THE SYCAMORE INSTITUTE

MEDICAID REFORM 101: MORE THAN JUST BLOCK GRANTS

PART 1 OF 5 – KEY FEDERAL MEDICAID REFORM DESIGN ELEMENTS

BOTTOM LINE

The White House and both houses of the U.S. Congress are now controlled by Republicans, who are planning changes to the Medicaid program. **While the buzz has been about "block grants," proposed reform efforts encompass so much more.**

This brief summarizes key elements and design options of proposals to reform Medicaid at the federal level. This, along with our follow-up briefs on state reform efforts and potential impact to Tennessee, provides context for actions that may be taken at both the federal and state levels over the coming months and years.

Washington, DC lawmakers are looking to save federal dollars by reforming Medicaid. The idea is that constraining federal Medicaid dollars paid to states will incentivize state governments to restructure their programs towards cost-savings using new program designs. The options are many. At this point, there are more questions than answers. For example, how will federal spending be controlled – through lump-sum block grants or per capita caps? Would states be allowed to scale back eligibility or benefits for certain populations, or would some populations continue to be guaranteed some minimum level of benefit?

How Congress approaches these design questions could have significant implications for Tennessee's ability to control its own spending on TennCare and for how state policymakers approach their own reforms. The other 4 briefs in this series explore these issues further.

THE SYCAMORE INSTITUTE'S "MEDICAID REFORM 101" SERIES:

PART 1: Key federal Medicaid reform design elements

PART 2: Summary of recent federal proposals

PART 3: Key TennCare reform design elements

PART 4: Summary of recent TennCare proposals

PART 5: Analysis of the potential impact on Tennessee

INTRODUCTION

Ideas to reform federal Medicaid requirements and financing pre-date the Affordable Care Act (ACA), passed in 2010. These proposals all share the goal of reducing federal spending and, in exchange, provide states with more flexibility to control costs. Following the ACA's Medicaid eligibility expansions and federal Medicaid spending increases, however, these ideas have been touted more than ever by Republicans as a way to reduce federal deficits. With the election of President Donald Trump and a continued Republican majority in both the U.S. House of Representatives and Senate, proposals including these ideas may well become law. This brief summarizes the specific design elements that are likely to be discussed as federal reforms are being considered. Our follow-up briefs summarize specific recent federal proposals, state reform efforts, and potential impact to Tennessee. This 5-part series provides a framework and context for changes to Medicaid and TennCare that may be adopted by state and federal policymakers in the coming months and years.

BACKGROUND

Medicaid is a health insurance program established in 1965 targeted at low-income Americans and individuals with disabilities and is jointly funded by the federal and state governments.

What is the goal of Medicaid? Broadly speaking, Medicaid is intended to provide health insurance, increase access to care, and improve health outcomes for vulnerable populations. These include people for whom private coverage is inaccessible because of cost and/or because of coverage restrictions that existed before the Affordable Care Act. The specific goals of Medicaid, however, have evolved over time as new populations and benefits have been added.

Who and what does Medicaid currently cover? Federal Medicaid law includes mandatory and optional standards for both eligibility and benefits. This means that, at a minimum, states must provide federally-mandated benefits to mandatory eligibility populations without imposing any limits or wait lists. States have the ability to get a waiver from a number of federal program requirements (see Part 3 in this series). Tennessee's Medicaid program, TennCare, operates under a waiver and largely serves populations required under federal Medicaid law: low-income children, low-income pregnant women, low-income mothers, and low-income aged, blind, or disabled individuals.

