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Between Barack and a Hard Place: The Looming Struggle Facing States Under Obama's Proposed Blended FMAP Rate Changes

Karim Hussein[*]

I. INTRODUCTION

Medicaid is the largest health insurer in the United States in terms of eligible beneficiaries, covering medical services and long-term care for sixty million low-income Americans.[1] The program is funded by a federal matching program, where the federal government matches a portion of state expenditures on Medicaid services, depending on the per-capita income in each individual state.[2] Generally, this Federal Medical Assistance Percentage (FMAP) is a reimbursement to states in the range of 50% to 74.18%.[3]

In recent years, due in part to the economic downturn and states struggling to keep up with Medicaid payments for services, the American Reinvestment and Recovery Act of 2009 (ARRA), provided significant

[*] Juris Doctor Candidate, Loyola University Chicago School of Law, Class of 2013. Mr. Hussein is a staff member of *Annals of Health Law*.

1. KAISER FAMILY FOUNDATION, STATE FISCAL CONDITIONS AND MEDICAID (last updated Feb. 2010), http://www.kff.org/medicaid/upload/7580-06.pdf.

2. E. Richard Brown, *Medicare and Medicaid: The Process, Value, and Limits of Health Care Reforms,* 4 J. OF PUB. HEALTH POL'Y 335, 347 (Sep. 1983).

3. Evelyne P. Baumrucker, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, CONGRESSIONAL RESEARCH SERVICE, 1 (Sep. 24, 2010), aging.senate.gov/crs/

funding increases for Medicaid.[4] The ARRA provided state fiscal relief through a temporary increase in the federal share of Medicaid costs in the amount of $87 billion, between October 2008 and December 2010.[5] During this time, all states received a 6.2% increase in their FMAP match rate, with additional increases awarded to states with higher rates of unemployment.[6] This increase was extended by H.R. 1586 (signed into law as P.L. 111-226) through June 2011, and funded with an additional $16 billion from Congress.[7] More precisely, there was a phased-down enhance match: 3.2% from January 1 to March 31, 2011, and 1.2% from April 1 to June 30, 2011.[8]

The temporary increase expired on June 30, 2011 and FMAP was reduced to pre-stimulus levels.[9] As a result, twenty-one states had lower FMAPs than they did in 2008.[10] This comes at a time when states have seen an eighteen percent increase in Medicaid enrollment from June 2007 to December 2010.[11] A provision of The Patient Protection and Affordable Care Act (PPACA) will help states cope with this loss of federal funding for Medicaid by requiring states to increase their Medicaid enrollment to all non-elderly, non-pregnant adults at or below 133% of the Federal Poverty Level (FPL) in 2014.[12] This expansion of the Medicaid program will include an increase of the FMAP reimbursement, beginning with 100% of state costs, to cover the newly eligible from 2014 to 2016, and then tapering

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medicaid6.pdf.

4. STATE FISCAL CONDITIONS AND MEDICAID, *supra* note 1, *at* 1.

5. *Id.* at 2.

6. Amanda Cassidy, *Extra Federal Medicaid Support Ends,* HEALTH POLICY BRIEF (Jul. 14, 2011), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=50.

7. Baumrucker, *supra* note 3, at 1.

8. *Id.* at 8.

9. Cassidy, *supra* note 6, at 2.

10. *Id.* at 2.

11. *Id.* at 1.

12. Baumrucker , *supra* note 3, at 11.

to 90% by 2020.[13]

Under President Barack Obama's proposed plan to change the PPACA provision, a new, blended FMAP rate would be imposed upon each state instead of the PPACA-mandated 100%.[14] This proposed calculation method would replace the various reimbursement rates with a single rate calculated by forecasting the level of enrollment after the implementation of the PPACA.[15] This blended rate would shift the increased costs of covering the "newly eligible" onto states, thereby decreasing federal dollars spent on Medicaid and increasing the burden on states to make up the shortfall.[16]

