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Restructuring Medicaid through a Swap: An Alternative to a Block Grant

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Introduction

The United States is now engaged in a major policy debate about the future of entitlement programs, including the Medicaid program. There is a widespread belief that these programs are contributing to growing federal debt and without some reform will continue to do so for a long time. Both the Centers for Medicare and Medicaid Services studies (CMS actuaries) and the Congressional Budget Office (CBO) project Medicaid spending to continue growing faster than the economy. CMS actuaries project Medicaid spending to increase by about 7 percent per year from 2010 to 2019, with the exception of an 18 percent growth in 2014, when the Medicaid expansion component of the Affordable Care Act (ACA) is implemented.[1]

The CBO projections are harder to interpret because they assume the Medicaid expansion would be phased in between 2014 and 2016.[2] The CBO projects Medicaid spending to increase by 6.9 percent between 2016 and 2020. Spending in the CBO baseline is virtually unchanged between 2010 and 2014 as the nation exits the economic downturn. Beginning in 2014 and continuing until 2016, spending increases for all groups but particularly for adults because of the ACA. After the large increase in enrollment due to the ACA, Medicaid enrollment is projected to grow at about 1.3 percent per year. This yields a projected growth in spending per enrollee of about 5.5 percent. The growth rates in spending projected by both CMS actuaries and the CBO are faster than growth in gross domestic product (GDP) over the same period, 4.6 percent. Assuming the CMS and CBO Medicaid spending projections are accurate, Medicaid will clearly contribute to the ongoing federal deficit problem.

In response to the deficit problem, Congressman Paul Ryan has proposed that Medicaid be turned into a block grant with fixed allocations of federal funds to states. The block grant would be based on current expenditures in 2012 and grow at the rate of the consumer price index plus population. This is about 3.0 percentage points each year below the expected rate of increase in Medicaid spending. A block grant would clearly save money at the federal level but would shift a large share of the cost of Medicaid programs to states. States have generally controlled spending per enrollee at rates that are favorable in comparison to other payers. Most Medicaid spending growth has been due to enrollment growth, particularly during the two economic recessions of the past decade and medical care inflation. States will have a difficult time controlling spending on a per enrollee basis significantly more than they have, even with the increased flexibility they ask for. This will likely mean that states will have to spend more of their own money or that they will reduce coverage. This will mean a rising number of uninsured; it will also mean more uncompensated care that state and local governments must finance with no federal matching payments.

As part of its many recommendations for deficit reduction, the Bipartisan Policy Center Debt Reduction Task Force in November 2010 proposed a major change in federal and state responsibilities for Medicaid (a swap), designed to address incentives with the current matching rate structure that have led to state efforts to “game” the system, that is, bringing in new federal spending with little or no real state matching

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expenditures.[3] The proposal would greatly reduce the incentives for gaming and reduce federal spending but has serious distributional effects—there would be large winners and losers among states.

This paper presents an approach that would restructure Medicaid with a form of a swap that would build upon the coverage expansion in the Affordable Care Act, largely eliminate incentives for creative financing, mitigate problems that the recessions cause for the current system, and strengthen incentives for cost containment. The proposal would not have the distributional effects that a straightforward swap proposal would have. The proposal would provide savings by greatly reducing the ability to use "creative financing," and have some effect on reducing spending growth. How much would be saved is uncertain because, as noted, Medicaid expenditures have not grown significantly over and above enrollment growth and inflation, particularly compared with other payers.

