Medicaid block grant risks and considerations

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Background

On September 17, 2019, the State of Tennessee, Division of Tenncare, released a draft version of Amendment 42 to its Section 1115 Demonstration Waiver, "Tenncare II Demonstration." With the exception of pharmacy and certain waiver services, the vast majority of Tennessee's Medicaid program services are funded under this Section 1115 Demonstration Waiver authority. Amendment 42 makes Tennessee the first state to take concrete steps to engage the Centers for Medicare and Medicaid Services (CMS) in a proposed block grant funding methodology.

Changing the Medicaid funding formula to a block grant is not a new idea. Block grants were recently promoted unsuccessfully as part of efforts to repeal and replace the Patient Protection and Affordable Care Act (ACA). In 2017, the American Health Care Act (AHCA) bill was introduced to institute per capita or global budget spending caps for Medicaid enrollees under a block grant arrangement. Additionally, in 2017, the Better Care Reconciliation Act (BCRA) contained a section (Section 133) for the Medicaid Flexibility Program, which also included per capita or global budget block grant options.

The purpose of this paper is to discuss the risks and considerations of changing Medicaid's funding formula to a general block grant structure.

Fundamentals of a block grant

A block grant funding arrangement is attractive from a federal financing perspective because it establishes an authorized level of spending, creating an incentive for states to better control costs. States could also find this structure attractive because it includes a savings component if efficient management of the program produces costs below the authorized spending levels. Block grants may also provide states with increased flexibility in the operation of their Medicaid program.

Given that there are not any block grant models in place today, there is not a standard formula for the calculation. The authorized level of spending under the block grant could be established using the following formula for each Medicaid Eligibility Group (MEG). This formula would be the same under both a global budget and per capita block grant model. A global budget block grant is generally assumed to be a fixed dollar amount of funding that does not vary with enrollment levels. In contrast, a per capita block grant model would institute a fixed amount of funding per person so the total amount of funding would vary with enrollment changes.

*Enrollment * Baseline PMPM * $(1+trend)^{Demonstration\ Year}$ * FMAP = Block Grant Amount*

Each component of this formula is described below.

- **Enrollment:** The annual member months eligible in the MEG.
  - Enrollment is utilized as outlined in the formula above in both a global budget block grant and a per capita block grant funding model. However, under a per capita block grant, the block grant amount would be redetermined each year using current enrollment figures.
  - MEGs are generally defined into three to five homogeneous groupings such as low-income family children, low-income family adults, blind and disabled, and elderly.
- **Baseline per member per month (PMPM):** The average expenditures incurred PMPM for a given MEG.

> Tennessee has proposed using the average of the most recent three years to establish the enrollment in this formula. Additionally, Tennessee proposed establishing a starting point funding floor and not allowing decreases below the floor if enrollment declines.
>
> Tennessee proposed to use the trend methodology developed and used by the CBO when projecting future healthcare costs.

- In the previously proposed block grants (i.e., in AHCA and BCRA), once the baseline PMPM or total expenditure is established, it remains the basis for the trended block grant amount for all future years. In contrast, most 1115 Waivers recently approved by CMS "rebase" the baseline PMPM cost every three to five years.

- **Trend rate:** The rate of growth to apply to the baseline PMPM to project costs in future years.
  - We would anticipate increased discussions between states and CMS over the methodology employed for trend selection in any future block grant proposal. Considerations for what populations and benefits are included in the block grant relative to what populations and benefits underlie the trend methodology will be critical.
  - The block grant proposals in 2017 tied the growth of per capita expenditures (i.e., trend) to the medical consumer price index (CPI-M) or the urban consumer price index (CPI-U), with adjustments in some cases for the disabled MEG.[1]

- **Federal medical assistance percentage (FMAP)**
  - The FMAP, or the percentage of the federal financial participation (FFP) in a state's Medicaid funding, is annually determined for each state based on a formula that was established in statute when Medicaid was authorized in 1965.[2]

- **Block grant amount**
  - The total block grant amount for a state would equal the sum of the formula result for each MEG.

Differences between a block grant and 1115 Waiver budget neutrality

For those familiar with the section 1115 demonstration waivers, the fundamentals of a block grant may appear very similar to the components underlying the budget neutrality requirements for 1115 waivers. In particular, the per capita block grant funding model used to establish the block grant amount in a given year is equivalent to the formula used to project expenditures in an 1115 waiver that could have occurred absent the 1115 waiver (again, assuming a per capita approach), referred to as the "without waiver" expenditures. Both structures establish a limit on the amount of federal expenditures available for the Medicaid program. Despite this similarity, the following list outlines key differences between a block grant funding model and 1115 waiver budget neutrality regarding the federal funding of Medicaid.