II. BACKGROUND

Medicaid and Medicare were part of the original movement for social insurance and public assistance following the passage of the Social Security Act of 1935.[17] While national compulsory health insurance was pursued in the 1940s, it was not until the 1960s when the government began actively implementing a system of government-subsidized healthcare.[18] The Kerr-Mills Act of 1960 expanded a previously paltry federal grant program that matched state expenditures on the "medically needy," mainly the elderly

13. *Id.*

14. White House Press Release, *The President's Framework for Shared Prosperity and Shared Fiscal Responsibility,* White House Press Release, 4 (April13, 2011), http://www.whitehouse.gov/the-press-office/2011/04/13/fact-sheet-presidents-framework-shared-prosperity-and-shared-fiscal-resp.

15. *See* Edwin Park & Judith Solomon, *Proposal to Establish Federal Medicaid "Blended Rate" Would Shift Significant Costs to States Would be Hard to Set Fairly and Accurately; Would Likely Force Cuts to Children, People with Disabilities, Seniors, and Health Care Providers* [hereinafter Park & Solomon], CENTER ON BUDGET AND POLICY PRIORITIES, 2 (Jun. 24, 2011), http://www.cbpp.org/cms/index.cfm?fa=view&id=3521 (explaining that calculation of the blended rate would involve the current 100% funding levels with what the government forecasts the expected levels of enrollment will be after implementation of PPACA).

16. Park & Solomon, *supra* note 15, at 4.

17. *See generally* Brown, *supra* note 2 (tracing the history of Medicare and Medicaid though the 1930s to the 1990s and the original purposes for the establishment of social welfare programs).

18. *Id.* at 337, 342.

who needed assistance paying their medical bills.[19]

Medicaid was intended to "pick up the pieces" left behind by the Medicare program.[20]

While Medicare is an entitlement program tied to Social Security, Medicaid was originally a supplemental and need-based system meant to serve the medically needy.[21] In fact, Medicaid has been tied to welfare from its beginnings, since it was originally set in place over existing welfare programs, which were the only state social services systems in existence at the time.[22] In order to encourage poorer states to implement their respective Medicaid programs in the 1960s, the original FMAP reimbursements were as high as eighty-three percent to such states.[23] By 1972, all states except for Arizona had adopted their own Medicaid programs, which did not follow suit until 1982.[24] No major changes were made to the Medicaid program until 1995, when a republican-controlled Congress, aimed at cutting government spending, converted Medicaid to a state-run program funded by federal block grants.[25] Then, in 1997, President Clinton and Congress agreed to establish a more balanced division of authority between the federal government and the states.[26]

More recently, with the downturn of the American economy and high levels of unemployment, Medicaid enrollment levels have increased and will likely continue to grow.[27] Even with stimulus funds and increases in

19. *Id.* at 342.
20. *Id.* at 346.
21. *Id.*
22. John K. Inglegart, *The American Healthcare System –Medicaid,* 340, NEW ENG. J. MED. 403, 403 (Feb, 1999).
23. Brown, *supra* note 2, at 347.
24. *Id*.
25. Inglehart, *supra* note 22, at 405.
26. *Id.*
27. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, RISING UNEMPLOYMENT, MEDICAID AND THE UNINSURED, 1 (Jan. 2009), http://www.kff.org/uninsured/upload/7850.pdf.

FMAP calculations, twenty-nine states are projecting budget shortfalls for fiscal year 2013, which begins July 1, 2012, in the amount of forty-four billion dollars.[28] As previously discussed, President Obama and Congress responded to these budget shortfalls by passing the ARRA and the PPACA, both of which increased FMAP reimbursements to the states. However, these increases were only temporary, and Obama's newest plan calls for reducing federal funding to FMAP calculations, as mandated by the PPACA, at a time when states have not even begun to recover from the recession.[29]

III. THE PROPOSED BLENDED FMAP CHANGES

President Obama's proposed plan would replace the various FMAP matching rates that states have traditionally enjoyed with one, single blended rate.[30] While the President has not yet announced the specific details of how the blended FMAP will be calculated, the Center on Budget Policy and Priorities predicts that it will be calculated through a two-part process.[31]

First, federal officials would need to determine a "current-law" blended matching rate to determine the average FMAP calculation for each state.[32] This would involve consideration of each state's regular FMAP calculation and its higher matching rate for newly eligible individuals under the

28. Elizabeth McNichol, Phil Oliff & Nicholas Johnson, *States Continue to Feel Recession's Impact,* CENTER ON BUDGET AND POLICY PRIORITIES, 1 (Jan. 9, 2012), http://www.cbpp.org/files/9-8-08sfp.pdf.

