DISABILITY LAW CENTER OF ALASKA

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To: People interested in Medicaid
From: Gayne Kalustian-Carrier and Mark Regan, Disability Law Center
Date: June 20, 2019, updated October 8, 2019
In re: Block grants, per capita caps, or global spending limits to implement a "private option"

The State has commissioned a contractor to propose how our Medicaid program could enroll people in Qualified Health Plans – the same sorts of plans that Premera Blue Cross Blue Shield now operates for people in the individual insurance market. An important question raised by the contractor's report[1] is whether, if the State sets out to use private market coverage for Medicaid enrollees, framing the proposal in terms of a block grant or per capita cap or global spending limit would make it possible for the proposal to satisfy federal cost neutrality requirements.

More specifically, the State asked the contractor to evaluate whether people covered under the Medicaid expansion may be required to get their coverage through Qualified Health Plans; whether people getting Medicaid as caretaker relatives of children, with incomes above 50% of the poverty line, may be required to get their coverage through Qualified Health Plans; whether the State may deny coverage to people who do not satisfy work requirements; and, finally, whether a block grant system would be helpful in implementing the proposed changes.

The contractor suggested that the State consider using Medicaid to pay people's way into Qualified Health Plans, and put together an 1115 waiver[2] that might find "shared savings" for the State to use, and to draw down federal funds for.[3] It proposed a "global expenditure cap" instead of a "block grant" or a "per capita cap," and called attention to the strong possibility that putting people in Qualified Health Plans would cost the State more money than enrolling them in standard Medicaid.[4] Finally, the contractor's report indicated that proceeding with a work requirement program at the same time as a block grant and a switch to Medicaid's paying for private health plans might be too complicated to pull off in a single 1115 waiver.[5]

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[1] Public Consulting Group, "Alaska Proof of Concept Analysis – FINAL," August 5, 2019, available at https://affordablecareactlitigation.files.wordpress.com/2019/08/pcg_medicaid_reportl.pdf.
[2] Section 1115 is codified at 42 U.S.C. § 1315.
[3] Proof of Concept Analysis at 41-47.
[4] Proof of Concept Analysis at 47.
[5] Proof of Concept Analysis at 43.

Our focus is not so much on the "private option" itself as on the way the contractor suggests the additional federal money necessary to pay Medicaid recipients' way into private health plans could be found.

Our basic conclusions are (1) that a block grant system would not add much to Alaska's other proposals, such as forced privatization and work requirements, and would create considerable legal and practical uncertainties, including whether block grants could be implemented at all under current federal Medicaid law; (2) that, in addition to changes in state statutes, federal 1115 waivers would be necessary to force people who are enrolled in Medicaid under categories other than the Medicaid expansion to receive their services from a Qualified Health Plan and to impose work requirements on enrollees;[6] (3) that federal law allows a state to restrict the benefits available to people who are getting coverage under the Medicaid expansion to parallel the benefits available in a Premera policy, but that this, too, would take a change in state Medicaid statutes; and (4) that the idea that "shared savings" could pay the additional costs of transferring people over to private health insurance won't work.

These conclusions come with a disclaimer: many of the issues facing Alaska now are unsettled and, in the case of the block grant/per capita cap/global spending cap, completely untested. (No other state currently operates its Medicaid program through a block grant. The federal government is considering, but has not yet released, a Dear State Medicaid Directors letter on how Medicaid block grants would work. Tennessee's block grant proposal, released September 17,[7] amends a complex existing 1115 waiver and thus covers much different ground than the Alaska system envisioned by the State and its consultant.) Our conclusions amount to predictions about which provisions of the Medicaid Act will be obstacles to the program the state administration has announced it would like to implement. The contractor's analysis's bottom line is quite different than ours, as are the issues on which it concentrated. Our analysis raises more questions about what the law allows than the contractor's does.

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[6] The Medicaid and Affordable Care Acts draw several legal distinctions between traditional Medicaid enrollees and enrollees made eligible by the ACA. These distinctions sometimes disparately affect a state's power to alter the terms of Medicaid with respect to one, or the other, group. For example, individuals made eligible for Medicaid by the Affordable Care Act may be limited to "benchmark benefits" even though the State does not apply for and receive an 1115 waiver. 42 U.S.C. §§ 1396a(k) and 1396b(i)(26). The traditional Medicaid population probably may not be forced to receive benchmark benefits without a waiver. In certain circumstances, however, a state's power with respect to the two is identical. For instance, a state will need to seek a waiver in order to impose work requirements on *any* Medicaid recipients. *See* 42 U.S.C. § 1396a(a)(10)(i). Also, even if the scope of benefits is the same as Premera offers for the expansion population, forcing people in the expansion to get benefits through Premera or Moda would require a waiver.

