WVAHC
West Virginians for Affordable Health Care
Consumer Voices for Health Care

Medicaid Block Grant ("Health Adult Opportunity") 1115 Waivers:

Questions and Answers

On January 30, 2019 the Centers for Medicare and Medicaid Services (CMS) released guidance on Medicaid block grants that encouraged states to radically restructure their Medicaid programs. These new waivers, misleadingly titled Healthy Adult Opportunity (HAO) waivers, are a stark violation of federal Medicaid law and any state that pursues a waiver will face long and costly litigation.

The new proposed financing waivers would limit or cap the amount of federal support to state Medicaid programs for the Medicaid Expansion Population. While the guidance specifically addresses changes to the financing of the Medicaid Expansion population, the negative impact will reverberate across the *entire* West Virginia Medicaid program. These changes will result in West Virginians losing coverage, critical benefits, and access to hospitals and doctors. In turn, West Virginia hospital and other health providers will face a tremendous financial blow – with many forced to close their doors.

The basic concept is to terminate the historical Medicaid state/federal financial partnership that provides a guarantee of federal matching dollars for state spending on Medicaid. Today, the federal match is not limited or capped – states design their Medicaid program and the federal government provides a set portion of the cost. If costs go up, the federal contribution goes up concurrently.

Bypassing Congress and testing the limits of this rulemaking authority, Tennessee has submitted a financing waiver to the federal Centers for Medicare and Medicaid Services (CMS).

It is critical that West Virginia policymakers understand how these financing waivers could limit federal Medicaid dollars available to West Virginia and entangle the state in costly litigation.

Further, unique factors in West Virginia put our state at higher financial risk of the loss of significant federal dollars under a block grant or per capita cap financing structure than most other states.

Q: How does the current state/federal Medicaid financial partnership work?

A: As created by Congress over 50 years ago, the Medicaid program is jointly funded by the federal government and states. The federal government pays states for specified percentages of all Medicaid program expenditures, called the Federal Medical Assistance Percentage (FMAP). Importantly, there is *no limit or cap* on how much the federal government will contribute to a state Medicaid program. The federal government must match all state Medicaid spending - regardless of how much a state decides to spend within the basic rules for who can be eligible and for allowable Medicaid covered benefits. States can add eligibility groups and add optional benefits within federal rules and the federal government remains obligated to match state spending. *If the number of people eligible for Medicaid or if demand for Medicaid services rise (and thus state Medicaid expenditures), the federal matching dollars concurrently rise.* In other words, the federal government and the state are true financial partners sharing the cost of coverage and the risk of cost increases.

Q: What is the basic federal Medicaid matching rating rate for dollars spent by West Virginia on Medicaid health services?

A: Every state has its own "Federal Medical Assistance Percentage (FMAP)," computed from a formula that takes into account the average per capita income for each state relative to the national average. By law, the FMAP cannot be less than 50%. Because West Virginia is a very poor state, our basic 2020 federal Medicaid matching rate for medical services will be 74.94%, the second highest in the country. This FMAP means that for every dollar West Virginia spends on medical services, the federal government provides $2.99.

Additionally, certain services have a higher federal matching rate to incentivize states to provide these services. An example is the higher matching rate for states that opt to cover certain women with breast or cervical cancer who do not qualify for Medicaid under a mandatory eligibility pathway and are otherwise uninsured.

Q: What is the federal Medicaid matching rate for the Medicaid Expansion population?

Under the Medicaid Expansion under the Affordable Care Act, West Virginia has chosen to cover adults not previously eligible under their Medicaid program up to 138% of the federal poverty level. For this population, the state receives a special generous federal Medicaid matching rate of 90%. Nearly 157,000 **West Virginians** enrolled in **expanded Medicaid** as of November 2019.

Q: What is a "block grant" and a "per capita cap" and how do these related financing schemes fundamentally change the current Medicaid's state and federal financial partnership?

A: These financing schemes are very different from Medicaid's statutorily required open-ended funding that allows states to receive a set federal match for every state dollar spent on Medicaid. The basic purpose is to limit or cap federal spending on Medicaid. The two basic variations of these limits on federal financial support of a state Medicaid program: 1) a *block grant* under which states would receive a limited, pre-designated amount of money from the federal government for their Medicaid program – regardless of increases or decreases in enrollment; and, 2) a *per capita cap*, which would pre-determine the amount of money spent *per person* enrolled in Medicaid – regardless of unexpected changes in cost and utilization of medical care. Both variations may provide an increase in the dollars each year – but these increases are often less than the rate of overall expected medical services inflation in the state or our nation.

