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The Buzz About Block Grants

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With the **recent scoop from Politico** that the Trump Administration is considering giving states the ability to implement Medicaid block grants, there has been considerable speculation on what the Administration is planning. Although we don't know exactly what the Administration has in mind, there increasing skepticism on the legality of this move. So we are laying out the fundamentals and past history as we await the final guidance.

It is being reported that the Administration will issue guidance to states to encourage them to apply for a waiver — likely through the 1115 waiver program — to cap federal Medicaid dollars and receive additional flexibility in how they run the program. This is a concept that sounds very similar to a block grant, which was a recurring theme in ACA repeal and replace efforts in 2017.

Many have questioned the legality of a move like this. So let's walk through the basics.

Currently, Medicaid has an open-ended funding structure in which states pay for a portion of the program and the federal government pays for a portion. The federal match is referred to as Federal Medical Assistance Percentage (FMAP) and it varies by state and by population (i.e., new adult group). States are required to cover mandatory populations and services. States also have option to provide additional coverage to optional populations and services, while receiving federal match. Now there are many asterisks and caveats to the above, but this is a general description of the current financing structure.

A block grant, or something similar, would totally change the current Medicaid financing structure. Under a block grant, a state receives a lump sum payment from the federal government. Whether the block grant funding can increase overtime with inflation or another rate is dependent on the proposal you are looking at or the person you ask. Additionally, the common view is that requirements on coverage mandatory populations and services would be reduced under a block grant, as the state would have increased flexibilities in defining coverage in its state and would be operating with a smaller budget.

Block grants were a key point of the many ACA repeal and replace bills we saw in 2017. With the failed attempts to implement a block grant in Medicaid, a move like this from the Administration is seen as a way to allow states to implement block grants without Congressional action.

Now comes the question – is this legal?

Ultimately, this answer will depend on what exactly the Administration does and rulings from the courts. But let's look at one of the closest models we have to a block grant via a Medicaid waiver – the **Rhode Island Global Consumer Choice Compact Medicaid Waiver** (Global Waiver).

The Rhode Island Global Waiver is commonly referenced when discussing block grants. In 2009, CMS approved Rhode Island's 1115 waiver demonstration program that essentially set a federal cap on the amount of federal Medicaid funding the state could receive in the five-year period of the waiver. This waiver also **did a number of other things** – implementing Medicaid managed care, reducing silos in how Medicaid was run in Rhode Island, and increasing flexibility in service coverage, specifically around long term care.

Under this waiver Rhode Island received a cap of $12.075 billion in federal funding for the five-year demonstration period. However, this waiver did not remove the FMAP system for Rhode Island. Instead Rhode Island drew "**federal funds for services in which the state expended its match portion up to an aggregate budget cap of $12.1 billion over the five year demonstration**." Additionally, Rhode Island set the federal cap well above projected Medicaid costs. The **Center on Budget and Policy Priorities reports** that in Rhode Island's initial request for a waiver, it requested $12.386 billion spending cap but the state only anticipated spending $10.761 billion.

In the end, the Rhode Island Global Waiver ended with the enactment of the ACA. As such, **Rhode Island dropped the aggregate cap** in favor of a more traditional Section 1115 financing. And although it is linked to block grants, the Rhode Island funding structure did not remove FMAP and the state received an increase in federal funding.

What the Administration proposes remains to be seen. But we can look to the past for clues for what the future might hold. Examining the Rhode Island waiver is a good starting point. Also, let's not rule out the possibility that the Administration could propose to allow states to fund Medicaid expansion through a

block grant – a totally new territory for the health policy world.

Another thing to keep in mind is that unlike the 2017 block grant and per capita cap proposals (tied to ACA repeal and replace) that would have been imposed upon states, the potential Administration action would give states the option to fund its program under a cap allotment. Meaning states need to actively decide that they want to do this. We will see how many come to the table.

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