Background

Two prominent commissions charged with entitlement reform, the President's National Commission on Fiscal Responsibilities and Reform and the Bipartisan Policy Center Debt Reduction Task Force, have made proposals to curtail Medicaid spending. Both commissions recommend placing dual eligibles in Medicaid managed care.[4] The need for coordination and management of the care of these extremely expensive individuals is indisputable, but whether it should be a federal Medicare initiative or left to Medicaid is not clear. The Bipartisan Policy Center argues that Medicaid has far more experience with managed care. This may be true but not necessarily for such a medically complex population like dual enrollees, and certainly not in all states. Federal savings may be greater if responsibility for duals was a federal initiative, for example, led by Medicare. Most savings from chronic care management programs are in acute care (e.g., reduced hospitalizations, fewer readmissions, better drug management) and thus would be realized by Medicare not Medicaid.[5] Both commissions also addressed the problem of states' "gaming" the Medicaid matching rate system, that is, state efforts to bring in federal matching dollars with little or no state expenditures. The President's Commission argued such activities be reduced and eventually eliminated.[6] The Bipartisan Policy Center proposal took a stronger stand against these gaming practices, calling the Medicaid system dysfunctional.[7] It argues that states have searched for and have found a wide range of ways of bringing in federal dollars. It also contends that as long as the federal matching rates structure is in place, the incentives for gaming remain and it will be difficult for the federal government to control Medicaid spending levels. The Bipartisan Policy Center argued that there should be a complete shift in responsibilities with some program responsibilities being shifted entirely to states and the remainder to federal government. The Center suggests this could be done by population groups; for example, one level of government taking over the care for the elderly and disabled and the others taking over families. Alternatively, there could be a swap of acute and long-term care.

There is a wide range of ways in which Medicaid gaming has taken place.[8] Generally, arrangements are variants of the following: If a state wants to increase the money going toward hospitals, it can raise reimbursement rates by say $100. Hospitals would pay a tax of $50. Assuming a 50 percent matching rate, the federal government would contribute a matching contribution of $50. The tax payment made by the hospitals would be returned to them; hospitals would be better off by the amount of the federal payment and the state would pay nothing. In some cases, a portion of the federal payment would also be returned to the state, in which case the state has actually gained money in the transaction.

States have used these arrangements for many years. They began with states making disproportionate share payments to hospitals that were funded by provider taxes. Subsequent limits on the ability and the amount of money that could be spent through disproportionate share payments led to the development of supplemental payment programs. Constraints on the use of provider taxes led to intergovernmental transfers and certified public expenditures. In supplemental payment programs, reimbursement rates could be

increased up to Medicare levels but with the state share financed through, say, intergovernmental transfers with local funds sent to the state but subsequently returned to the original source. These efforts have been carried out in many other ways, particularly when the ultimate provider was a state or local entity. These policies are legal and have been approved by the federal government under both Democratic and Republican administrations. While legal, they certainly undermine the spirit of the matching rate structure in Medicaid law and have increased federal spending considerably. According to the Government Accountability Office (GAO), these efforts are continuing to emerge; from 2009 to 2010, 38 states reported introducing new provider taxes, 35 reported new or increased use of intergovernmental transfers, and 35 new certified public expenditure programs.[9]

States have also brought many state-funded services into Medicaid.[10] While this is legitimate, the states have expanded the reach of the Medicaid benefit package to allow it to fund many previously state-funded programs with federal matching contributions. States have an incentive to push as much of state public health, social service, mental health, and substance abuse spending onto Medicaid as they can. Some observers comment that states think of Medicaid as a verb and often make "Medicaidization" a top priority. The GAO has cited the use of targeted case management programs, rehabilitation services, and school-based clinics as other areas where the state share is questionable.[11]

There is a long history of federal efforts to constrain Medicaid gaming that have been somewhat successful. At the same time, legislators have often resisted strong efforts, wanting to protect their own states. The reality has been a constant stream of efforts by states to bring in federal dollars, followed by federal government efforts to limit the initiatives, followed by creative new efforts by states. The result is the federal government pays for a higher level of Medicaid spending than was intended or set out in law. Measuring the degree to which the federal spending is higher is almost impossible. The effect of Medicaid gaming also means that we do not know how much money the nation is spending on Medicaid because some of the state share is not real spending but funds essentially making a round trip from provider (or locality) to state and back to provider (or locality) without adding to the money spent for health care. Since the state spending level is overstated, the total amount spent on Medicaid is also overstated.

