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What Block Grants Could Mean For State Medicaid Programs

By **Miranda Franco** (February 21, 2020, 3:58 PM EST)


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The Centers for Medicare & Medicaid Services released a state Medicaid director letter and fact sheet on Jan. 30 that encouraged states to pursue block grant or per capita cap funding through their Medicaid programs as part of the new Healthy Adult Opportunity. The guidance would provide for greater Section 1115 demonstration waiver authority for Medicaid funding.

The HAO is an optional funding model that allows states to utilize Medicaid block grants to share in savings resulting from unused federal funds. The program would allow states to operate under the block grant or a per capita cap financing model for adult populations younger than 65 years old for whom coverage is not mandatory, such as those who are not eligible for Medicaid based on disability or a need for long-term care and are not eligible under a state plan.

About 2 million people in nonexpansion states could theoretically be eligible under the criteria CMS outlined. CMS states that other low-income adults, children, pregnant women, elderly adults and people with disabilities will not be affected by this initiative.

The HAO is available to all states and will be initially approved for five years and may be renewed for up to 10 years. States may target a defined subset of high-need individuals for HAO demonstration participation and states can migrate Medicaid enrollees from current Section 1115 waiver demonstrations to the HAO demonstration.

States participating in the HAO program will need to agree to operate their program within a defined budget target and choose between a per capita cap where the cap is imposed per enrollee or an aggregate cap (block grant) where the cap is imposed on total spending.

A per capita cap allows federal funding to adjust for changes in enrollment but not health care costs, while block grants put states at risk for both higher costs and increased enrollment. States agreeing to the total spending model will be required to maintain spending on health services at a level of at least 80% of the target amount.

Caps are set when the waiver is first approved and are applied annually. They are based on states' historical spending for the waiver population or for newly covered populations, based on CMS estimates that can be adjusted later using state expenditure data. Once the base amount is set, it is trended forward using the medical consumer price index, or CPI, for the per capita cap or medical CPI plus 0.5% for the aggregate cap, or the state's own historical growth rates if lower.

States using the HAO to expand Medicaid may access enhanced Federal Medical Assistance Percentages, or FMAP, for the expansion population if the state fully expands Medicaid. States still must provide matching dollars to draw down federal funds under a capped funding waiver, but the federal government stops contributing matching funds once the state reaches the cap. States that spend less than their cap in a given year could divert up to 50% of the unused federal funds to health-related services outside of Medicaid if they meet specific performance standards.

CMS will not provide enhanced FMAP for partial Medicaid expansion, which includes implementing asset tests. Notably, the governor of Oklahoma (a nonexpansion state) has already announced that the state will pursue an HAO waiver.

States may impose conditions of eligibility on coverage under an HAO demonstration that does not generally apply to Medicaid coverage under state plans. CMS references work requirements as an example. CMS also notes that states can require an asset test for eligibility and can set the income standard for eligibility for coverage under an HAO demonstration. States also can limit coverage to a defined subset of individuals.

The HAO initiative grants states the "ability to pay for services that cannot traditionally be funded by Medicaid, including those designed to address certain health determinants, such as enhanced case management services that link individuals to housing or other supports." However, this coverage cannot extend to room and board. States may include coverage of services provided by a federally qualified health center as part of the state's value-based payment reform efforts.

This guidance also notes that states must cover essential health benefits and will be expected to align benefits structures with those available in the individual insurance markets. However, CMS notes that it will allow states to adopt closed prescription drug formularies.

The guidance also indicates a willingness to grant states additional flexibilities that could impact payment rates, most notably by eliminating the need for CMS to review payments from states to managed care organizations to ensure actuarial soundness, and by giving states greater authority in determining network adequacy.

Democrats have attacked the plan as they fear that less funding and more program flexibility will constrain access and result in cuts to the safety net program. Avalere estimates that over five years potential percentage reductions in total Medicaid funding could range from 0.1% in Nebraska to 8.1% in California.

Notably, Democrats in the U.S. House of Representatives passed by a vote of 223-190 a nonbinding resolution, H.R. 826, disapproving of the administration's new proposal. On the other end, proponents of the plan argue that block grants could help control rising costs and Medicaid enrollment and pave the way for state innovation.

If the demonstrations are deemed successful in reducing Medicaid spending while providing similar levels of coverage to the eligible population, they could encourage more far-reaching spending cap proposals down the line. However, there likely will be legal challenges arguing that all or parts of the HAO initiative are illegal.

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