HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HM 7033 PCB HIS 17-01 Medicaid Block Grants
SPONSOR(S): Health Innovation Subcommittee, White
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Innovation Subcommittee	8 Y, 5 N	Calamas	Poche

SUMMARY ANALYSIS

The Medicaid program is a partnership between the federal government and the states in which the federal government makes matching funds available for state health care expenditures for certain low-income residents. The program design is largely prescribed by federal laws and regulations, which may be waived in certain, limited circumstances.

HM 7033 urges the U.S. Congress to implement the Medicaid program through per capita block grants to the states, including a rate of growth and various adjustments for risk and enrollee income, and including state authority to design programs without reference to current federal Medicaid laws and regulations.

Copies of the memorial will be sent to the President of the United States, to the President of the United States Senate, to the Speaker of the United States House of Representatives, and to each member of the Florida delegation to the United States Congress.

Legislative memorials are not subject to the Governor's veto power and are not presented to the Governor for review. Memorials have no force of law, as they are mechanisms for formally petitioning the federal government to act on a particular subject.

The memorial does not have a fiscal impact on state or local governments.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Medicaid Overview

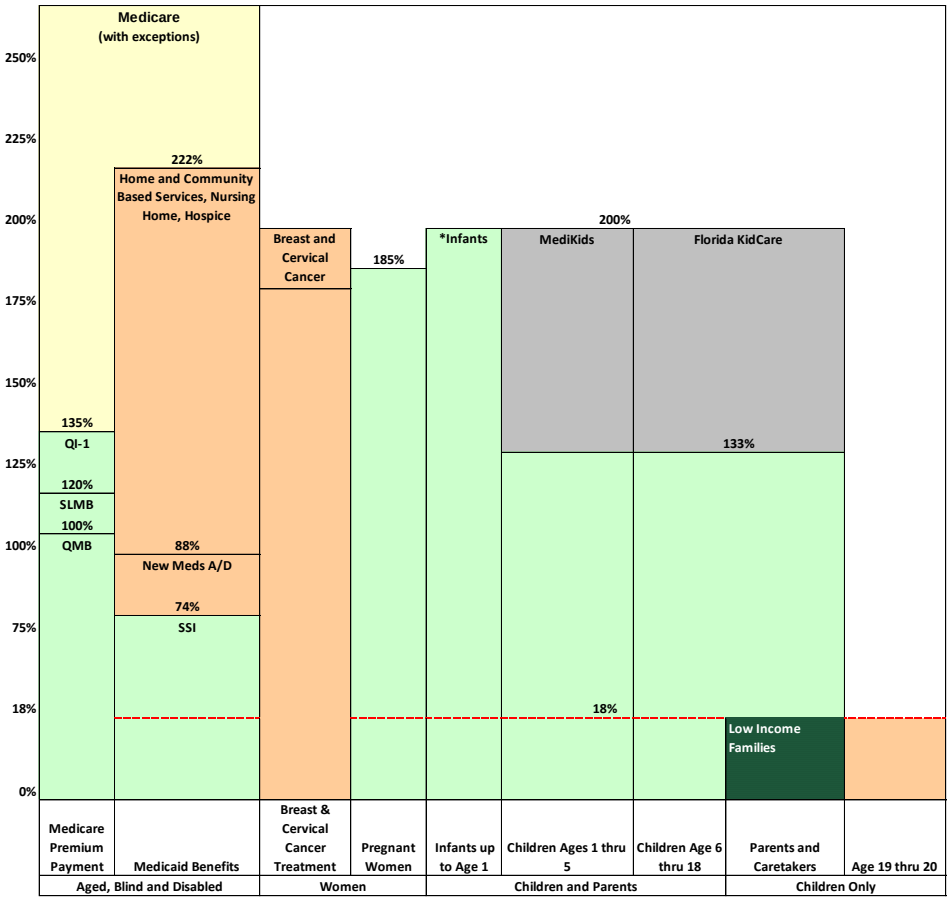
Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Agency for Persons with Disabilities, and the Department of Elderly Affairs.