The incentives in the ACA will likely exacerbate the problem of Medicaid gaming. For example, under reform, the increase in a provider tax needed to leverage additional federal dollars will be substantially lower, at least for new eligibles for whom the federal matching rate will begin at 100 percent and phase down to 90 percent. A relatively small new provider tax will allow a state to generate federal matching payments of 90 percent. For example, a provider could pay a tax of $10; the state could increase provider payments to $100. The federal government would make matching payments of $90. The provider gains by $90, the federal government spends $90 and the state pays nothing. If the state wishes, it can keep some of the gain by increasing the provider tax. (This example is purely for illustration; any increase in provider payment would also be made on behalf of current enrollees for whom the current matching rate applies—the new average matching rate would be a combination of the higher rates on new eligibles and the current matching rate for current eligibles.)

The Bipartisan Policy Center Proposal

Given these problems, the swap proposal of the Bipartisan Policy Center is worthy of attention. The Center proposes to shift responsibilities for some parts of Medicaid entirely to the federal government, and the rest would devolve to states.[12] Their proposal is not heavily prescriptive as to what services should be shifted. One approach is a "swap" of Medicaid responsibilities — with acute care becoming a federal responsibility and long-term care a state responsibility. Swapping along population lines (for example, the federal government is responsible for the elderly and disabled and states are charged with families) is another option but it would leave both levels of government responsible for managing both acute and long-term care. While it would be advantageous for one level of government to have full

responsibility for dual eligibles, what seems most important is having one level responsible for the acute care services of dual eligibles, even for those residing in long-term care settings. Further, a swap of populations would complicate the implementation of health reform. For example, with the expansion of coverage under health reform, it seems easier for the federal government to pay for what is now Medicaid acute care along with income-related subsidies.

A swap of acute and long-term care has a fundamental problem (as would a swap of populations) in that it creates many large winners and losers. States with large long-term care programs relative to the amount of acute care would likely be losers under a swap of acute and long-term care. States with high matching rates would gain less from having the federal government take over acute care because the federal government is paying such a large share already. Depending on the commitment of these states to long-term care, they would have to pick up the entire federal share, which, given high matching rates, could be substantial. States with a high ratio of acute to long-term care tend to be winners, particularly those with high matching rates.

Estimates of the gains and losses in a single year are shown in table 1. Alabama and Mississippi would lose because they already have high matching rates on their acute-care spending and would have to take over all federal long-term care expenditures. Maintaining their current long-term care programs would require increases in state expenditures (from their own revenues) by 22.8 percent.

California and Texas would be winners because they have much more acute-care spending than long-term care. They could reduce state expenditures by 22.7 and 29.6 percent, respectively, and still maintain their current long-term care programs. These large gains and losses would make such a proposal politically infeasible. Efforts to compensate losers without taking from winners would be quite expensive for the federal government. A swap that would shift full responsibility for the elderly and disabled (or dual eligibles) to the federal government and adults and children to states would have even worse consequences for lower income states, especially with the coverage expansion in the Affordable Care Act.

An Alternative Proposal

An option to restructure Medicaid, one that would likely reduce Medicaid spending growth, is set out below in four steps. The proposal changes incentives at the margin—federal or state government has full responsibility for spending growth—without the large distributional effects shown above.

1. *Shift all state Medicaid premiums and cost sharing for dual eligibles now paid by states to the federal government.* In other words, the federal government would be fully responsible for all Medicare-related obligations for duals; there would be no state maintenance of effort. This would clearly be a win for states and an increased cost to federal government, but it would place all Medicare financing at the federal level and provide some fiscal relief to states. It would be consistent with some of the other proposals to rationalize Medicare premiums and cost sharing.[13] Instead of ending premium assistance when the Medicare savings programs phase out with an abrupt increase in Medicare premiums, premiums could increase with incomes as with the premium schedule in the ACA for the nonelderly. This would increase federal costs, but not substantially, and consolidate all acute care spending on Medicare beneficiaries at the federal level.