[7] See https://affordablecareactlitigation.files.wordpress.com/2019/09/tenncareamendment42.pdf

I. What is Medicaid? What are block grants?

Medicaid is a jointly funded federal-state program which provides health insurance to vulnerable individuals. Costs of running the program are split between the federal government and the states. The federal government commits to paying a percent of the cost of each state's plan and currently does not place an overall limit on the amount of federal funding a state can receive. States operate their Medicaid programs by complying with a large number of federal conditions. For example, 42 U.S.C. § 1396a(a) lists more than 80 conditions state plans must meet for states to receive federal matching funds. Additional conditions are contained elsewhere in the Medicaid Act.

A block grant would reduce the number of federal funding conditions, and – under some versions of the block grant – provide a set amount of federal funding for Alaska that would not change if the State spent more of its own dollars on the program than anticipated.

.Recently, the Trump administration urged Alaska to apply for a Section 1115 waiver to pilot block-granting the federal share.[8] At the same time, the Tennessee legislature enacted a bill directing Governor Lee to apply for an 1115 waiver to block grant Medicaid;[9] the State duly released a draft of its waiver amendment proposal on September 17, 2019.[10] Alaska solicited proposals on a proof of concept analysis,[11] selected a contractor on May 29, 2019,[12] and got the contractor's report, a bit more than a month late, on August 5.[13] Meanwhile, the Centers for Medicare & Medicaid Services (CMS) is working on a "Dear State Medicaid Directors Letter" that would set out its interpretation of whether and how block grants might work under existing statutes.

While no state has block-granted Medicaid, some proposals have come close. CMS has already approved Utah's 1115 waiver application placing a per capita cap on Medicaid funding for certain eligibility categories.[14] Utah is seeking additional approval of an 1115 waiver which

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[8] Nathaniel Weixel, *Trump administration urging Alaska to be first to apply for Medicaid block grant*, The Hill, Apr. 4, 2019, last accessed June 17, 2019, available at https://thehill.com/policy/healthcare/437369-trump-administration-urging-alaska-to-apply-for-medicaid-block-grant.

[9] Pub. Char. No. 481, HB 1280, SB 1428, May 29, 2019, available at https://legiscan.com/TN/text/HB1280/id/2029577/Tennessee-2019-HB1280-Chaptered.pdf

[10] Division of TennCare, *TennCare II Demonstration Amendment 42 DRAFT*, available at https://affordablecareactlitigation.files.wordpress.com/2019/09/tenncareamendment42.pdf.

[11] *Informal Request for Proposals (IRFP) # 190000114: Proof of Concept Analysis*, Dep't of Health and Social Services, State of Alaska, May 10, 2019.

[12] Elwood Brehmer, *State awards contract for Medicaid block grant study*, Alaska Journal of Commerce, June 5, 2019, last accessed June 17, 2019, available at http://www.alaskajournal.com/2019-06-05/state-awards-contract-medicaid-block-grant-study.

[13] https://affordablecareactlitigation.files.wordpress.com/2019/08/pcg_medicaid_report1.pdf.

[14] *Demonstration Approval*, Centers for Medicare & Medicaid Services, Dept' of Health & Human Services, Mar. 29, 2019, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-ca.pdf.

would, in addition to keeping the per capita cap, increase the federal medical assistance percentage ("FMAP") for the Affordable Care Act (ACA) population despite not offering Medicaid to all individuals up to 133 percent FPL.[15] In its most recent 1115 application, Utah suggests establishing a per enrollee base amount for each relevant enrollment group, adjusted each year by the medical consumer price index.

Whether Utah will be able to proceed with anything like its initial proposal is doubtful. When CMS informally rejected the idea of providing 90% federal match even though Utah has not yet raised the eligibility threshold to 133% of poverty and would do this only with an enrollment cap, CMS moved Utah into a complicated series of fallbacks,[16] and it's not at all clear what will happen, or when.