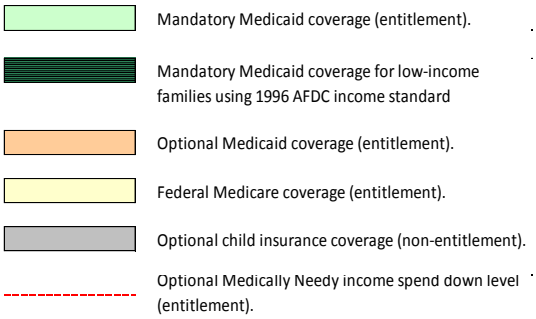
The Florida Medicaid program covers 1.7 million low-income adults (parents, aged and disabled) and 2.3 million children, or 46.8% of the children in Florida. Approximately 85% of the Medicaid population is enrolled in Medicaid Managed Care. Approximately 61% of all nursing home days are covered by Medicaid, and 62.8% of childbirths/deliveries are covered by Medicaid.

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[1] Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states: Some populations are entitled to enroll in the program; and enrollees are entitled to certain benefits.

The federal government sets the minimum mandatory populations to be included in every state Medicaid program. In the chart below, the yellow and light green sections are mandatory populations by federal law. States can add eligibility groups, with federal approval. In the chart below, the orange sections show the groups Florida has added over the years. Once these optional groups are part of the Medicaid program the entitlement applies to them as well.

[1] See, Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).





Family Size	**Annual Income
1	$12,060
2	$16,240
3	$20,420
4	$24,600
5	$28,780
6	$32,960
7	$37,140
8	$41,320
Each Additional	$4,180

* Coverage for infants up to 200% Federal Poverty Level is required in order for states to receive Title XXI funding.

**Federal Poverty Level as of January 2017

The federal government sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.[2] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.[3]

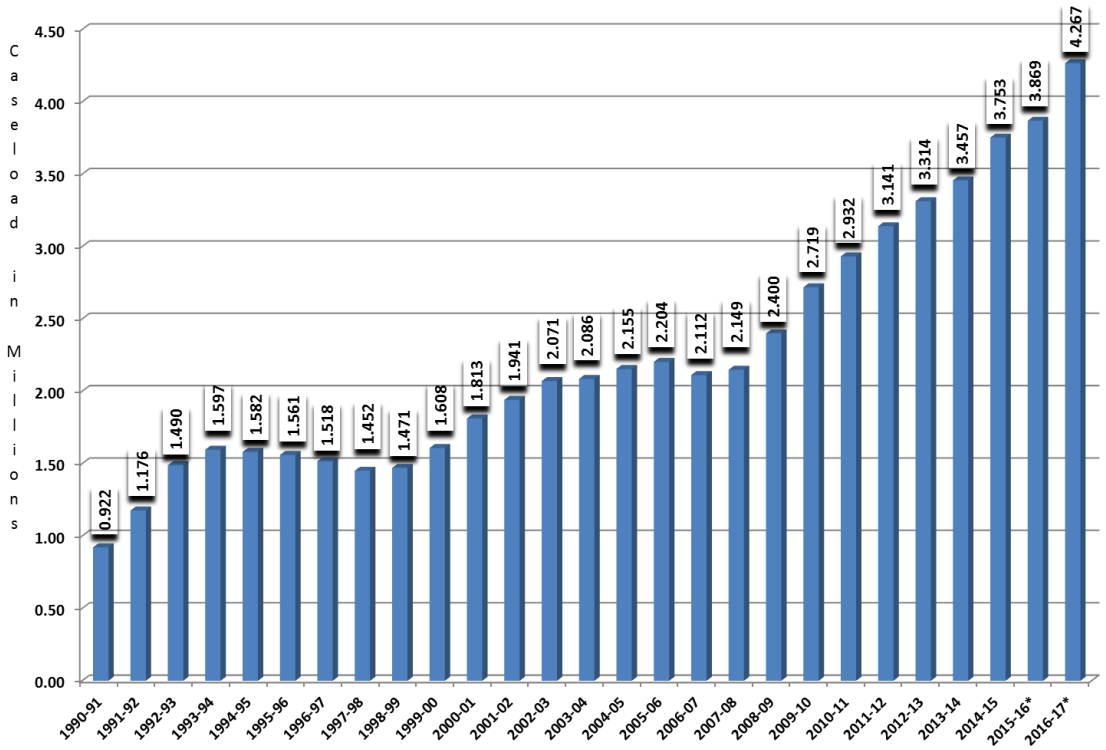
States do have some flexibility. States can ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. For example, Florida has an 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, so-called because it is authorized by Section 1115 of the federal Social Security Act. Similarly, Florida also has a waiver under Sections 1915(b) and 1915(c) of the Social Security Act for the long-term care managed care program. However, waiver authorities are limited and federal laws and regulations are extensive; states do not have the flexibility to design any type of low-income health care program they choose. In addition, waivers require extensive negotiation with the federal Centers for Medicare and Medicaid Services, which depending on the waiver type, is not obligated to respond on any specific timeline.