2. *Shift all spending for Medicaid acute care for children, adults, and non-dual disabled to the federal government.* The federal government would administer the acute care program and could perhaps redefine the benefit package to be less extensive or keep it as is. If the benefit package were tightened, some services covered by Medicaid would shift back to being a state responsibility. The benefit package would be the same across all states — no more mandatory and optional services. To avoid the distributional effects described above and thus avoid large gains and losses, there would have to be a state "claw-back" payment equal to current state payments.

States would not have to pay for new enrollees in the ACA, meaning a small increase in federal spending. States would pay the same amount initially as they do under current law, but this payment would grow over time by, say, the increase in GDP, slower than the anticipated growth in state Medicaid spending.

States would thus save by the amount of this differential between growth in GDP and growth in spending that would have otherwise occurred. Moreover, states would have much more predictability in their spending, which would no longer spike in recessions (in fact, it would fall as GDP declines). The claw-back would be adjusted to reflect any changes in the benefit package. The federal government would bear any incremental cost to the extent the spending growth increases beyond GDP growth. The federal government would now have full responsibility for cost containment for acute-care services for the current Medicaid population. It would probably also be necessary for the federal government to take over the Children's Health Insurance Program (CHIP) and integrate the two programs or to roll CHIP into the health insurance exchanges with appropriate benefit enhancements. The state claw-back would also include current state payments for CHIP plus any adjustments to account for increases or decreases due to the ACA.

3. *Shift Medicaid long-term care services to the states under a closed-end matching grant.* States would receive a payment equal to current federal spending in the state based on current long-term care spending per low-income individual over a certain age. Long-term care spending would be most nursing home and home health care, institutions for mental disease, intermediate care facilities for the intellectually disabled, personal care services, and home and community-based waiver services. Current federal spending in each state would be increased over time by GDP, adjusted for the greater increase in the population over age 65. The latter is necessary to avoid states being hit by the cost of the growing aging population. The growth rate for federal spending would be adjusted to reflect the long-term growth in GDP; thus, payments would not decline in recessions. Because of the wide variation in long-term care spending, maximums and minimums could be established, with states above the maximum having a lower rate of growth. States below the minimum could be allowed to grow faster.

   A set of federal guidelines would be developed that would provide minimum federal standards for eligibility and benefits that states would have to meet to get continued federal funds. Under a closed-end matching grant, states would only receive federal matching funds if they both met minimum standards and spent their commensurate matching share. Federal outlays would be capped as described above; if state spending grew faster than GDP, as adjusted for an aging population, the state would be responsible. There would still be the risk of states using creative financing to generate the state share but only up to the cap on the matching grant. Federal spending beyond the cap could not be affected. Below the cap, however, the potential for state gaming remains and would have to be monitored.

4. *Eliminate or greatly reduce Medicaid disproportionate share hospital payments.* Under this proposal, the federal government would take over responsibility for acute-care services in Medicaid. Under the ACA, the number of uninsured will decline substantially. The savings to states from Medicare premiums and cost sharing along with the other savings in this proposal, and all the other ways states gain from the ACA, should allow states sufficient funds to help local hospitals deal with the problems of the remaining uninsured. Alternatively, the distribution of disproportionate share hospital funds could be restructured, as called for in the ACA.

Advantages

This proposal has several advantages over the current system. For one, it would greatly reduce most of the incentives for states to game Medicaid. Without such a change, incentives for

states to increase gaming would actually increase under ACA. There would be a clearer delineation of what is a Medicaid health benefit. No creative financing can increase federal payments because the acute care is fully a federal responsibility. States could continue to use intergovernmental transfers and provider taxes or whatever mechanisms they want to finance the state share. But no actions a state could take would result in higher federal payments. These payments would be set by policies established by the federal government designed to achieve goals of access and cost containment. Long-term care allotments would also be predetermined and could not be manipulated.