A per capita cap, as proposed by Utah, is different than a block grant – it provides more federal money if more people are enrolled in Medicaid. A block grant involves a single federal sum that does not vary by enrollment. Both ideas ultimately feature a federal cap and have been prominent in recent political proposals to change Medicaid.

For example, the federal Better Care Reconciliation Act (BCRA) of 2017[17] – a bill which would have passed the Senate but for Senators Murkowski's and Collins's no votes, and Senator McCain's "thumbs down" – set forth two possibilities: per capita cap funding and block-granting for certain eligibility categories. Under the BCRA's block grant scheme, states would have received a block grant to provide services for non-disabled, nonelderly adults, or for the ACA expansion group, or both. In exchange for assuming additional financial risk, participating states would have been able to impose other conditions of eligibility and forego fulfillment of several of Medicaid's traditional requirements for those two categories of recipients. Though the Act ultimately did not pass, its terms may provide insight into the block grant proposal being formulated in Juneau on the recommendation of Public Consulting Group.

A straight block grant scheme in Alaska might well cause many residents to lose some, or all, of their health coverage, if the State ran out of money to pay for services and the federal government was barred by the block grant from making up for the shortage.

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[15] *Utah Section 1115 Demonstration Application: Per Capita Cap*, Utah Dep't of Health, available at https://medicaid.utah.gov/Documents/pdfs/Utah%201115%20Demonstration%20Application-%20Per%20Capita%20Cap-%2031May2019.pdf, last accessed June 17, 2019.

[16] Wendy Leonard, "Utah inching toward full Medicaid expansion after latest fed rejection," August 22, 2019, https://www.deseret.com/utah/2019/8/22/20828699/utah-full-medicaid-expansion-after-latest-federal-government-rejection.

[17] H.R. 1628, 115th Congress (2017), available at https://affordablecareactlitigation.files.wordpress.com/2018/09/ern17500.pdf.

The State's consultant has suggested that the State might be able to gain additional federal funding through "shared savings" achieved by the waiver, by analogy to additional federal funding allowed to New York State in a 2016 waiver amendment.[18]

However, as the law stands today, block granting Medicaid via a Section 1115 waiver may not be possible because (1) a block grant financing structure does not fit into the reimbursement scheme established by the Medicaid Act, and (2) 1115 waivers cannot modify provisions of the reimbursement statute.

Also, because 1115 waivers need to be budget neutral, it is very hard to see how "shared savings" would allow for new federal money to come in to the system to support a private option.

II. As a general matter, Medicaid's federal funding mechanism operates on an estimate, payment, and audit system which calculates federal financial participation based on a state's quarterly expenditures – inconsistent with a block grant.

Generally, 42 U.S.C. § 1396b directs the federal government to collect state Medicaid expenditure reports (or state Medicaid expenditure projections) and pay federal matching funds to the states using various FMAPs. Under 1396b(a)(1), the central idea is:

> (a) Computation of amount. From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this subchapter, for each quarter, beginning with the quarter commencing January 1, 1966—
>
> > (1) an amount equal to the Federal medical assistance percentage (as defined in section 1396d(b) of this title, subject to subsections (g) and (j) of this section and section 1396r–4(f) of this title) of the total amount expended during such quarter as medical assistance under the State plan;

Each other provision under 1396b(a) establishes a different percentage that needs to be paid in response to the sums expended or potential limitations on federal reimbursements. For example, Alaska's general FMAP is 50 percent, but the federal government will pay 75 percent of costs

[18] Proof of Concept Analysis at, e.g., 32-35, 42, and 47. The amendment, available at https://affordablecareactlitigation.files.wordpress.com/2019/08/ny-medicaid-rdsgn-team-appvl-120716.pdf, indicates that from 2014 through 2020 New York could receive up to $8 billion in new federal funds for "Medicaid Redesign Team" activities. Amendment approval at 46. Although the consultant's analysis does not acknowledge this, the activities through which New York proposed to draw down this funding principally involve incentive payments to providers and are not directly relevant to Alaska, even as a model.

attributable to translation or interpretation services used in connection to program enrollment. 42 U.S.C. § 1396b(a)(2)(E).

However, estimates, not expenditures, trigger the release of federal funding at the beginning of the quarter for initial, prospective reimbursement. Under 1396b(d), prior to the beginning of each quarter, the Secretary will estimate the reimbursement due to the state and distribute those funds to the state. The Secretary will base the estimate on both a report authored by the state estimating its total expenditures and "such other investigation as the Secretary may find necessary." At the start of the next quarter, the state is audited, and under- or overpayments are built into the next quarters' federal outlays.