- **Spending of funds below block grant amount or Without Waiver expenditure limit:** Under a block grant funding model, states would receive the block grant amount and could either spend up to that amount or use it to reduce the state share of total spending. If actual expenditures are below the Without Waiver expenditure limit under 1115 Waiver budget neutrality, the federal expenditure reduction does not transfer to the state budget unless an approved investment of savings is negotiated with CMS.

- **Amendments:** Historically, CMS has not placed limits on what changes can be made through amendments to 1115 Waivers.[3] However, in a state Medicaid director (SMD) letter, CMS cited amendments as "leading to increased federal Medicaid spending and putting the fiscal integrity of the program at risk."[4] It is uncertain whether CMS will allow amendments to budget neutrality in the future, but the previously proposed block grants appear to not allow amendments for items such as state policy and program changes.

- **Rebasing of per capita cost:** 1115 Waiver budget neutrality typically requires rebasing (i.e., updating the baseline PMPM used to project expenditures) every time the demonstration is renewed (generally every five years). In contrast, previously proposed block grants would not be rebased on a recurring basis. However, some states historically have requested to "extend" the prior demonstration, which would project the next five years of costs based on the previously established baseline PMPM, because of the savings (Without Waiver expenditures limits less actual expenditures) accrued as part of the prior demonstration. CMS also cited extensions to 1115 Waivers as another source of increased federal Medicaid spending.[5]

- **Flexibility in expenditures subject to funding limit:** States use 1115 Waivers in a variety of ways. Some states use 1115 Waivers to get authority to operate an entire managed care program. In this example, under an adverse scenario where actual

[1] Markus, A.R., Gianattasio, K., Llio, E.Q., & Strasser, J. (October 16, 2019). Predicting the Impact of Transforming the Medicaid Program on Health Centers' Revenues and Capacity to Serve Medically Underserved Communities. Milbank Quarterly. Retrieved on November 1, 2019, from https://onlinelibrary.wiley.com/doi/full/10.1111/1468-0009.12426?utm_source=Milbank+Email+List&utm_campaign=636ecc1588-EMAIL_CAMPAIGN_2018_01_09_COPY_01&utm_medium=email&utm_term=0_dbce9df54c-636ecc1588-3870821&.
[2] Kaiser Family Foundation (September 30, 2012). Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP). Health Reform. Retrieved on November 1, 2019, from https://www.kff.org/health-reform/issue-brief/medicaid-financing-an-overview-of-the-federal/.
[3] U.S. Government Accountability Office (April 2019). Medicaid Demonstrations: Approvals of Major Changes Need Increased Transparency. Retrieved on November 1, 2019, from https://www.gao.gov/assets/700/699222.pdf.
[4] CMS (August 22, 2018). Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects. Retrieved on November 1, 2019, from https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf.
[5] Ibid.

managed care program expenditures exceed Without Waiver expenditures, states may have flexibility to transition managed care authority for state plan services using Section 1932(a), which does not have expenditure limits. Under the previously proposed block grants, states may not have flexibility to transition expenditures outside of the block grant funding model in adverse scenarios.

As states like Tennessee propose alternatives to the previously proposed per capita block grants, the delineation between a block grant funding model and 1115 Waiver budget neutrality requirement may become more difficult to distinguish.

Risks to consider when evaluating a block grant arrangement

As outlined above, one of the goals of a block grant is to control spending by limiting expenditure growth to fixed PMPM trend increases (and enrollment increases under a per capita approach). Therefore, under a block grant, a state is exposed to several types of risks that are outlined below: some risks are driven by policy and program changes while others are inherent in the population and benefits covered by state Medicaid programs (utilization, morbidity, and unit cost risk). While we discuss these risks and considerations separately below, they should be considered concurrently when making decisions under a block grant funding model.

POLICY AND PROGRAM CHANGES AS DRIVERS OF RISK

Most Medicaid programs experience frequent changes to the amount, duration, and scope of the benefits provided to beneficiaries. These program changes can originate from the federal government, state government, or from within the Medicaid agency. The number and extent of program changes can also be significantly affected by turnover at the state executive, administrative, and legislative levels. Program changes can affect eligibility, utilization, unit cost, and the penetration of members using services. Figure 1 illustrates a few examples of unintended but realistic program changes that a state can be at risk for under a possible per capita block grant structure.

