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A New Approach to Financing Medicaid?

Block Grants, Per Capita Allotments, Shared Savings and the State Budget

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On December 2nd, House majority leadership sent a letter to governors and state insurance commissioners[i] asking for input on a way to refine and augment Speaker Ryan's *A Better Way* policy package regarding health care reform. Indeed, with Republicans maintaining control over Congress and Donald Trump winning the presidency, Medicaid, as entitlement reform, might be one of the most significant targets of policymakers on the national level. However, in Ohio alone, Medicaid comprises nearly 56 percent of the state budget, pays for one in two childbirths, and covers one in four Ohioans. Medicaid is also big business in Ohio, contributing one out of every four dollars spent in Ohio's $82 billion health care economy, supporting major employers like hospitals and nursing homes, as well as the higher education institutions that supply their workforce and the multiplying effect those dollars can have on general economic activity. Given the size and scope of Medicaid in Ohio's economy, policymakers in the Ohio Statehouse should understand what some of these new financing options may be so as to better inform their federal level counterparts.

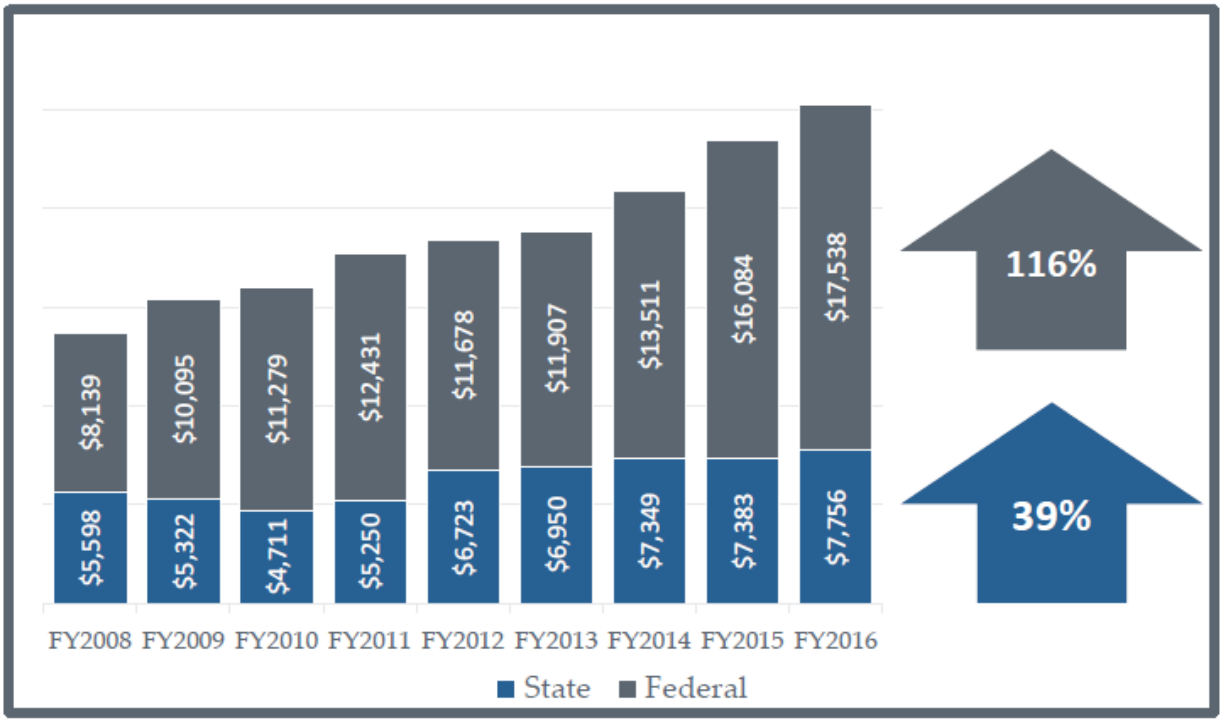
Today's System: The Federal Medical Assistance Percentage (FMAP)

FMAP is the calculation that represents how much money is required from any given state and the federal government, respectively, and is based on two factors. First, the federal dollars (often called "draw down") are based on the actual amount spent by the state. The percentage of that match is then driven by a formula that takes into account the average per capita income for each state relative to the national average. The Social Security Act (SSA) limits this "regular FMAP" match to be no less than 50 percent and no more than 83 percent. The calculation of FMAP changes every year, though it can vary depending on the program being implemented, sometimes with the added benefit of a higher federal match[ii]. FMAP rates also tend to lag the economy, meaning the adjustment of these rates often does not keep pace with major economic events, which can make the fiscal administration of the program more difficult.