These schemes are intended to put the financial risk of unexpected cost increases in the Medicaid program on the states, and to reduce the federal share of the cost of Medicaid and shift a greater share of spending onto the states.

These schemes can also reduce the higher federal matching dollars that support the Medicaid expansion population by using a formula for calculating limits or caps that do not fully take into account the 90% matching rate for this population.

Q: Is this type of fundamental change to Medicaid normally done through administrative rulemaking?

A: No. The federal law (not regulations) clearly defines the rules that control the financing of the Medicaid program.

Block grants and per capita caps have been the core of every proposal to cut federal Medicaid spending and shift Medicaid costs to the states for over 20 years. Block grants and per capita caps are antithetical to the spirit of the Medicaid program where the federal government has made a commitment to states to help fund the program at a certain level for anyone who qualifies.

President Trump and the head of CMS, Seema Verma, have stated that they plan to bypass Congress and use administrative rulemaking to establish block grants in Medicaid. Normally the President would propose a change like this in his annual budget proposal and Congress would have to pass the change. President Trump has proposed block grants and per capita caps in his annual federal budget proposal before - his past annual budget proposals make clear that his goal is to dramatically cut federal Medicaid dollars and to renege on the long-standing Medicaid financial partnership with the states. Congress has not acted.

In fact, even when other programs were on the chopping block in Congress, Medicaid funding has not been altered or cut. The federal budget sequestration process put into law in 2011 as part of the Budget Control Act – a set of automatic spending cuts that occur if Congress cannot identify and agree to specific spending cut targets - excluded cuts to Medicaid even though Medicare and Social Security were placed within the scope of automatic cuts to spending.

While the details of block grant and per capita cap proposals vary, the question is *always how big is the federal funding cut* – not will there be a federal cut in Medicaid dollars. Republicans in Congress have proposed changes that result in significant cuts to federal spending on Medicaid in every year since 1981 - without success. Governors and state legislators of both parties have spoken against these proposals as Medicaid cuts in disguise.

For example, looking at the proposed Better Care Reconciliation Act of 2017, which did not pass a Congress, provides insight into these proposals. This Republican proposal would have phased out the higher federal match for Medicaid Expansion enrollees to the regular match and converted federal Medicaid funding to a per capita allotment. To maintain its current Medicaid program, West Virginia would have had to make up $3.4 billion in loss of federal funds between 2020-2029, including $1.5 billion for the phase-out of the enhanced match for the ACA expansion and $1.9 billion for the per enrollee cap on all groups.

Q: What does the proposed Tennessee Medicaid financing 1115 waiver do?

As of December 2019, Tennessee is the only state considering the conversion of the state's Medicaid program to a hybrid type of block grant. Tennessee's Medicaid program already operates under an 1115 demonstration waiver (known as "TennCare"). On November 20, 2019, the State of Tennessee submitted Amendment 42 to their section 1115 demonstration to CMS. Tennessee proposes a per capita block grant with a so-called "shared savings model" based on legislation passed by state lawmakers this past spring.

As mentioned above, states are reimbursed by the federal government for at least half of the cost of their Medicaid programs and often more. In contrast to this current matching funding mechanism, which provides Tennessee with a reimbursement rate of about 65%, the state instead wants the federal government to provide it with an upfront, lumpsum amount, and for that amount to increase – if enrollment increases – by a pre-set per-person dollar figure. This cap would force Tennessee to control health services inflation and to take on the risk for any unexpected increase in service utilization, for example from a flu epidemic or new breakthrough life-saving treatments that cause current Medicaid enrollees to use more services. Tennessee would be locked into its current program with no ability to expand covered services if needs arise in the state.

Further, the proposal asks that if the state spends less than the blocked amount in a given year, it can split those savings 50-50 with the federal government. This creates a state incentive to cut Medicaid eligibility, cut the roles through enrollment barriers, and cut benefits. Revealing is that Tennessee is asking that federal funding increase if enrollment increases and, at the same time, asking that there be no decrease in funding if enrollment decreases – so that split savings to the state can be maximized if enrollment is reduced by state action.

In exchange for accepting a federal funding limit, Tennessee is asking for authority to bypass Medicaid core enrollee protections. The waiver asks for authority for Tennessee to:

• Limit the "amount, duration, and scope" of core benefits that Medicaid provides, and limit or even eliminate some benefits, without requesting approval from the federal government or providing for public comment.