Program changes can present anticipated and unanticipated cost changes in a Medicaid program. The source, complexity, and magnitude of program changes varies considerably. CMS and states entering into block grant arrangements will need to define a process for adjudicating program changes and whether they are incorporated into the block grant or if the state should be at risk. TennCare has proposed that state-initiated program adjustments will be funded for three years using a traditional Medicaid financing model, with block grant funding after year 3 adjusted based on actual experience related to the program adjustment. This use of a program change "incubator" could help reduce cost variance within the block grant funded program. The ongoing management of what goes into the incubator will require close coordination between a state and CMS. Program change disposition could be evaluated by characteristics such as size and source of the change. In Tennessee, some program changes could be funded with shared savings.

FIGURE 1: RISK OF EXAMPLE PROGRAM CHANGES

PROGRAM CHANGE EXAMPLE	RISK PRESENTED	POTENTIAL IMPACT TO PER CAPITA COSTS
A state Medicaid agency lost a lawsuit when a hepatitis C pharmacy treatment was denied to a member because that person's fibrosis score did not meet the prior authorization requirements. As a result, the state relaxed the prior authorization requirements.	Utilization risk	Relaxing the prior authorization requirements caused an increase in utilization of the hepatitis C treatment, driving up the state's per capita drug costs.
CMS issued a letter to state Medicaid directors advising that treatment for autism spectrum disorder (ASD) should be considered covered under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.[6]	Utilization risk	States may experience a significant increase in utilization and corresponding expenditures to cover this benefit.
A state implements new eligibility system functionality that takes advantage of automated income data processing. The new system functionality increased the rate of membership redeterminations and removed members from the program faster.	Morbidity risk	The members exiting the program were healthier than the overall population, resulting in an increase to per capita costs.
A state legislature passes a bill requiring cost of living adjustments for direct care workers in the state.	Unit cost risk	Because wages increased for all direct care workers in the state, the rates paid by agencies for applicable services increased commensurately, driving up overall unit cost.

[6] CMS (September 2014). Medicaid and CHIP FAQs: Services to Address Autism. Retrieved on November 1, 2019, from https://www.medicaid.gov/federal-policy-guidance/downloads/faq-09-24-2014.pdf.

UTILIZATION RISK

Controlling the risk of utilization increases has been a growing state concern under the existing financing structure as state budgets have become more constrained over time. The primary way states have gained more control over this risk is through the transition of large portions of their Medicaid programs into managed care. For states that have not implemented a Medicaid managed care program, other models such as working with an administrative services organization (ASO) have become an option where the entity managing the utilization is not at risk. States can use their experience in operating these programs, and their overall success in managing utilization, when determining whether the populations and benefits covered would be good candidates for including in a block grant arrangement.

Today, there are several states with almost all of their populations and benefits in managed care programs. However, this does not necessarily mean that each of these populations and benefits represent similar risks to state budgets. For example, certain populations are more susceptible to needing certain benefits to support their health and community-based living. Managed care programs supporting these specialty populations include waiver services and may be limited to beneficiaries needing those services. e.g., managed long-term supports and services (LTSS) programs. Under the proposed block grant legislation in 2017, a separate MEG was proposed for the elderly population, which is the one of the populations in need of LTSS. However, as the population ages and lives longer, the caseload of those needing increased LTSS is anticipated to grow significantly.[7] Additionally, the number of people relying on Medicaid for this benefit could be even higher than expected under economic recessions as beneficiaries spend down their assets. Therefore, without normalizing for the number of people requiring LTSS (i.e., caseload), the Medicaid cost trend (driven by LTSS utilization) is anticipated to be significantly higher than CPI-M. One strategy to make a block grant arrangement more feasible in this environment is to normalize for the caseload increases by creating separate MEGs for certain specialty populations.

Epidemics or other health-related disasters could also significantly affect the caseload for certain services as has been seen most recently with the opioid epidemic. Medicaid expenditures for opioid treatment alone grew annually by 19% between 2011 and 2016.[8] Under the current Medicaid financing structure, Medicaid can rapidly respond and adjust federal payments in the face of epidemics and natural disasters,[9] but this may not be the case under a block grant. Including language in block grant arrangements to adjust for significant changes in caseload for certain services is another strategy for states to ensure that appropriate levels of funding are maintained under a block grant.

