ACHI
INSPIRING HEALTHY ACTS

MEDICAID FINANCING ALTERNATIVES

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Summary

Medicaid cost-saving and cost-containment strategies continue to be at the forefront of health reform discussions as policymakers consider options to modify current Medicaid financing in anticipation of additional federal flexibility. In fiscal year 2022, total combined federal and state estimated spending on Medicaid in Arkansas accounted for $8.8 billion of the state's estimated $32.1 billion total expenditures.[1] Alternative financing models such as block grants are frequently discussed by federal and state lawmakers as part of Medicaid reform. Federal lawmakers have sought to convert Medicaid fianancing into block grant funding on several occasions, the most recent the American Health Care Act of 2017.[a] Tasked with recommending an alternative approach to Medicaid financing in the state, the Arkansas Health Reform Legislative Task Force in 2016 examined the potential of block grant programs. This explainer looks at traditional Medicaid financing, finance reform inlcuding block grants, and how those approaches 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 varies based on a state's average per capita income (ranging from 50% minimum to 83% maximum), with lower-income states such as Arkansas receiving greater federal assistance when compared to the national average (see table).

ARKANSAS MATCH RATES FOR FISCAL YEAR 2023

	Federal Share	State Share
Standard Medicaid FMAP[2]	71%	29%
Children's Health Insurance Program	80%	20%
ARHOME	90%	10%
Administrative Services	50%	50%

[a] The American Health Care Act of 2017 would have converted federal Medicaid funding to a per capita allotment and added a state option to receive a Medicaid block grant. It was passed by the House of Representatives but not the Senate.

1401 W. Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201

501-526-2244
achi@achi.net
achi.net

Shared contribution allows the federal government to set minimum standards while allowing for some state flexibility and innovation. 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, which have largely been met with strong legal and policy concerns.[3] During the final year of the Trump administration, however, the Centers for Medicare and Medicaid Servcies (CMS) sought to test this approach by announcing the Healthy Adult Opportunity initiative, which invited states to explore an aggregate or per capita financing model under a Section 1115 waiver.[4] Arkansas law requires the governor to request a block grant for funding of the Medicaid program "as soon as practical if the federal law or regulations change to allow the approval of a block grant for this purpose."[5] In the absence of changes to federal law, it appears this requirement has not yet been triggered.

Fixed Lump Sum Option

Under a fixed-amount, lump sum approach, states would receive a fixed allotment based on historical spending levels in exchange for increased flexibility on program management.[7] The allotment would be adjusted annually at a predetermined, formula-driven rate.[8] States would be responsible for all costs that exceed the federal allotment.

MEDICAID BLOCK GRANT LEGAL CONSIDERATION

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,[b] which would be required to allow for block grant financing.[6] Federal legislation is necessary to permit this change.

The Children's Health Insurnace Program (CHIP) and some other programs, such as the Temporary Assistance for Needy Families program, which provides cash assistance to families in need, are financed this way. While other block grant programs have seen reduced funding over time, CHIP funding has been relatively generous over the life of the program. In some instances, however, funding shortfalls in CHIP have led states to freeze enrollment in the program, leaving those who would otherwise be eligible on waiting lists for coverage.[9]

The existing FMAP approach is countercyclical — i.e., designed to counteract the effects of the economic cycle — offering increased financial protection for states during periods of economic recession when they may experience more potential enrollees. Under a fixed lump sum approach, federal funding would be capped and additional program expenses during an economic downturn would be the states' responsibility. If the strategy to determine the fixed federal allotment does not anticipate state and national economic cycles in such circumstances,

[b] The HHS Secretary's authority under Section 1115 does not include the authority to waive requirements of 42 U.S.C. § 1396b, which establishes how the federal government makes payments to states under the Medicaid program. The Secretary's waiver extends only to § 1396a.

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 likely still be subject to some level of federal oversight.

In 2019, Tennessee submitted a Section 1115 demonstration project that proposed to convert the federal share of Medicaid funding to a block grant.[10] In January 2021, CMS approved Tennessee's amended Section 1115 waiver application to implement an aggregate funding cap for the state's Medicaid program. In the approval letter, CMS noted that the aggregate cap approved was not the block grant approach that the state described in its original application.[11] In addition, CMS agreed with public comment that "Section 1115 does not give the Secretary authority to alter the medical assistance matching rate" and that "giving Tennessee a lump sum of federal funds isn't allowable."

The Tennessee apprpoach places a fixed funding cap on four major beneficiary groups: blind and disabled enrollees, low-income children, low-income adults, and the elderly. Costs to cover these groups are based on historical estimates and trended forwarded annually, with a reassessment after five years.[12] The plan also includes a "safety valve" to increase funds due to unexpected increases in enrollment, a fundamental feature of the FMAP approach.[13] The aggregate caps create the potential for shared savings, up to 55%, on an annual basis if expenditures fall below the cap and the state satisfies certain quality targets. Savings achieved may be earned by the state in the form of additional federal matching funds.