The main question, so far as block grants are concerned, appears to be whether this projections/payments/audits system might allow for payments to be made solely on the basis of agreed-upon projections – that is, without reference to what the State eventually is found to have spent.

We think the answer to this question is no. Current regulations require the disposition of federal funds be made and reported on the basis of actual expenditures, not estimates. 42 C.F.R. § 430.30(c)(2).[19] The Secretary could change these regulations, but he or she may not rewrite the statute. The statute itself speaks in terms of reimbursement, which is contrary to the idea of an up-front block grant.

III. Section 1115 waivers do not enable states to change the structure of Medicaid from a reimbursement to a block grant system because they reach only state plan requirements and not the funding mechanism.

Section 1115 of the Social Security Act empowers the Secretary to grant waiver requests for (1) experimental, pilot, or demonstration projects (2) he or she judges "likely to assist in promoting the objectives" of Medicaid. 42 U.S.C. § 1315(a)(1). To be approved, an 1115 waiver must be budget neutral in terms of federal spending.

a. State Plan Requirements in § 1396a

By its terms, section 1115 enables waiver of only those requirements contained in 42 U.S.C. § 1396a. *Id.* The reimbursement requirements are not directly found in § 1396a. Moreover, cross-

[19] The grants are also subject to the requirements of 45 C.F.R. 75, with the exception of 45 C.F.R. 75.306 (Cost sharing or matching) and 45 C.F.R. 75.341 (Financial reporting). 42 C.F.R. 430.30(e). That Part — Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards — provides that fewer requirements govern fixed amount awards than govern grant agreements and cooperative contracts. 45 C.F.R. § 75.101. Regulations can be changed by the Secretary without Congressional action.

references to § 1396b contained in 1396a likely do not sufficiently implicate Medicaid's funding mechanism to justify a block grant. *See, e.g.*, 42 U.S.C. § 1396a(a)(42).

Principally, § 1396a sets forth requirements that, without a waiver, state plans must meet in order to gain plan approval from the Secretary. Alaska will need to waive several provisions in order to effectuate the proposals outlined in its request for a proof of concept analysis.[20] For instance, moving people from regular Medicaid to a qualified health plan would require a waiver of Medicaid's "free choice of provider" statute, § 1396a(a)(23). Also, in order to implement a work requirement, the State will likely seek waiver of § 1396a(a)(10), which requires Medicaid be furnished to all individuals in an eligibility category. Otherwise, imposing a work requirement would violate the statute.

To petition for a block grant, the State will likely attempt to waive §§ 1396a(a)(10)(B) and 1396a(a)(1) in order to unequally alter the amount, duration, or scope of services provided to certain individuals across the state. Depending on the State's strategy, it may seek waiver of many other provisions in § 1396a in exchange for its agreement to cap federal funding below currently projected future expenditures.

However, while these waivers would make it possible for the State to operate a Medicaid program without having to follow so many federal Medicaid conditions, these waivers would not by themselves alter § 1396b's reimbursement system.

b. Costs Related to 1115 Projects

Suppose the State obtained an 1115 waiver of Medicaid freedom of choice, so that it could require people to get benefits through Qualified Health Plans. Would the existence of this project mean that its operation could be funded directly under 1115, as opposed to the standard reimbursement system in § 1396b?

Though 1115 projects are, by definition, out of conformity with the traditional requirements for state plans, their associated costs are to be regarded as expenditures under state plans. 42 U.S.C. § 1315(a)(2); *see Portland Adventist Medical Ctr. v. Thompson*, 399 F.3d 1091, 1097 (9th Cir. 2005) (holding that individuals receiving Medicaid under an 1115 waiver program are to be regarded as eligible for Title XIX assistance under the state plan though they are only made eligible by a waiver).

Section 1115 does not authorize any particular set of federal payments to fund a project. Instead, it establishes that a project's costs are eligible for federal *reimbursement*, inputting the state costs back into the reimbursement funding mechanism, which under § 1396b does not operate as a

[20] *Informal Request for Proposals*, *supra* note 4.

block grant. In other words, the fact that the Secretary approves a project does not in itself give the Secretary authority to pay for that project via a block grant, outside the ordinary system for matching state expenditures.