Often, it is the policy process of leveraging higher FMAP rates for Medicaid that plays out in other parts of the state budget. For example, where the "family planning" eligible Medicaid recipients received a 90 percent FMAP rate before Medicaid expansion, this group now receives services under the new expansion coverage, thereby allowing the state to access a higher federal match and commit less state resources to that population. Conversely, if the state developed policies which removed coverage under the expansion for this group, that match would be lost, not only preventing the state from accessing the economic benefit of more dollars coming into Ohio, but also that of a decreased state obligation. Medicaid can also be used to offset state dollars in other health-related programs. In the budget bill of the 129th

General Assembly (House Bill 153), "Help Me Grow," a home visitation case management program for pregnant women, leveraged Medicaid in this way.

FMAP is a critical piece in understanding the Medicaid budget process. While a tremendous amount of state resources are dedicated to funding the Medicaid program through FMAP, federal dollars have their benefit on state budgeting, as well. In fact, only 29 percent of the spending in Medicaid is from State General Revenue Fund (GRF) and non-state GRF resources. Additionally, of the state spending that draws down the federal matching dollars, 31 percent comes from fees on hospitals, nursing facilities, and financing mechanisms like drug rebates. Specifically with rebates, Medicaid agencies are able to offset their costs on prescription drugs through a mandatory rebate process with drug manufacturers who have their outpatient drugs covered by the program. When a state pays for any given drug, the Medicaid agency then receives a rebate payment from the manufacturer directly. Overall, when thinking about all sources of funding, only one in five Medicaid dollars that flows through the state budget actually comes directly from state taxpayers.



Source: Ohio Legislative Service Commission, All-Funds Medicaid Expenditure History

Block Grants and Capped Allotments

Block grants are prospective lump-sum payments made to states based on a predetermined formula. Typically, states do not need to provide any match in order to secure the funding, but often are subject to "maintenance-of-effort" obligations based on current spending. With block grants, states would have to "live within their means," meaning federal funding would not be automatically increased to respond to enrollment growth, shifts in categorical or disease-based spending (like increases of the elderly population or HIV infections, respectively), or price increases on technologies or breakthrough medications. On this last point, it is worthy to note that the trend of medication price increases have been a major factor in the increases of Medicaid expenditures[iii], both on the national and state level.

In order to accommodate any changes, states would have to become more efficient or have to obligate more state-based resources to accommodate policy. Proponents of this approach also explain that block grants would free up states to be more innovative in the design of the Medicaid program overall, loosening the federal oversight and prescriptiveness, thus allowing for state-based experimentation. Governor Kasich has lauded this type of approach[iv], though he and his cabinet staff have pointed to the fact that the design elements of how such an approach would work would have to be closely examined.

Capped allotments operate much the same way as block grants, but the state provides a certain amount of matching funds. In fact, the Children's Health Insurance Program Reauthorization Act of 2009 uses an allotment methodology, though the design also relies on adjustments for inflation and population growth.

Many questions remain with a block grant approach to funding Medicaid as it would essentially end the entitlement. Because the amount is fixed, there would be little adjustment based on caseload or casemix, so state legislatures and Medicaid directors would have to look to a combination of service cuts, eligibility restrictions, or provider payment decreases to accommodate budget constraints. When looking at how block granting affected Temporary Assistance for Needy Families (TANF) since 1996, for example, states saw an inflation adjusted decrease of value of around 32.5 percent[v], and restrictions on access to the program have deepened the poverty rates for children[vi].