Second, all acute care for the poor would now be a federal responsibility. There would no longer be 52 governmental entities making acute-care policy for low-income Americans. There would be predictable state contributions, but any faster growth in spending would be the federal government's responsibility. Many state leaders complain vociferously about Medicaid year in and year out. Many also strongly oppose health reform; financing of health reform would no longer be a state problem.

Third, much of the very difficult problems that states have had with the business cycle (e.g., increased enrollment and loss of tax revenue) would go away. The federal government is in a much better position to handle countercyclical problems. State payments would fall with GDP, while federal payments for acute care would rise automatically. Federal payments for long-term care would reflect long-term GDP growth and thus would not fall off in recessions; they could also be adjusted upward. The endless debate over the timing and amount of federal relief during recessions would end, as would the cliffs that occur when assistance ends.

Fourth, the problems that will likely emerge under the ACA with different matching rates for new and old eligibles would be eliminated. This includes the equity issues in how different states are treated — new eligibles have much higher matching rates than current eligibles and states have very different proportions of new and current eligibles. There is also the complex administrative issue of identifying for each new applicant whether they are eligible under old or new rules.

Fifth, there would be opportunities for more rational payment systems, including increases in some provider payments, which should improve access. The federal government through its payment policies would have far more ability to affect access, quality, and costs because of the ability to coordinate Medicare and Medicaid payments. This should not only affect levels of payments but efforts to adopt policies toward hospital readmissions, bundling, medical homes, and accountable care organizations. Having all these policies affect many more lives should accelerate reform of the delivery system.

Sixth, the proposal would also facilitate more rational policy toward dual eligibles. Both commissions argued for placing dual eligibles in Medicaid managed care. The problem here is that Medicaid is not currently responsible for most acute care for dual eligibles; rather, Medicare pays for most acute care. Under this proposal, managing acute care for dual eligibles, even those in nursing homes, would be a federal responsibility. The federal government would have added incentives to develop and improve special needs plans because it would receive all of the benefits from savings. States would be responsible for long-term care policy, including reducing institutionalization and coordinating community based care. This proposal does not solve the problem of coordination across acute and long-term care, which would still require federal-state cooperation.

Finally, the proposal would probably result in the ACA covering more of the uninsured. The federal government would use funds for outreach and participation and would not rely on state efforts to enroll individuals. Enrollment would now be handled through exchanges, but since both the federal subsidies and Medicaid acute-care program would now be federal, problems of coordination would be substantially reduced.

States have expressed concerns over taking on responsibility for long-term care expenditures because of the fear future costs would increase because of the growing elderly population. But in truth, acute-care spending has been growing faster than long-term care spending for many

years, even after adjusting for differences in enrollment growth.[14] This is because the latter is very labor intensive, unlike acute care, where technology and pharmaceuticals drive expenditure growth.

Some also raise concerns over a race to the bottom and poor treatment of elderly and disabled populations, but the risk can be overstated. States now provide a considerable amount of long-term care services. What is often not appreciated is that most of these services are optional services provided to optional groups. States are required to provide long-term care services for cash recipients, essentially the supplemental security income (SSI) population. Nursing home care is a mandatory benefit. Other long-term care services, such as personal care, home and community-based waivers, intermediate care facilities for intellectually disabled, and mental hospitals are all optional benefits. Most of the individuals who receive these benefits are also optional groups. So states already spend well beyond what they are required to spend by federal law. Since states would only receive large federal payments that would increase with population aging if they expended matching funds, state efforts should be maintained. Political pressure from disabled and elderly constituencies, many from middle-class families, as well as provider interests should also help.