IV. The State can limit benefits of the expansion population to the benefits provided by a Qualified Health Plan by making changes in state law. The State also has legal authority under 1115 to ask to limit benefits provided to other people, require people to get benefits through Qualified Health Plans, and impose work requirements on them. (It can ask, but the courts can say no, too.) Given federal budget neutrality requirements, the State may not be able to use a block grant in order to pursue the objectives set out in the request for a proof of concept paper.[21]

Federal Medicaid law allows a State to provide benefits to the expansion population that are limited to "benchmark benefits" or "benchmark-equivalent benefits." In Alaska, the benchmark benefits are either as provided by the principal Premera Blue Cross Blue Shield Qualified Health Plan or as approved by the Secretary for coverage amounting to the traditional Medicaid system. *See* 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), 1396a(k), and 1396b(i)(26). Current State Medicaid law makes no distinction between people getting Medicaid under the expansion and people getting Medicaid as, say, caretaker relatives or people with disabilities: everyone gets the same benefits package. Any changes to that equality among beneficiaries would need to be made through changes to state Medicaid statutes – by, for example, changing AS 47.07.030 to specify that benefits for particular groups are restricted to the "benchmark benefits" in the Premera plan. At the federal level, these changes could then be implemented through a state plan amendment as opposed to an 1115 waiver.

However, there are three possible changes that could only be implemented through an 1115 waiver. First, in order to compel people actually to get their Medicaid benefits through a Qualified Health Plan – to have the benchmark benefits provided by Premera as opposed to through fee-for-service Medicaid -- Alaska would need an 1115 waiver of, among other things, the Medicaid freedom of choice provision. (This was what happened in Arkansas in 2013.) Second, the State would probably need an 1115 waiver to limit the benefits of anyone outside the expansion population to "benchmark benefits," even if those benefits are provided through traditional Medicaid sources as opposed to a Qualified Health Plan. That is because the explicit federal authorization to limit benefits to "benchmark benefits" applies to the expansion population but not to anyone getting Medicaid under another category. Third, to impose work requirements – which the consultants questioned in their report -- the State would need an 1115 waiver of, among other things, the provision requiring coverage of everyone who satisfies particular income and resources requirements. All three of these changes would presumably require changes in state Medicaid law. Further, it is likely that at least some 1115 waivers would

[21] *Id.*

be challenged in court, in the same way that the Kentucky, Arkansas, and New Hampshire work requirements waivers have been challenged.

The single most obvious obstacle to requiring people to get their benefits through a Qualified Health Plan, and to using Medicaid money to pay their way into a program operated by Premera or Moda, would be the federal budget neutrality requirement. It is unlikely that the kind of block grant approach proposed by Tennessee would work in Alaska, or that the approach taken by Tennessee will work even for Tennessee. This is because Tennessee's shared savings idea, predicted and endorsed to some extent by the Alaska consultants, depends on the state Medicaid program saving money below a without-the-waiver cap, and then on the Federal Government sharing that money with the state. The problem with the Tennessee proposal is that it asks the Federal Government to spend more money in Tennessee than it is currently spending, which would violate the budget neutrality requirement. The problem for Alaska is even worse, because the State has not in any way identified how it would produce savings from existing operations, and the added costs of a 'private option' in Alaska are so obvious, as acknowledged by the consultants. Technically, also, the idea of the Federal Government sharing savings with the State is contrary to the requirements of the Medicaid Act. A state has to spend money in order to draw down federal reimbursement. "Savings" by a state are not expenditures that may be reimbursed.[22]

Would a block grant approach add anything to these possibilities? Probably not. A block grant approach might lead to reduced benefits or eligibility for people if and when the State drew down all the money available under a block grant. It is not at all clear that the State could set up a block grant system through 1115 waivers, given that 1115 does not directly allow for waivers of the reimbursement statute, § 1396b. Finally, 1115 waivers must be tested against the objectives of the Medicaid program, which include providing health care coverage. That is the problem that has led to court decisions against the Kentucky and Arkansas work requirement waivers. There is certainly a legal case to be made that converting Medicaid into a block grant would not be consistent with this objective.

[22] See Andy Schneider, *Tennessee Medicaid 'Block Grant' Proposal: Imagination Gone Wild,* September 25, 2019, available at https://ccf.georgetown.edu/2019/09/25/tennessee-medicaid-block-grant-proposal-imagination-gone-wild/.