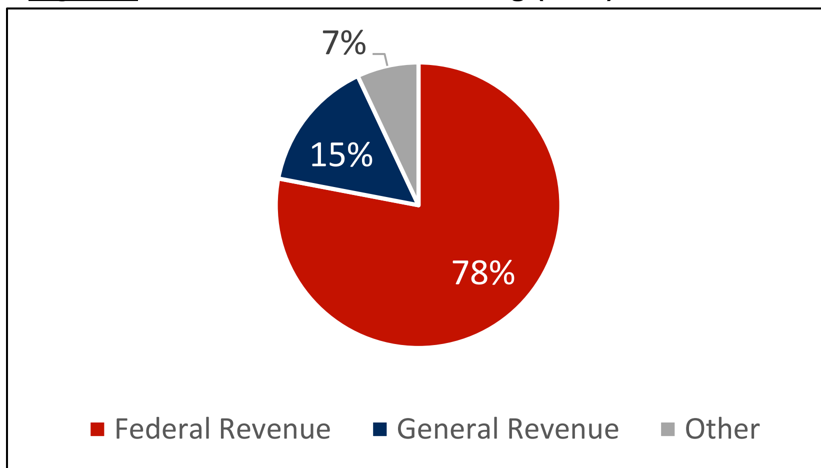


Figure 3: Arkansas Medicaid Funding (2016)



The state of Arkansas funded nearly one-quarter of Medicaid program-related costs during the 2016 fiscal year, with the federal government providing the remaining funds (see Figure 3).[7] A majority of the state's share of funding comes from general revenue, which includes sales and income taxes. Other revenue sources include provider taxes and funds from the state's Medicaid Trust Fund.

Between 2010 and 2013, an increasing budget shortfall anticipated in the 2014 fiscal year escalated state efforts to reduce Medicaid cost trends. The shortfall was intensified by the economic recession between 2007 and 2009, along with continued growth in healthcare costs. This need helped foster an innovative, multi-payer effort to move the state's Medicaid reimbursement model from a traditional fee-for-service model to a value-based payment model, which has led to statewide improvements in quality and avoided costs.[3]

SERVICES

State Medicaid programs must cover mandatory services (see Table 1) in order to receive federal-funding shares.

Table 1: Mandatory Medicaid Services

• Inpatient hospital services	• Federally qualified health center services
• Outpatient hospital services	• Laboratory and X-ray services
• Early and periodic screening, diagnostic, and treatment services	• Family planning services

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• Nursing facility services	• Nurse midwife services
• Home health services	• Certified pediatric and family nurse practitioner services
• Physician services	• Transportation to medical care
• Rural health clinic services	• Tobacco cessation counseling for pregnant women

Along with mandated federal services, states can also provide optional services to their Medicaid population. Optional services in Arkansas include prescription drug coverage and services that allow beneficiaries to receive care in home-based or community-based settings.[3]

MEDICAID EXPANSION

Under the ACA, states had the option to expand Medicaid coverage to individuals up to 138 percent of the federal poverty level. For states that chose to expand coverage, the federal government would cover 100 percent of expansion costs for the first three years of implementation, with a decreasing match in subsequent years. Table 2 shows funding allocations outlined in the ACA for Arkansas's Medicaid expansion (known as Arkansas Works).[11]

Table 2: State and Federal Share of Medicaid Expansion Financing

Year	State Share	Federal Match
2014-2016	0%	100%
2017	5%	95%
2018	6%	94%
2019	7%	93%
2020-beyond	10%	90%

Arkansas took a unique approach in developing and implementing its version of Medicaid expansion. The state covered newly eligible individuals by using premium assistance to purchase qualified health plans offered through the Health Insurance Marketplace (HIM). This approach required a Section 1115 Medicaid demonstration waiver, which allows states to test care delivery and financing models that promote the goals of Medicaid.[12] Pending waiver modifications to Arkansas Works include an income eligibility cap at 100 percent of the FPL, which would disenroll approximately 60,000 people from the program, and a work requirement (with some exemptions) for those remaining in the program.

Arkansas's expansion approach has helped to stabilize the state's marketplace and improved market competition. Since 2014, Arkansas has had three or more insurers participating in all of the state's 75 counties. By comparison, many states in the South have only one participating insurer in many of their counties, with an exception being Louisiana, which expanded Medicaid in 2016.[12]

MEDICAID FINANCING ALTERNATIVES

Recent proposals have suggested the use of different financing strategies to fund Medicaid programs with a fixed federal contribution through block grants. There are benefits to this approach for states because it enables stabler budget forecasting, but there are also risks during periods of economic downturn. The current FMAP approach is countercyclical, providing increased financial protection for states during periods of economic recession when Medicaid enrollment may increase. Under a block grant, federal funding would be capped and additional program expenses during an economic downturn would be the states' responsibility. Because a 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.[13] Per-capita caps, which would set a limit on federal spending per enrollee type, may protect against unexpected enrollment increases due to changes in the economic environment or natural disasters maintaining the countercyclical protections of state budgets.

CONCLUSION

Medicaid is a crucial healthcare safety net for some of Arkansas's most vulnerable populations. Medicaid serves the elderly, disabled, children, pregnant women, and individuals for whom healthcare coverage is financially out of reach. Much of the recent healthcare policy debate at the federal level has focused on Medicaid cost containment. Not unlike private insurance, Medicaid costs are both sensitive to healthcare inflation and reflective of the health status of the populations served. Unless underlying medical costs across both the public and private sectors are adequately addressed, the proportion of Arkansans for whom private insurance coverage is financially out of reach, along with continued dependence upon publicly financed coverage, will continue to grow.

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