MORBIDITY RISK AND THE COUNTER-CYCLICAL NATURE OF MEDICAID

Morbidity risk can be defined as the underlying level of illness in a population. In mature programs with little change, morbidity can be stable for long periods of time. However, in times of rapid change, population morbidity can materially change. This happens primarily when there are changes in the number of members in a MEG. Without a way to periodically rebase underlying costs, a state or the federal government can be at risk for a favorable or unfavorable morbidity that is different from the assumptions that underlie an initial per capita block grant calculation.

The risk related to a change in population morbidity is also inherent with the countercyclical structure of Medicaid. Because some Medicaid eligibility groups are based on financial status of individuals, a downturn in the economy can result in more people becoming Medicaid-eligible. Because the members adversely affected by an economic downturn are likely working age and with children, these members tend to be healthier than existing Medicaid beneficiaries, improving the covered population's overall morbidity. Conversely, a

> **Retroactive scenario modeling of optimal MEG construction to eliminate utilization fluctuations is an important exercise before committing to a block grant.**
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> **Utilization management of pharmacy costs was a possible reason Tennessee decided to exclude pharmacy from the block grant unless CMS can approve the use of more stringent formulary constraints. The techniques requested are very similar to a recent Massachusetts proposal that was denied by CMS.**

[7] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. An Overview of Long-term Services and Supports and Medicaid: Final Report. (August 8, 2018). Retrieved on November 8, 2019, from https://aspe.hhs.gov/basic-report/overview-long-term-services-and-supports-and-medicaid-final-report

[8] Vestal, C. (January 30, 2019). Opioid Money Has Helped, but States Want More. Retrieved on November 1, 2019, from https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/01/30/opioid-money-has-helped-but-states-want-more.

[9] Rudowitz, R. (January 2017). 5 Key Questions: Medicaid Block Grants and Per Capita Caps. Kaiser Family Foundation Issue Brief. Retrieved on November 1, 2019, from http://files.kff.org/attachment/Issue-Brief-5-Key-Questions-Medicaid-Block-Grants-&-Per-Capita-Caps.

rapidly improving economy can allow healthy working age members to return to the workforce and private health insurance, thus removing healthier people from the Medicaid population and increasing the measured morbidity of the remaining population. Other environmental and demographic forces can change the underlying morbidity of a MEG, but the elasticity of membership to the economy is a prominent risk for a state as it considers moving to a per capita block grant model.

UNIT COST RISK

Once a state has determined what populations and benefits will be subject to the block grant, it would be prudent to also understand the financial well-being of the provider networks supporting the underlying services prior to entering into a block grant arrangement. There may be significant disparities in Medicaid payment levels relative to what Medicare or commercial insurers pay, or relative to the reasonable and necessary costs of providing services. The magnitude of those differences may vary significantly depending on the type of service. Given that block grant arrangements limit annual unit-based payment increases over time for affected services, it may be difficult to "make up ground" in payments for services that are potentially underfunded. To the extent that a state is currently at risk for having to make significant increases in payments, either as a result of political pressure or through a threat of rate litigation, such risk should be considered and mitigated before "locking in" to a block grant arrangement.

> **In Tennessee's draft 1115 Waiver amendment, it specifically cites the state's low Medicare wage index and has requested that CMS accommodate this unit cost issue in the calculation of the block grant. This example illustrates the concern for unit cost adequacy across the entire provider network.**

Additionally, there may be significant disparities in the payment methods employed by Medicaid agencies relative to national best practices, depending on the type of service. It is common for states to postpone needed upgrades to payment methods, or even to have payment methods require legislative approval before changes can be implemented, which can add significant complexity to the process. Particularly for LTSS and for home and community-based services (HCBS), rate-setting methods can be antiquated and reliant on assumptions and inputs that are no longer valid. Careful consideration of the validity of current rate-setting and payment methods should take place before moving affected services into a block grant arrangement. Once a state has entered a block grant funding model, it is critical to continually update fee schedules to ensure that unsustainable savings are not generated (i.e., savings are generated at the state level while the provider network is underfunded). Historically, some states have not increased fee schedules for multiple years only to eventually have large provider rate increases to maintain provider access.

Another driver of unit cost risk is found in new treatments or services replacing the existing service array, but at an increased cost. A cost-benefit analysis could be considered prior to implementation of new treatments or services (or appropriate medical necessity limits set, where implementation is necessary), in order to weigh the budget neutrality of the new treatment compared to the change in outcomes.