• Eliminating the federal standards for Medicaid managed care plans. Tennessee asks to be exempt from all federal regulations for Medicaid managed care plan organizations (MCOs). Without these protections, MCOs could make dramatic reductions in reimbursement to providers and would have no obligation to have adequate provider networks for consumers. The MCOs would have no obligation to report on the services they are (or are not) providing, and enrollees would have no appeals protections for denials of eligibility or benefits.

Q: Will a state block grant or per capita cap or other financing waiver – if approved - be challenged in the courts?

A: Yes, definitely. This dramatic change in the financing structure of the Medicaid program as defined under the Social Security Act exceeds what is allowable under section 1115 waiver authority. Advocates for beneficiaries in Tennessee have already stated that they will challenge the waiver if approved in the federal courts, and any state to move forward with this type of waiver will face costly litigation.

The basic open-ended federal-state matching arrangement is codified in sections 1903 and 1905 of the Social Security Act. Under section 1115 of the Social Security Act, the Secretary's waiver authority is limited to provisions of section 1902. The Secretary does not have the authority to waive sections 1903 or 1905. Payment to the states and the matching financing structure are clearly defined in section 1903. Only Congress, not the Secretary or the state of Tennessee, has the authority to change the fundamental 50-year Medicaid financing state/federal financing structure.

Q: Proponents of these financing waivers suggest that West Virginia and other states give up the federal financial guarantee of matching Medicaid funds – and risk federal dollar cuts - in exchange for Medicaid program flexibility. Does the Medicaid program provide state design flexibility now?

A: Yes. States have significant flexibility to design a Medicaid program. Every state Medicaid program is different – defined by the needs in the state and the decisions of elected policymakers.

West Virginia designs and runs their own Medicaid program with minimal federal guidance. West Virginia and other states have a great deal of flexibility to cover different benefits or alter the mix of services, to pay different reimbursement levels, to modify elements of cost-sharing, and to use different payment systems (for example, using a fee-for-service approach or managed care contracts or a combination of the two). Medicaid state plan amendments and other types of waivers give the states even more flexibility. For example, West Virginia was the

first state to move forward with a waiver to allow the Medicaid program to expand needed Substance Use Disorder services to help our state battle the Opioid addiction crisis.

West Virginia also has the flexibility to use cost-containment strategies such as prescription drug formularies or delivery system reforms that lower costs and improve quality of care. States can establish their own Medicaid provider payment rates within federal requirements, and generally pay for services through fee-for-service or managed care arrangements

While West Virginia must cover several specific groups of people – low-income children, pregnant women, and certain seniors and people with disabilities – we also have flexibility to provide coverage to other adults and to set higher eligibility levels in our low-wage state. To participate in Medicaid, federal law requires states to cover certain groups of individuals. Very low-income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI) are examples of mandatory eligibility groups. States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community-based services and children in foster care who are not otherwise eligible.

Q: What are the risks for West Virginia if the current federal/state financial partnership for Medicaid funding is waived?

Today, Medicaid spending in West Virginia goes up if the demand for services or as medical inflation rises – and the federal matching dollars also increase to help ease the financial burden on the state. *The risk for West Virginia – and for any state – under a block grant or per capita cap financing structure is the loss of significant federal dollars to support Medicaid program services.* Capping federal Medicaid funding would leave West Virginia on the hook to pay for unanticipated financial costs – due to higher than projected medical inflation or higher than expected medical service utilization - with only state money to fill in the gap.

Medicaid has done a better job than other payers to hold down medical inflation, but rising costs of health care are a fact across all health sector payers. Block grant and per capita cap proposals in the past have set unrealistic goals for state Medicaid programs to reduce medical inflation. This alone makes these radical financing changes a dangerously costly proposition

Although Tennessee's proposed waiver asks to adjust federal dollar caps upward if Medicaid *enrollment* grows, the proposal still leaves Tennessee at risk if *per capita or per-person* Medicaid costs grow faster than expected. By limiting funding when per-person costs rise, the waiver leaves Medicaid budgets with a shortfall

that must be filled with state money. In this way, even a per capita cap puts every enrollee in the Medicaid program at risk - even groups excluded from the block grant itself, such as seniors and children with disabilities.

West Virginia may have more to lose than most other – if not all other – states if we were to adopt a block grant or per capita cap Medicaid waiver.

First, West Virginia has the second highest FMAP – the basic federal matching rate in the nation. When Congress created Medicaid, they intended to provide a higher level of assistance to poor states as they recognized the special challenges faced by a state with a larger number of poor families who need affordable health insurance and a smaller tax base to generate revenues to support Medicaid. This historical financial advantage to West Virginia (and other poor states) will be lost under a block grant or per capita cap.