Florida Medicaid is the second largest single program in the state, behind public education, representing 31 percent of the total FY 2016-2017 budget. Medicaid expenditures represent over 19 percent of the total state funds appropriated in FY 2016-2017. Florida's program is the 4th largest in the nation by enrollment, and the 6th largest in terms of expenditures.[4]

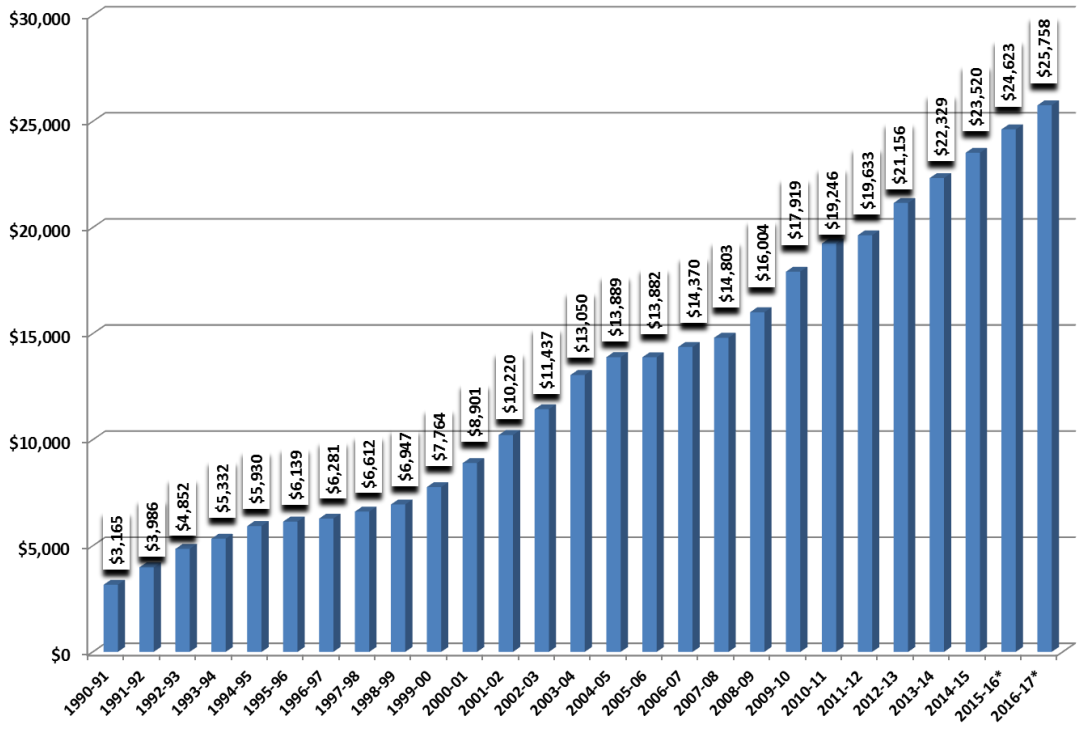
[2] S. 409.905, F.S.
[3] S. 409.906, F.S.
[4] The Henry J. Kaiser Family Foundation, State Health Facts, Total Medicaid Spending FY 2015 and Total Monthly Medicaid and CHIP Enrollment Nov. 2016, available at http://kff.org/statedata/.