Understanding the unit cost issue should also consider the funding side of provider payments. Many states rely on non-state sources to supplement the funding of the non-federal share of Medicaid payments. Non-state funding sources can include contributions made through intergovernmental transfer (IGT) arrangements, certified public expenditure (CPE) arrangements, and healthcare-related tax programs. These non-state funding approaches are typically linked to supplemental payments to providers, with the distribution of resulting Medicaid payments being directed to the entity providing the state's share of the funding. As states evaluate their rate-setting or payment methods, or the adequacy of Medicaid payments to providers for services being considered for a block grant arrangement, they also need to consider those critical "local" funding sources and, to the extent appropriate, their preservation.[10]

State risk exposure under block grant

The current federal financial participation in all state Medicaid programs is equal to the total expenditures incurred during a time period multiplied by the FMAP. A block grant would transition federal participation to a fixed amount regardless of the amount of actual expenditures by limiting year-over-year per capita growth to a predefined trend rate. By fixing the federal expenditure outlay under a block grant, state funding will exhibit increased variability depending on how actual PMPM cost trends compare to the benchmark trends used in the block grant funding model.

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[10] Pettersson, J., Mori, B., Roth, L. and Clarkson, J. Approved Medicaid State Directed Payments: How States are Using Section 438.6(c) "Preprints" to Respond to the Managed Care Final Rule. (October 2018). Retrieved on November 8, 2019, from http://www.milliman.com/insight/2018/Approved-Medicaid-state-directed-payments-How-states-are-using-438_6c-Preprints-to-respond-to-the-managed-care-final-rule/

To put this transition in a state's risk exposure into perspective, we have compared a state's Medicaid funding model to a provider who is considering entering an alternative payment model (APM). In the Health Care Payment Learning and Action Network (HCP-LAN), there are four different categories of risk.[11] Figure 2 provides a description of each of the four categories in the HCP-LAN framework as well as where the standard FMAP and block grant Medicaid funding models may be categorized.

FIGURE 2: MEDICAID FUNDING MODELS UNDER HCP-LAN RISK CATEGORY FRAMEWORK

	CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
HCP-LAN	Fee-for-service (FFS) – no link to quality	FFS – with a link to quality and value, such as quality bonus payments	APMs built on FFS architecture, such as bundled payments or shared savings	Population-based payments, such as total cost of care and capitation
Description	Payments based on volume of services	At least a portion of payment tied to quality or efficiency of service delivery	Payments triggered by volume of services, but opportunities for two-sided risk	Payment is not directly triggered by volume of services
Medicaid Funding Model	Standard FMAP	-	-	Block grant

To illustrate the additional downside risk exposure and potential savings of entering a block grant funding model compared to a standard FMAP funding model, we have modeled state and federal funding using both a standard FMAP and a block grant funding model under three scenarios. Figure 3 provides the state and federal funding in year one for an "average state" under both the standard FMAP (the straight average of state's FMAP is approximately 60.00%)[12] and block grant funding models. In this example, we have illustrated state and federal funding under three scenarios: if actual year one PMPM cost trend increases relative to the baseline (Year 0) are equivalent to the block grant benchmark trend of 4%, if actual PMPM cost trend is 5% (i.e., 1% above benchmark), and if actual PMPM cost trend is 3% (i.e., 1% below benchmark). Lastly, figure 3 provides the required percentage increase in state funding under a block grant funding model relative to the standard FMAP in each scenario.

FIGURE 3: STATE AND FEDERAL FUNDING COMPARISON - STANDARD FMAP VS. BLOCK GRANT (IN MILLIONS)

	TOTAL MEDICAID	STANDARD FMAP		BLOCK		PERCENTAGE CHANGE IN STATE FUNDING
		FEDERAL	STATE	FEDERAL	STATE	
Year 0	$ 4,530.0	$ 2,718.0	$ 1,812.0			
Year 1 - Benchmark	$ 4,711.2	$ 2,826.7	$ 1,884.5	$ 2,826.7	$ 1,884.5	0.0%
Year 1 - 1% Above Benchmark	$ 4,756.5	$ 2,853.9	$ 1,902.6	$ 2,826.7	$ 1,929.8	1.4%
Year 1 - 1% Below Benchmark	$ 4,665.9	$ 2,799.5	$ 1,866.4	$ 2,826.7	$ 1,839.2	(1.5%)