Second, West Virginia has nearly 157,00 low-income adults enrolled in the Medicaid Expansion population at the special 90% federal matching dollars rate. It is unclear if or how these financing waivers will build in the higher federal match for this population.

Third, one of the hallmarks of the Medicaid program has been its ability to respond to unpredictable and uncontrollable situations in a state that increase Medicaid spending. The state and the federal government together have shared the responsibility of meeting the increased costs in these circumstances. West Virginia faces unique obstacles that can raise Medicaid costs.

Economic Obstacles

Medicaid serves as an important safety net for unemployed workers and their families. A common measure of the economic health of a state is the median annual income. West Virginia is the fourth poorest state in the nation with only Mississippi, Kentucky, and Arkansas ranked worse. Our Medicaid program supports families on low-wages and without access to employer-based health insurance. West Virginia has one of the highest unemployment rates among the states. In 2018, our rate of unemployment was 2nd among the states. West Virginia has seen less job growth in the past five years than all but one state. And job growth has only occurred in the health sector – and that is thanks to the Medicaid expansion in West Virginia.

When workers become unemployed, they forego health care services to stretch the dollars in a reduced family budget. Some of these workers will not move back into employment with private coverage. When some of workers move on to Medicaid, not only does enrollment increase, but pent-up demand for health services can raise per capita costs. For example, a worker who foregoes their high blood pressure

medication may have cardio-vascular complications by the time they enroll in Medicaid.

Opioid Addiction Crisis and Other Health Epidemics

West Virginian has been one of the states hardest hit by the national opioid addiction epidemic – with rural areas in our state being overwhelmed by the health crisis.

Medicaid is the primary source of funding for substance use disorder (SUD) prevention programs, early intervention strategies, and treatment; it is the single largest payer of these services in the state. Medicaid also is an innovator in programs that coordinate services that address both behavioral and physical health services needed to successfully address many health problems. We were the first state to expand Medicaid coverage of critically needed SUD services. If we had been under a Tennessee-like waiver, the additional per capita cost of addressing opioid addiction and SUDs would have fallen on West Virginia's shoulders without federal Medicaid matching dollars.

If other types of health crises emerge – for example a severe flu or Zika epidemic – the Medicaid federal-state matching funds mechanism makes sure that the Medicaid program can be there to provide treatment that help save lives and pay for public health measures (such as additional screenings and immunizations) that can reduce the public health impact.

West Virginia's population faces multiple high health needs and limited access to care. Reducing federal funds through a per capita cap or block grant would limit West Virginia's ability to respond to public health crises.

Floods

West Virginia has seen a history of severe flooding in some of our poorest counties that has put people out of work and stymied economic development. Medicaid has been there to help West Virginia families struggling to recover from the impact of floods – the loss of homes and jobs – and often a set of flood-related serious health issues. Unsanitary conditions can increase infections and magnify chronic health problems such as asthma and bronchitis. Natural disasters like flooding are unpredictable but the geography of our state makes the state susceptible to future events. Dealing with the health impact of floods and other natural disasters can raise the per capita cost of Medicaid as well as increase enrollment.

Aging, Disabled, and Sicker Population

West Virginia's population is becoming older. According to the United States Administration on Aging, almost one-third (30 percent) of West Virginians will be age 60 or over by 2025; only Florida has a projected higher percentage of people age 60 and over. Older West Virginians are less likely to work and pay taxes yet at the same time they can create greater demands on the state for a range of social services. And with aging comes a greater demand for medical services.

While Medicare pays for most for seniors' health care services, low-income seniors rely on Medicaid-Medicare dual eligibility to help them afford Medicare's premiums and copayments as well as to fill in the gaps in services. And Medicaid pays for long-term care services whether in a nursing home or through home-and community-based care programs. West Virginia's faster growing older population will put the state at a disadvantage compared to other states under a block grant or per capita cap.

20% of West Virginia's non-institutionalized population reported a disability, the highest reported percentage compared to a U.S. average of 13%, requiring additional treatment and regular monitoring to stay productive and health - which can raise the average cost per person of Medicaid care. West Virginia also has the highest obesity rate in the country (71.1%) which increases healthcare costs. West Virginia ranks 43 among the states in overall health status. This need to deliver additional health interventions is made more challenging – and costly – in a rural state. 30% of people in West Virginia live in a health professional shortage area for primary care and have limited access to health providers. All of these factors drive up our per capita costs higher as compared to other states. It is unclear if a per capita cap formula will be based on state or national inputs or adequately consider the unique health challenges of West Virginia's Medicaid program.