29. Michael Leachman, Erics Williams & Nicholas Johnson, *Failing to Extend Fiscal Relief to States Will Create New Budget Gaps, Forcing Job Cuts and Job Loss in at Least 34 States More Cuts in Health, Education and Other Areas Could Stall Nation's Economic Recovery,* CENTER ON BUDGET AND POLICY PRIORITIES, 1 (Aug. 13, 2011), http://www.cbpp.org/cms/index.cfm?fa=view&id=3207.

30. Park & Solomon, *supra* note 15, at 1.

31. Park & Solomon, *supra* note 15, at 6.

32. *Id.*

PPACA.[33] Then, federal officials could determine what each state's current federal funding level is under the current mix of matching rates.[34] Second, federal officials would then reduce this "current-law" blended matching rate by a specified percentage in order to reduce the overall federal expenditures on state Medicaid programs.[35] Unfortunately, this would ensure all states receive less funding than they otherwise would in 2014 under the PPACA.[36]

The rate calculation would also include assumptions made by federal officials in determining the projected increases in enrollment.[37] In order to determine the first part of this rate, officials would need to estimate how many newly eligible people are likely to enroll in each state under the PPACA Medicaid expansion.[38] Additionally, officials will need to estimate the current health status of the newly eligible so that they can determine whether costs for covering this group would be higher or lower than those already covered.[39]

IV. INCREASED FINANCIAL PRESSURE ON STATES

As a condition of accepting any Medicaid funds moving forward, the PPACA requires the states to comply with maintenance of effort (MOE) provisions that require them to maintain existing eligibility levels until state exchanges become operational in 2014.[40] However, this is difficult for states to do with high levels of unemployment and increases in Medicaid enrollment.[41] If the new blended FMAP rate is implemented, states will no

33. *Id.*
34. *Id.* at 2.
35. *Id.*
36. *Id.*
37. *Id.*
38. *Id.*
39. *Id*. at 7.
40. Letter from Department of Health & Human Services to State Medicaid Directors, 1 (Feb 25, 2011), *available at* https://www.cms.gov/smdl/downloads/SMD11001.pdf, [hereinafter *DHHS Letter*].
41. STATE FISCAL CONDITIONS AND MEDICAID, *supra* note 1, at 3.

longer have an incentive to increase the number of enrollees because they will not be able to receive the increased levels of reimbursement to cover the newly enrolled. This frustrates the original purpose of the PPACA's extension of Medicaid, since states will no longer be receiving 100% reimbursement for the newly eligible enrollees.[42] Accordingly, some states have already applied for exceptions to the MOE requirements, which allow states an exemption from enrolling certain adults if they have a projected budget deficit.[43]

In the wake of the enhancements to FMAP reimbursement rates that expired in 2011, states have implemented cuts to state programs, including Medicaid.[44] Additionally, outside of Medicaid funding, 2011 state budgets had to account for the dropping off of the ARRA funding that further constricted their budgets and exacerbated gaps in state funding.[45] "Without the ARRA funds and Medicaid eligibility protections, states may face considering severe cuts to Medicaid provider payment rates, benefits and eligibility cuts."[46]

VI. THE WINNERS AND LOSERS OF A BLENDED FMAP CALCULATION

The obvious winner of reduced federal spending on Medicaid is the federal government, while the losers will be spread among providers, states, and the medically needy. The increased pressure on states to make cuts to their respective Medicaid programs is substantial, especially considering the various cuts and reductions in services states have already made. Although most states have begun the road to economic recovery, they are now faced with both dried up ARRA funding[47] and the possibility for reduced federal