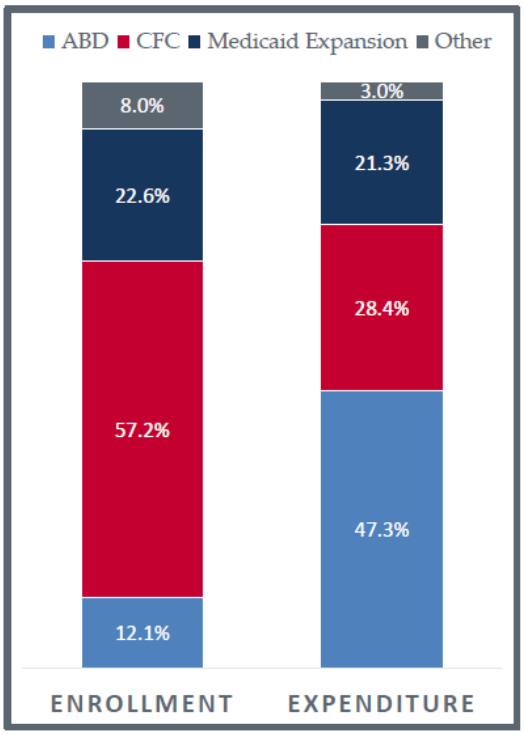
Block granting also has some practical effects in terms of how Ohio operates its program and the potential for redefining the benefit. As a managed care state, Ohio is bound by federal regulations regarding "actuarial soundness," meaning managed care plans need to have rates that sufficiently accommodate service need. As Ohio's population grows older (and thus more in need of health care services), rates may not be sufficient enough to delivering service, thereby terminating Ohio's managed care plan system. Also, since eligible services for reimbursement may be more open-ended, it is feasible to predict interests beyond the health care delivery system seeking financial support for services that are not typically Medicaid reimbursable (transportation, housing, etc.), something which occurred with TANF[vii].

Per Capita Caps

Per capita caps would establish limits on federal payments to states based on a number of enrollees, but not necessarily cost per enrollee. Per capita caps could be designed in such a way as to restrict or accommodate different eligibility groups, thus accounting for some of the dynamics of states and their populations, but this would maintain the variability of federal contribution (as opposed to block grants).

The development of per capita caps would vary by state, and the complexity of the policy would be significant. In fact, if looking at how Ohio currently spends its resources on Medicaid, policymakers would be left with some difficult choices in regards to management of the program.

In the figure to the right, one can see that the majority of expenditures lies with the Aged, Blind and Disabled Population (ABD). Moreover, when looking at the funding of population groups for Covered Families and Children (CFC) and the Medicaid Expansion, the potential to save state-based funding is limited as (1) these populations benefit from higher federal matching rates, and (2) these populations have less complex needs, meaning their potential for increased efficiency is lower. Also, since these populations would be capped, the federal government may not be able to provide additional funding for states to innovate, thereby leaving policymakers with the choice of appropriating additional state dollars, cutting services for the disabled, seniors, and children, or restricting eligibility for those same groups.



Source: Ohio Department of Medicaid Eligible and Expenditures Report, September 2016

Interestingly, this type of design seems to comport with 1115 Demonstration Waivers that utilize a "budget neutrality" cap for states to innovate with specific populations. However, with waivers, some demonstrations have allowed states to apply prior year savings to future expenditures and these limits have adjusted based on the state's experience in covering a particular group. Moreover, states have had the ability to renegotiate their caps[viii] during these time-limited waivers, meaning any federal effort with per capita spending would have to do the same to truly be comparable.

Shared Savings Model

Shared savings models would be similar to per capita spending, though states would be able to earn additional dollars based on underspending as well as hitting performance and quality benchmarks. In this model, the federal government would establish caps based on historical spending and provide matching funds based on the state's FMAP rate. States would then be able to retain a higher FMAP if they achieve savings under the cap and would be at risk for any spending that exceeds those caps.

While a relatively new concept, programs built around shared savings have taken place in several states in both Medicare and Medicaid. In the context of Ohio, the current managed care system operates much the same way by providing a capitated global payment to the plans, though overall spending is still subject to actuarial soundness. On this point, this type of programmatic change would be complex and the elements of design would have to be specific and state-oriented.

Conclusion

Medicaid now comprises nearly 10 percent of federal outlays, making it a natural focus for conservative-minded policymakers in Congress. Much remains to be seen as to how the federal government will tackle health care reform, notably the restructuring of the fundamental state and federal Medicaid financing relationship. A number of options are available to policymakers for reform that have drastic impacts on the program, generally. Impacts may include the end of the entitlement, potential service cuts, eligibility restrictions, greater flexibility for states, and a diminished federal obligation. In Ohio's Statehouse, policymakers should review what this means in terms of its own budget process, given Ohio's reliance on federal Medicaid funding to offset state GRF and the influence that such funding has in one of Ohio's largest industries.