States would have more flexibility in developing long-term care policy. They could develop home and community-based care programs to reduce institutionalization without the need for waivers and the need to prove budget neutrality. The wide range of new long-term care initiatives in the ACA would be available to states. A downside of shifting responsibility for long-term care to states is that state performance would vary; but the reality is that it already does. Medicaid long-term care spending per low-income person varies by state by a factor of ten as opposed to a factor of three for acute care.[15] Many states provide poor long-term care services today, and that is not likely to change absent a broader rethinking of long-term care policy.

A significant problem with this proposal is that it would be a major change in the middle of many other major changes. States now have a fair amount of administrative capacity in managing acute care; this would have to be expanded under the ACA, but nonetheless, there is a base to build on. The federal government now administers Medicare, with the help of intermediaries, and this capacity would have to be expanded considerably under this kind of a swap. This could include making use of state administrative capacity.

Conclusion

The swap proposal outlined here has the potential to improve the efficiency of the current Medicaid program and reduce the rate of growth in spending. The federal government would save by eliminating most incentives for Medicaid gaming and to the extent it was able to control the rate of growth in spending over time below currently projected rates. The federal government would also have its liability for long-term care fixed. Medicaid's contribution to the federal deficit would thus be lessened. The proposal would help ease state opposition to the ACA, would eliminate the complex matching rate structure in the ACA, would help accelerate payment and delivery system reform, and end problems of financing Medicaid during economic downturns.

States would save on acute care because their acute-care claw-back payment would be less than the baseline projections and to the extent they managed their long-term care programs more efficiently. They would also gain by no longer paying the state share of Medicare premiums and cost sharing. They would, of course, be adversely affected by losing most opportunities for Medicaid gaming.

Table 1: Gains and Losses to States from an Acute-Long-Term Care Swap

State	Gain or loss to state from shifting acute care to federal government and long-term care to state government (In millions of dollars)	Gain or loss as a percent of state Medicaid expenditures
Alaska	135.6	25.0
Alabama	-333.0	-22.8
Arkansas	-368.7	-38.0
California	4,889.2	22.7
Colorado	313.6	17.3
Connecticut	-570.7	-18.5
Delaware	265.6	42.0
District of Columbia	13.8	2.8
Florida	1,633.1	23.5
Georgia	481.1	17.1
Hawaii	337.4	56.9
Idaho	-52.9	-13.2
Illinois	2,740.2	40.8
Indiana	-194.4	-9.0
Iowa	-333.1	-29.0
Kansas	-142.3	-14.2
Kentucky	35.6	2.1
Louisiana	-451.4	-23.2
Maine	15.8	1.7
Maryland	1,019.9	30.8
Massachusetts	2,426.6	38.5
Michigan	1,463.1	34.1
Minnesota	352.2	9.4
Mississippi	-437.0	-44.5
Missouri	512.5	17.5
Montana	-105.8	-36.8
Nebraska	-109.1	-16.1
Nevada	201.2	28.3
New Hampshire	-16.9	-2.5
New Jersey	121.7	2.5
New Mexico	431.4	45.0
New York	1,459.8	5.7
North Carolina	316.8	7.5
North Dakota	-168.5	-78.3
Ohio	-788.0	-14.6
Oklahoma	-24.3	-1.8
Oregon	-47.1	-3.4
Pennsylvania	748.3	9.4
Rhode Island	219.4	24.2
South Carolina	95.9	6.1
South Dakota	-23.8	-8.6
Tennessee	452.2	16.7
Texas	2,937.3	29.6
Utah	12.4	2.5
Vermont	-7.1	-1.7
Virginia	563.8	19.2
Washington	816.4	24.6
West Virginia	-345.5	-50.5
Wisconsin	594.9	21.1
Wyoming	15.4	5.7
National Total	23,913.6	14.8

Source: Urban Institute estimates based on data from the 2009 CMS Form-64 and the Federal Register (Volume 72, Number 228, pp.67305).

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