As an example of how program goals have evolved over time, Medicaid eligibility was originally restricted to aged, blind, and disabled individuals and parents and children receiving public assistance when it was established in 1965. Amendments in 1984 and 1985 expanded mandatory eligibility to all pregnant women eligible for public assistance. In 1988, all pregnant women and children with incomes below the poverty line were added – a threshold that was raised to 133% in 1989. And finally, in 2010, the ACA expanded mandatory eligibility to all individuals under 138% of the poverty line. A Supreme Court decision in 2012 made the ACA's Medicaid eligibility expansion optional. [1]

How is Medicaid currently financed? Medicaid is considered an entitlement because anyone meeting eligibility criteria is entitled to enroll and receive all covered benefits. As an entitlement, spending on Medicaid is tied to the cost of providing covered benefits to these enrollees. The federal government covers a state-specific portion of these costs (i.e. the federal medical assistance percentage (FMAP)). States are eligible to receive the FMAP for expenses that align with any of the federal mandatory and optional standards described above. The FMAP is more generous for lower-income states and for enrollees added under state Medicaid eligibility expansions allowed for under the ACA. Across the country, state-specific FMAPs range from a high of about 75% to a floor of 50%. At 65%, Tennessee's FMAP is the 17th highest in the country. [2] It is important to understand that federal contributions under the FMAP are unlimited. States cover the remaining portion of their Medicaid costs. For Tennessee, that state matching requirement is 35%.

FMAP

The state-specific rate at which the federal government covers the cost of providing benefits to Medicaid enrollees. These federal contributions are unlimited.

Tennessee's is

65%.

Entitlements are different from discretionary grant programs, another common federal funding mechanism. The federal funding available for each discretionary grant program – including block grants – is capped by the U.S. Congress' annual appropriations process. Discretionary grants are awarded to states as a fixed amount of funding for some specific purpose. Although these grants may include state matching fund requirements, once states spend their discretionary grant funding for the year, no additional federal funds are available regardless of whether the state spends more of its own funds than required or whether more need exists.

TENNCARE FINANCING 101

FEDERAL GOVERNMENT

- Congress and/or the federal Centers for Medicare and Medicaid Services (CMS) set national rules about mandatory and optional Medicaid eligibility and benefits.
- The federal government covers about 65% of most TennCare costs.

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TENNESSEE

- The General Assembly and/or the TN Division of Health Care Finance & Administration set specific parameters for TennCare eligibility and benefits within federal rules.
- Tennessee covers about 35% of most costs, some of which is contributed via assessments or taxes paid by TennCare providers.
- The state sets and makes capitated payments to insurance companies for providing benefits to all TennCare enrollees via a "waiver."
- The state also makes select payments directly to certain kinds of providers, like hospitals that provide uncompensated care to the uninsured.

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HEALTH INSURANCE COMPANIES

- Medicaid managed care organizations (MCOs) provide insurance coverage to TennCare enrollees consistent with state-set benefits.
- MCOs manage the costs of TennCare enrollees within the payment rates provided by TennCare.
- MCOs negotiate and make payments to health care providers.

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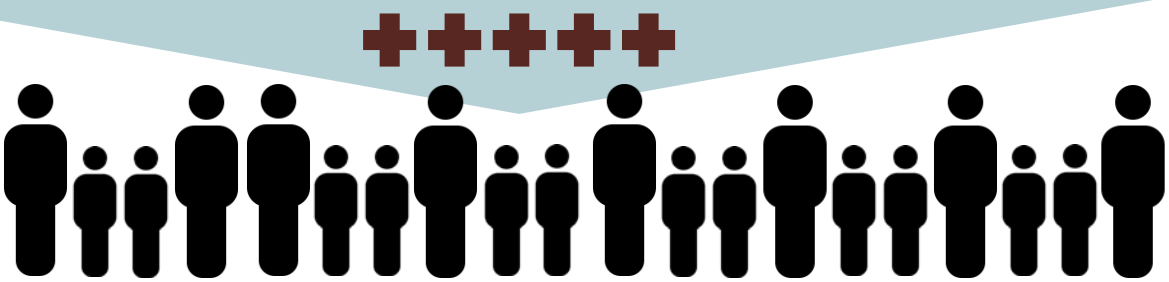
HEALTH CARE PROVIDERS

- Health care providers deliver care directly to TennCare enrollees.
- Some providers pay assessments or taxes to help the state cover its portion of TennCare costs.