CHART COMPARING ALTERNATIVE FINANCING ARRANGEMENTS

Medicaid and CHIP Payment and Access Commission, June 2016[1]

Point of comparison	Current financing	Block grant	Capped allotment	Per capita cap	Shared savings
Overview of approach	Each state receives federal matching funds for eligible Medicaid spending. The FMAP, or matching rate, is determined by a formula that compares each state's per capita income to the U.S. per capita income.	There is an overall cap on the total annual federal contribution, with state-specific federal grants.	There is an overall cap on the total annual federal contribution, with state-specific federal grants. States must spend matching dollars to draw down the allotment and are not guaranteed to receive the entire allotment amount—the amount they receive depends on their level of spending.	Per enrollee limits on federal payments to a state are established, with spending rising based on the number of enrollees. Per capita caps could be designed on an aggregate level or on a more targeted basis for each eligibility group.	Maintains existing FMAP. States that lower their per capita cost trends below a certain level while improving quality and outcomes would keep a higher share of savings. Those that spend above their cost trend would pay a higher share of the costs.
How does it control federal spending?	Federal definitions of allowable expenses and appropriate state share. Policy decisions regarding mandatory and optional requirements.	Establishes an overall spending limit. Often projects cost growth at lower than historic rates. May also include constraints similar to current financing, such as definitions of allowable expenses.	Same as block grant, although states must spend in order to draw down federal matching funds.	Establishes per enrollee spending limits. Often projects cost growth at lower than historic rates. May also include constraints similar to current financing.	Adjusts the state share depending upon the level of savings achieved. Spending levels for savings could be set below current spending levels.
How does it account for inflation and medical cost growth?	Federal spending is tied to state spending, so matching amount increases accordingly.	Annual changes in federal and state limits are typically tied to specific economic indicators, which may include general inflation or medical cost growth, and are often lower than historical rates.	Same as block grant.	Per capita limits may include growth factors based on general inflation or medical cost growth. These growth rates are typically lower than historic growth rates.	Same as per capita cap.
How does it account for the enrollee mix?	Federal match is a percentage of each state's spending, and therefore accounts for changes in spending as the health of enrollees changes.	It depends. A block grant would likely be based on historic spending, which might reflect the current case mix in the state. A case-mix adjustment could also be made to account for changes in the health of enrollees.	Same as block grant.	It depends. Per capita caps determined by eligibility category will likely account for state case mix. A case-mix adjustment could also be made to account for changes in the health of enrollees.	Same as per capita cap.

CHART COMPARING ALTERNATIVE FINANCING ARRANGEMENTS

Medicaid and CHIP Payment and Access Commission, June 2016[1]

Point of comparison	Current financing	Block grant	Capped allotment	Per capita cap	Shared savings
How does it respond to economic downturns and other current events?	As enrollment or per enrollee costs increase, federal matching funds increase. To the extent a state's economy declines relative to the national average, the FMAP would increase.	Under most block grant proposals, grant amounts would not be affected by economic conditions. However, an adjustment could be made to the grant amount to reflect economic conditions and other events (such as natural disasters).	Same as block grant.	Increases in enrollment, such as might occur during an economic downturn, would result in an increase in a state's total amount. Unless specifically adjusted, per capita caps would not adjust for medical innovations or new diseases.	As enrollment or per enrollee costs increase, federal matching funds increase. To the extent a state's economy declines relative to the national average, the FMAP would increase.
How does it influence the variation across states?	Maintains existing variation.	To the extent that historic spending levels are used when establishing limits, existing program variation and spending differences across states would persist. However, adjustments could be made to the state grant amounts in an attempt to distribute funding more uniformly.	Same as block grant.	To the extent that historic spending levels are used, same as block grants. Growth factors or nationally based caps would diminish state variation.	To the extent that historic spending levels are used, same as block grants. However, the saving incentives would likely reduce spending variation between high- and low-cost states.
What types of spending would be exempt?	The territories and the District of Columbia have fixed FMAPs in statute; special situations, certain populations, providers and services, and spending on administration receive different FMAPs.	It depends. Administrative spending is typically included within block grants, although specific populations (such as those who are dually eligible for Medicaid and Medicare) could be excluded.	It depends. For example, under CHIP, administrative spending is included in the allotment and is subject to a 10 percent cap.	It depends. Per capita caps could exclude the territories, certain populations and services, and certain administrative expenses.	It depends. The shared savings requirements could exclude certain populations and services as well as certain administrative expenses.
How much flexibility would states be given?	Within federal requirements—such as coverage of mandatory eligibility groups—states have flexibility to design their programs.	It depends. Although details are sparse, block grants are generally combined with reduced federal requirements, including more flexibility in required state spending, mandatory eligibility groups, and covered services.	It depends. Under CHIP, states are still required to meet certain federal requirements, but are given greater flexibility, for example, in determining the benefits provided to low-income children.	It depends. Details are sparse, but states could be given broader flexibility (for example, in terms of benefits) to stay within their established caps.	It depends. Similar to per capita caps, states could be given additional flexibility to manage their programs within the caps and achieve desired savings.