To further illustrate state's downside risk exposure and potential savings under a block grant over a five-year period, figure 4 illustrates the changes in state funding required under a block grant funding model as compared to a standard FMAP approach if actual annual PMPM cost trend is either 1% or 2.5% above (below) the benchmark block grant PMPM cost trend (assuming 4% benchmark). There is a leveraging effect on state funding (represented as a multiplicative percentage change) because states pay (save) both the state and federal portion of costs above (below) the established block grant amount. Figure 4A illustrates the percentage change in the average state's share of total cost (40.00%) and figure 4B illustrates the percentage change in the state's share from the highest FMAP in FY 2020 (23.02%).[13] States with a higher standard FMAP than the average state will experience a greater leveraging effect in state expenditures if costs deviate from the baseline because the federal share is a greater percentage of total cost.

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[11] HCP-LAN (January 12, 2016). Alternative Payment Model (APM) Framework. Retrieved November 1, 2019, from https://hcp-lan.org/workproducts/apm-whitepaper.pdf.
[12] https://www.federalregister.gov/documents/2018/11/28/2018-25944/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for
[13] Federal Register. Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2019 Through September 30, 2020. (November 28, 2018). Retrieved on November 8, 2019, from https://www.federalregister.gov/documents/2018/11/28/2018-25944/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for

FIGURE 4A: PERCENTAGE CHANGE IN STATE FUNDING USING BLOCK GRANT FUNDING MODEL RELATIVE TO STANDARD FMAP (AVERAGE STATE FMAP)

	ANNUAL TREND DIFFERENTIAL (40.00% STATE SHARE)			
	(2.5%)	**(1.0%)**	**1.0%**	**2.5%**
Year 1	(3.7%)	(1.5%)	1.4%	3.5%
Year 2	(7.5%)	(2.9%)	2.8%	7.0%
Year 3	(11.4%)	(4.4%)	4.2%	10.3%
Year 4	(15.3%)	(5.9%)	5.6%	13.6%
Year 5	(19.4%)	(7.4%)	7.0%	16.8%

FIGURE 4B: PERCENTAGE CHANGE IN STATE FUNDING USING BLOCK GRANT FUNDING MODEL RELATIVE TO STANDARD FMAP (HIGHEST STATE FMAP)

	ANNUAL TREND DIFFERENTIAL (23.02% STATE SHARE)			
	(2.5%)	**(1.0%)**	**1.0%**	**2.5%**
Year 1	(8.2%)	(3.2%)	3.2%	7.8%
Year 2	(16.7%)	(6.5%)	6.3%	15.5%
Year 3	(25.3%)	(9.8%)	9.5%	23.0%
Year 4	(34.2%)	(13.2%)	12.6%	30.3%
Year 5	(43.3%)	(16.6%)	15.6%	37.4%

Because state Medicaid programs may not be able to control all risks leading to increased costs, simply entering into a block grant arrangement could put state budgets in financial distress under adverse scenarios. In an adverse scenario, decreasing provider payment rates may be the quickest way to rectify a cost of care overrun because most other cost savings initiatives require time to implement and take effect, given claims lag and the time it takes to implement new or modify existing Medicaid program policies. The delay in achieving savings is further exacerbated by states' frequent use of cash-based accounting methods. While faster and easier, decreasing provider payment rates could have the adverse impact of limiting access to members, resulting in unmet care needs, which could decrease quality and increase overall costs in the long term. Additionally, the Congressional Budget Office (CBO) has recognized that states considering a block grant may choose to limit mandatory or optional benefits to save money. Prior to making adjustments to limit mandatory or optional benefits, it is important to have a clear vision of the potential impacts of such adjustments and to consider whether reducing or eliminating benefits may increase costs for states long-term. Lastly, if decreasing provider payments and limiting benefits are not viable options, a state may resort to decreasing Medicaid eligibility to remain within its budget.

As the state and federal governments weigh potential changes to their Medicaid funding models, certain principles should be considered, including increased accountability and transparency, improved quality and outcomes, and continuing to protect the needs of our most vulnerable citizens. Notwithstanding these principles, it is also critical that states not lose sight of some of the most basic tenets related to Medicaid program funding as promulgated in Section 1902 (a)(30)(A) of the Social Security Act, which states that methods and payments must be "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers" for access. If the previously proposed block grants do not produce a viable long-term Medicaid financing model, there are adjustments that can be made to block grants or other alternative funding models that would move the Medicaid program closer to achieving and maintaining these key principles.

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