TENNCARE ENROLLEES

What are the unintended consequences of the FMAP? To fulfill their share of spending on Medicaid and trigger the drawdown of more federal dollars, states are able to use sources of revenue that are not, in the purest sense, state taxpayer dollars. The most common of these are taxes or assessments levied on Medicaid providers. Providers pay the state a tax for participating in Medicaid. The state uses that tax towards its Medicaid program (which in turn pays those same providers who paid the tax), which triggers the federal match. Some argue that the financing structure of Medicaid combined with these sorts of state expenditure flexibilities create an incentive for states to spend evermore federal dollars.

The graphic on the previous page provides an overview of how Medicaid and TennCare are financed. See Parts, 3, 4, and 5 in this series for additional background on TennCare.

STATED GOALS OF FEDERAL MEDICAID REFORM

reduce
FEDERAL SPENDING

increase
PROGRAM DESIGN FLEXIBILITY

The 2 primary goals of federal Medicaid reform that have been articulated by nearly all proposals in recent years are:

1. To reduce federal spending on Medicaid and
2. To provide states with more flexibility to tailor their Medicaid programs and implement innovative approaches.

In addition to these, federal policymakers have signaled a handful of other goals, including:

- To improve access to care for the most vulnerable, which some proposals imply or state are the original eligibility groups for which the program was established in 1965;
- To improve the quality of care in Medicaid programs;
- To improve access to providers in the Medicaid program; and
- To reduce fraud, waste, and abuse. [3] [4] [5] [6]

KEY DECISION POINTS FOR FEDERAL MEDICAID REFORM

This section summarizes both the key decision points that must be addressed in accomplishing the 2 primary goals above. Part 2 in this series summarizes how specific recent proposals by Congressional Republicans have approached these design choices.

To accomplish the dual goals outlined above, recent reforms (see Part 2) rely on constraining federal spending in order to incentivize states to restructure their programs through new program design flexibilities. This approach is in the lieu of the alternative: providing flexibilities to allow states to restructure their programs in order to produce cost-savings that reduce federal spending.

The Congressional Budget Office (CBO) and the Medicaid Payment and Access Commission (MACPAC), both nonpartisan advisors to Congress, have laid out key design choices that would need to be addressed in reform efforts to cap federal contributions to states. All of these decision points affect any reform's impact on federal spending, state spending, and coverage. [7] [8] These decision points are broken down into two broad categories: federal financing and state benefit design.

FEDERAL FINANCING

Basic Structure: What would the basic structure be for limiting federal contributions to state Medicaid spending? Four basic structures have been discussed:

1. Under a **block grant**, states would receive a lump sum from the federal government to to help cover Medicaid costs. The funding under a block grant would not change based on changes in enrollment.
2. Similar to a block grant, a **capped allotment** would be driven by a lump sum cap for all Medicaid costs. Under this structure, however, states would draw funds down from the allotment *up to* a cap based on their own spending triggered by some kind of match requirement. The funding cap under a capped allotment would not change based on changes in enrollment. Although, the amounts actually drawn down by a state could be affected by enrollment. The Children's Health Insurance Program (CHIP) is financed via a capped allotment.
3. **Per capita caps** would apply a cap on federal Medicaid contributions on a per enrollee basis. The funding under a per capita cap would change as enrollment changes. Lawmakers would need to decide if a state would be subject to a single per capita cap for all enrollees or if different caps would be applied to different eligibility categories.
4. Under a **shared savings** approach, the federal government would continue to provide unlimited contributions driven by the FMAP, but a spending target would be set on a per enrollee basis, similar to a per capita cap. A portion of any savings achieved between actual spending and the target could be kept by the state. If spending exceeded the target, a state would have to take on a larger share than would normally be required under the FMAP.