CHART COMPARING ALTERNATIVE FINANCING ARRANGEMENTS

Medicaid and CHIP Payment and Access Commission, June 2016[1]

Point of comparison	Current financing	Block grant	Capped allotment	Per capita cap	Shared savings
What financial obligations would states be subject to?	Within federal requirements, states receive federal match for allowable state expenditures.	It depends. States may be subject to a maintenance of effort on existing spending.	State spending would be matched with federal funds up to the capped allotment amount.	The federal government would pay a fixed cost per enrollee; states would be responsible for any remaining costs.	States would receive federal matching funds for allowable state expenditures.
How would states be held accountable for the use of federal funds?	States currently must report quarterly expenses. Compliance with federal policies is monitored through several avenues, for example, State Plan Amendment approvals and Payment Error Rate Measurement reviews.	It depends. It is likely that states would minimally be required to report how they are spending their federal grant amount.	It depends. Under CHIP, states are subject to the same reporting requirements as in Medicaid.	It depends. It is likely that states would minimally be required to report per capita spending.	It depends. States would likely have to report per capita spending to be eligible for shared savings or be subject to shared losses. They would also need to report quality measures.
What data would be needed to establish the alternative financing structure?	Already in place.	It depends. Proposals typically use historical spending and an inflation factor to determine grant amounts. If desired, any data to account for changes in the economy or other growth factors.	Same as block grant.	It depends. Proposals typically use historical spending per enrollee, by eligibility category (and, if desired) risk-adjusted by state. Would also require a growth factor.	It depends. Proposals typically use historical spending and an inflation factor to determine benchmark amounts. Would also need consistent quality and outcome measures. The FMAP is used to determine matching rates.

[i] "Letter to State Governors and Insurance Commissioners Requesting Ideas for How to Reform Our Health Care System for the Benefit of the American People." Kevin McCarthy, Kevin Brady, Fred Upton, John Kline, Greg Walden, and Virginia Foxx to State Governors and Insurance Commissioners. December 2, 2016.

[ii] "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier." 2016. Accessed December 6, 2016. http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0.

[iii] United States. General Assembly of Ohio. Joint Medicaid Oversight Committee. Preliminary Report from the JMOC Actuary. Columbus, OH: Optumas, 2016. 16.

[iv] Livengood, Chad. "Kasich Pushes Medicaid Block Grants to States." The Detroit News. September 2, 2015. Accessed December 6, 2016. http://www.detroitnews.com/story/news/politics/elections/2015/09/01/kasich-medicaid-block-grants-states/71539302/.

[v] United States. US Congress. Congressional Research Office. By Gene Falk. March 18, 2016. Accessed December 6, 2016. https://fas.org/sgp/crs/misc/RL32760.pdf.

[vi] Corlett, John R. "Living on $2 a Day." October 29, 2015. Accessed December 6, 2016. https://www.linkedin.com/pulse/living-2-day-john-corlett?articleId=8720458617761788842.

[vii] "Distribution of Federal and State Welfare Spending, 1996 and 2000 (in 2000 Dollars)." Digital image. May 2002. Accessed December 6, 2016. http://www.urban.org/sites/default/files/alfresco/publication-pdfs/900514-How-are-TANF-Dollars-Spent-.PDF.

[viii] United States. US Congress. Medicaid and CHIP Payment and Access Commission. Alternative Approaches to Federal Medicaid Financing. June 2016. Accessed December 6, 2016. https://www.macpac.gov/wp-content/uploads/2016/06/Alternative-Approaches-to-Federal-Medicaid-Financing.pdf.

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