A group of Tennessee Medicaid recipients filed a lawsuit seeking to halt the changes approved by CMS, claiming that the federal government exceeded its authority in approving the proposal.[14] The lawsuit was paused to allow CMS under a new administration to issue another comment period. On June 30, 2022, CMS sent Tennessee officials a letter citing significant concerns about their proposal, including the aggregate cap, and questioning whether the proposed changes promoted the objectives of Medicaid and were supported by Section 1115 waiver authority. Tennessee officials then requested a new financing model with a cap based on a fixed amount per enrollee (see below), in addition to supplemental payments to providers, instead of an aggregate cap approach.[15]

Fixed Amount per Enrollee

Another approach to Medicaid financing is to provide states a fixed amount per enrollee, or a "per capita cap," instead of a fixed lump sum. Per capita caps would set a limit on federal spending per enrollee, either for all beneficiaries or for certain eligibility groups. 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, per capita caps may protect against unexpected enrollment increases due to natural disasters or changes in the economic environment, maintaining the countercyclical protections for state budgets. Many comprehensive Section 1115 waivers that include beneficiaries from different eligibility categories have relied on this financing approach.

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 two of the most commonly referenced examples of a global cap are the Rhode Island Global Consumer Choice Compact Medicaid Waiver and the Vermont Global Commitment to Health Waiver (see "Case Studies" in the appendix).

Conclusion

Medicaid program financing is complex. Due to innovative approaches to care delivery — such as Arkansas's premium assistance model, which is used to finance healthcare coverage for low-income Arkansans — and the need for states to more readily project and control budget expenditures, there has been significant state and national pressure to seek alternative financing 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.

Appendix

CASE STUDIES	
Rhode Island Global Consumer Choice Compact Medicaid Waiver ("Global Waiver")	Vermont Global Commitment to Health
In 2006, Medicaid accounted for one quarter of Rhode Island's budget. The state originally asked for a fixed, upfront lump sum, which would have terminated the state match, but ultimately it used the standard Medicaid funding process. HHS agreed to an aggregate budget ceiling of $12.08 billion over a five-year demonstration period, and the state had to spend the first dollar. In exchange, Rhode Island 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 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 of 2009 (which provided states with enhanced federal fiscal support), CNOM dollars, and a generous global cap, the federal government spent more money than it would have absent the global waiver. Moreover, Rhode Island did not receive significantly more discretion to administer Medicaid and was required to request permission from HHS to make additional changes throughout the waiver. The state asked the federal government to remove the cap in 2013.	In 2005, Vermont received approval for a Section 1115 waiver demonstration, known as the Global Commitment to Health, that capped total program expenditures at $4.7 billion over a five-year period. To implement the demonstration, the state was allowed to operate its own managed care organization. The state assumed responsibility for risks associated with unexpected enrollment changes and costs that exceeded the cap. In exchange, the waiver allowed Vermont to use federal Medicaid funds to refinance a broad array of its non-Medicaid health programs. It also gave Vermont flexibility to reduce benefits, increase cost sharing, and implement new cost-control strategies. Like Rhode Island, Vermont's original cap was generous, as it provided the state with more federal funding than the federal government would have otherwise expended without the waiver ($4.2 billion). In the most recent extension of the demonstration – effective July 1, 2022, through Dec, 31, 2027 – the state continues to maintain funding caps, with adjustments to accommodate provider rate increases.[16]

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[3] Health Affairs. The Problematic Law and Policy of Medicaid Block Grants. Accessed April 24, 2023. healthaffairs.org/do/10.1377/forefront.20190722.62519
[4] Centers for Medicare and Medicaid Services. Trump Administration Announces Transformative Medicaid Healthy Adult Opportunity. Accessed April 24, 2023. cms.gov/newsroom/press-releases/trump-administration-announces-transformative-medicaid-healthy-adult-opportunity
[5] Ark. Code Ann. § 23-61-1004(h)
[6] 42 U.S.C. § 1315(a)(1)
[7] Medicaid and CHIP Payment and Access Commission. June 2016 Report to Congress on Medicaid and CHIP. Accessed April 27, 2023. macpac.gov/publication/june-2016-report-to-congress-on-medicaid-and-chip
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[16] Centers for Medicare and Medicaid Services. Vermont Extension Approval Letter. Accessed April 26, 2023. humanservices.vcms9.vt.prod.cdc.nicusa.com/sites/ahsnew/files/doc_library/VT-GCH-Extension-Approval-06-28-2022.pdf