BLOCK GRANT VS. PER CAPITA CAPS

per capita caps would allow federal support to change with enrollment while block grants would not

Spending Categories: Medicaid dollars are spent on different categories of activities – including, for example, traditional health care benefits, nursing home care, administrative costs, and direct payments to certain hospitals for their uncompensated care costs. A fixed federal contribution of any kind – whether a block grant or per capita caps – would be based on some base level of spending. Would that base include all state Medicaid spending currently matched by the federal government, or would it treat some categories differently? For example, reforms could choose to continue reimbursing some costs as they are today (e.g. separate payments related to hospitals' uncompensated care costs), end reimbursement for some activities entirely (e.g. optional benefits), or apply different reform structures to different categories of spending (e.g. block grant support for long-term services and supports while placing a per capita cap on traditional health care benefits).

Eligibility Categories: Would the structure apply to all Medicaid eligibility categories or would some categories be excluded or treated differently? For example, financing could remain the same as today for low-income individuals who are elderly or have disabilities; while support for low-income pregnant women and children could be converted to a block grant.

Base Year: What year would serve as the base year for determining a grant, cap, or spending target? Some time period would have to be identified as the starting point for calculating the base level of spending on which a state's federal funding limits would be determined. Using a past year, for example, would essentially preserve states' past Medicaid decisions (e.g. coverage of optional eligibility populations and/or benefits and provider payment levels); while a future year could create an unintended incentive for states to change their program designs and provider payments to maximize the base for their federal cap.

Cap Growth: How would a cap on federal contributions under any of the 4 basic structures grow from year to year? All proposals share a goal of saving federal dollars. They would accomplish this by constraining the annual growth in federal contributions to states to a rate less than estimated under the current structure. Some options include general inflation, health care cost growth, or economic growth.

State Differences: How would reform account for state differences in spending and program design? For example, some state programs may be relatively more generous in the benefits offered and populations covered than others. Additionally, some states may already be relatively good at controlling costs. A reform effort could include some mechanism to try to smooth out these differences.

State Contribution: To what extent would states need to share in the costs? For example, Congress could retain an FMAP-like requirement under which a state would continue to have to cover some minimum percentage of overall costs. Another option would be imposing a maintenance-of-effort requirement under which states would have to continue spending at least as much as they do today.

ACA Expansions: How would reforms treat the eligibility expansions allowed for under the ACA? Would federal policymakers choose to end funding altogether for expansion populations? Alternatively, the base level of spending for determining a cap could include current spending on new enrollees only in states that have chosen to expand their Medicaid programs, or it could provide an opportunity for all states to expand before imposing a federal cap. Furthermore, would a cap account for the enhanced federal match rate available under the ACA for expansion populations?

STATE BENEFIT DESIGN

State Flexibility: How much flexibility would states be given to define eligibility, benefit design, and cost-sharing requirements? Would state flexibility reforms apply to all eligibility categories uniformly, or would different eligibility categories be treated differently? Even with financing reforms, federal requirements related to eligibility and benefits could conceivably remain the same. Any flexibilities, however, could be more narrowly focused on specific populations while retaining current federal standards for certain, potentially more vulnerable eligibility categories.

Federal Accountability: To what extent will states have to continue to collect, analyze, and report data and/or quality measures to the federal government in exchange for federal dollars? New requirements could, for example, help state and federal officials track the impact that reforms might have on coverage, access to care, quality, and health outcomes.

PARTING WORDS

The years of work ahead to reform Medicaid at both the federal level and in Tennessee are sure to be full of trade-offs. Accomplishing the goals of reducing federal spending while increasing state flexibility comes with a number of choices that federal policymakers will have to address. These choices, of course, will drive the choices that our own state's lawmakers will then have to make using their own goals to guide their action. And at all levels, these choices will have to be weighed with other goals – such as preserving access to care for the most vulnerable.

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