Florida's Medicaid costs have increased significantly since its inception in 1967, due to substantial eligibility expansion as well as the broad range of services and programs funded by Medicaid expenditures. The growth in Florida's Medicaid population and expenditures since 1990 is shown in the figures below.

Growth in Medicaid Caseload[5], 1990-2017



Growth in Medicaid Expenditures[6], 1990-2017



[5] Caseloads budgeted in the General Appropriations Act.

[6] General Appropriations Act.

Medicaid Financing

In addition to prescribing the terms of the program, the federal government provides significant funding for state Medicaid programs. Federal funds come in the form of a match for state expenditures. The matching rate, called the Federal Medical Assistance Percentage (FMAP), is set annually by the federal government based on each state's per capita income relative to the national average. States with lower per capita incomes receive higher FMAP, while states with higher per capita incomes receive a lower FMAP. Nationally, the 2017 FMAPs range from 50% (13 states) to 74.63% (Mississippi).[7] Florida's 2017 FMAP is 61%: the federal government pays 61 cents and Florida pays 39 cents of every dollar spent.

The FMAP funding mechanism has no upper limit; whatever amount states choose to spend, the federal government will match. Some policy analysts indicate that this incentivizes states to move state health care expenditures into the Medicaid program, to draw down federal funds and reduce state costs.[8] Conversely, the FMAP funding mechanism means states must share spending reductions with the federal government. This reduces state incentives to pursue improved delivery models that reduce catastrophic or unnecessary spending[9], even assuming such models would be approved by the federal government.

Medicaid Block Grants and Per Capita Spending Models

In general, a block grant is a finite sum of federal funds granted to states for a particular purpose. Unlike mandatory, or entitlement, programs, which obligate the federal government to provide funding for a benefit with no limit on that funding, a block grant is a mechanism to fund a non-entitlement program that provides the federal government greater budget certainty and increases state incentives to control costs[10], while giving states complete flexibility to design the program. Rather than funding increasing (or decreasing) according to state need, the fixed-amount nature of a traditional block grant means benefits and enrollment increase or decrease, rather than funding.

Traditional block grant proposals control costs by imposing hard caps on federal investments.[11] Critiques of such proposals assume they will result in reduced enrollment and benefits, and in cost-shifting to states.[12] However, whether block grants succeed at reducing the rate of cost growth while maintaining an acceptable level of enrollment and service depends on their design.[13]

A variant of a block grant is a per capita funding model. Rather than setting a match rate based on state per capita income, the federal government would set a per enrollee defined contribution. The

[7] U.S. Dept. of Health & Human Svcs., FY2017 Federal Medical Assistance Percentages, available at https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages (last viewed Feb. 18, 2017).

[8] Joseph Antos, et al., *Improving Health and Health Care: An Agenda for Reform*, AM. ENTERPRISE INST. (Dec. 9 2015), http://www.aei.org/publication/improving-health-and-health-care/; John C. Goodman & Peter Ferrara, *Health Care for All without the Affordable Care Act*, NAT'L CENTER FOR POL'Y ANALYSIS (Oct. 17, 2012), http://www.ncpa.org/pub/ib116; Linda Gorman, *Medicaid Block Grants and Medicaid Performance*, INDEPENDENCE INST. (Mar. 2012), https://www.i2i.org/medicaid-block-grants-and-medicaid-performance/.

[9] Id.

[10] Lambrew, Jeanne M., *Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals*, MILBANK Q. 2005 Mar; 83(1): 41–63 at 41.