42. Park & Solomon, *supra* note 15, at 3.
43. DHHS Letter, *supra* note 40, at 4.
44. STATE FISCAL CONDITIONS AND MEDICAID, *supra* note 1, at 3.
45. *Id.*
46. *Id.*
47. THE FISCAL SURVEY OF STATES, NAT'L GOVERNORS ASS'N & NAT'L ASS'N OF ST.

matching funds through this blended FMAP rate. In 2010, during the temporary ARRA increases to FMAP reimbursement, Medicaid accounted for twenty-two percent of total state spending.[48] Now that these funds are being reduced with the expiration of the ARRA, state spending on Medicaid is expected to jump nearly nineteen percent in fiscal year 2012, with federal funds decreasing by thirteen percent.[49] These figures are not taking into account the proposed FMAP changes.

It is not only states that will lose out if the proposed blended FMAP rate goes into effect. Providers too, will feel this tightening of purse strings, as thirty-three states will be reducing already low provider rates, and sixteen states will be freezing rates in fiscal year 2012.[50] This comes at a time when ten states will see their Medicaid enrollment increase by ten percent or more.[51] The medically needy, those who depend on Medicaid as their sole source of health insurance, will feel these reductions in spending too, as twenty-seven states will reduce spending on prescription drug benefits, twenty-one states will require new or higher copayments, and eight states will reduce their coverage of long-term care.[52]

V. CONCLUSION

The President's proposal to blend FMAP calculations state-by-state will only result in less funding to states for their respective Medicaid programs at a time when they are already experiencing budget shortfalls.[53] While the country struggles to recover from the recession, and with the passage of comprehensive health reform, reducing funds for Medicaid at this crucial

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BUDGET OFFICERS, viii (Spring, 2011) [hereinafter FISCAL SURVEY].

48. *Id.* at 51.
49. *Id.*
50. *Id.*
51. *Id.* at 53.
52. *Id.* at 57.
53. STATE FISCAL CONDITIONS AND MEDICAID, *supra* note 1, at 3.

time will only be counter-productive and lead to a decrease in coverage and services for Medicaid enrollees across the country.[54]

Health reform was intended to provide coverage to a larger portion of the uninsured by increasing eligibility.[55] Reducing federal payments to states for Medicaid will cause at least thirty-four states to cut jobs and services.[56] Once these cuts are made, states will receive even less federal funding, since their ability to commit funding to their Medicaid programs will be severely hindered. Because their funding commitments will be reduced, and Medicaid is based on the federal match, smaller funding commitments will leave states eligible for lower federal matches, as they will only receive matching federal funds on the dollars they are able to commit.[57]

Medicaid was enacted to provide public assistance for the poor and other low-income individuals who were not receiving adequate medical care, as previously discussed.[58] Unfortunately, President Obama's new plan puts the PPACA-mandated funding levels in jeopardy with the goal of saving federal funds.[59] This will come at great cost to states, providers, and the medically needy in states that depend on Medicaid funding from the federal government.[60] The proposed blended FMAP calculation is flawed, and will only lead to decreases in funding for Medicaid and ultimately, decreases in Medicaid enrollment.

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54. Leachman, *supra* note 29 at 1.

55. Baumrucker, *supra* note 3, at 10.

56. Leachman *supra* note 29 at 2.

57. *See* Robert Helms, *The Medical Commission Report: A Dissent,* AMERICAN ENTERPRISE INSTITUTE FOR PUBLIC POLICY RESEARCH HEALTH POLICY OUTLOOK, 3 No. 2, January 2007 (discussing the FMAP reimbursement system and the extreme pressure on states to fund their Medicaid programs to obtain the federal matching dollars, and that the less money states have to commit to their Medicaid programs, the less they will be able to receive as reimbursement).

58. *See generally* Brown, *supra* note 2 (tracing the history of Medicare and Medicaid though the 1930s to the 1990s and the original purposes for the establishment of social welfare programs).

59. Park & Solomon *supra* note 13 at 2.

60. *Id.*