[11] See, e.g., S 1377, 97th Congress; H.R. 2425, 104th Congress; Bush FY 2004 Medicaid and SCHIP Budget, White House Office of Management and Budget, February 2003, available at http://www.policyalmanac.org/health/archive/medicaid_budget_FY04.shtml.

[12] See, e.g., Edwin Park, M*edicaid Block Grant Would Slash Federal Funding, Shift Costs to States, and Leave Millions More Uninsured*, Center on Budget and Policy Priorities, Nov. 30, 2016, available at http://www.cbpp.org/research/health/medicaid-block-grant-would-slash-federal-funding-shift-costs-to-states-and-leave.
Caroline Pearson, *Capped Funding in Medicaid Could Significantly Reduce Federal Spending*, Avalere Health, Feb. 6, 2017, available at http://avalere.com/expertise/managed-care/insights/capped-funding-in-medicaid-could-significantly-reduce-federal-spending.

[13] Lambrew at 55.

defined contribution could vary by eligibility group, such that a larger contribution would be made for higher-cost enrollees (like disabled persons and frail elders), and a smaller contribution would be made for lower-cost enrollees (like children). The defined contribution could vary by enrollee income, as well, to incentivize states to provide for the most vulnerable low-income people before higher income groups.

In a per capita block grant model, states could supplement the federal contribution in any manner they choose, without affecting the federal contribution. States could vary the state investment by eligibility group, adjust the investment each year, or choose to pay more for one service or type of coverage than another.

A per capita block grant model would allow the program to accommodate variations in state demographics, such as Florida's disproportionately expanding elderly population. Similarly, states would not be harmed by economic downturns that increase enrollment as might occur with a capped block grant model; states could accommodate such events at the level they choose.

A reasonable, predictable funding mechanism that no longer incentivizes state cost-shifting to the federal government, with significant flexibility as to program design could encourage states to make more rational, efficient spending choices, which could reduce the rate of cost growth more naturally than a hard federal cap. In this model, federal cost savings would result not from hard caps, but from state innovation.

Currently, federal Medicaid laws do not authorize block grants, in traditional or per capita form. They can only be authorized by action of the U.S. Congress.

Effect of the Memorial

HM 7033 urges the U.S. Congress to establish Medicaid block grants. The memorial outlines a broad structure for such block grants, requesting Congress to provide block grants based on risk-adjusted, income-adjusted per capita amounts. The memorial requests Congress to index such per capita amounts for inflation, which builds in a rate of growth separate from enrollment. The memorial does not specify the type of inflation to be used for indexing; possible options for negotiation include (but are not limited to) general inflation and medical inflation.

Consumer Price Index Annual Percent Change (U.S. City Average)[14]

Year	Medical Care	All Items
2007	4.4	2.8
2008	3.7	3.8
2009	3.2	-0.4
2010	3.4	1.6
2011	3.0	3.2
2012	3.7	2.1
2013	2.5	1.5
2014	2.4	1.6
2015	2.6	0.1
2016	3.8	1.3
Jan. 2017	3.9	2.5

The memorial urges Congress to allow states to design state Medicaid programs without reference to the requirements of current federal Medicaid laws and regulations, but which would be subject to monitoring by the federal government by measuring state progress at achieving mutually agreed-to outcome measures.

[14] U.S. Dept. of Labor, Bureau of Labor Statistics Data Series, available at https://www.bls.gov/data/ (data extracted Feb. 17, 2017).

The memorial urges Congress to implement the block grants over several years.
Copies of the memorial will be sent to the President of the United States, to the President of the United States Senate, to the Speaker of the United States House of Representatives, and to each member of the Florida delegation to the United States Congress.

Legislative memorials are not subject to the Governor's veto power and are not presented to the Governor for review. Memorials have no force of law, as they are mechanisms for formally petitioning the federal government to act on a particular subject.

B. SECTION DIRECTORY:

Not applicable.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES