Insight on the Issues

Block Grants and Per Capita Caps Pose Risks for Medicaid Beneficiaries and for States

Lynda Flowers
AARP Public Policy Institute

Medicaid is a lifeline for millions of Americans, including over 17 million children with disabilities, adults with disabilities, and poor seniors, many of whom need health care and long-term services and supports to address their daily needs. Some have proposed replacing the current Medicaid financing structure with block grants, per capita caps, or both. The price of moving to these types of financing systems is high: millions of Americans could lose access to basic health services and long-term services and supports they need to address their chronic conditions and to live independently in their homes and communities. In addition, states would experience significant cost shifts.

Medicaid is a critical safety net that provides vital health care and long-term services and supports (LTSS) to individuals in every state.[1] In addition to serving other low-income groups—like nondisabled children and pregnant women—the program also serves over 17 million children with disabilities, adults with disabilities,[2] and poor seniors.[3,4]

Under current law, states and the federal government share the costs of financing Medicaid based on a funding formula that has been in effect since the program began in 1965. States with lower per capita personal income (compared with the national average) receive more federal funding than those with higher per capita personal income.[5]

This funding arrangement guarantees that the federal government will share the costs of medically necessary health care and needed LTSS regardless of state policy decisions (e.g., expanding eligibility) or circumstances outside of a state's control (e.g., the introduction of new pharmaceuticals and medical technologies). Recent proposals would fundamentally change this long-standing financial arrangement by replacing the existing federal funding structure with block grants or per capita caps.

This *Insight on the Issues* briefly defines block grants and per capita caps, and describes how block grants and per capita caps reduce federal spending. It discusses why some federal and state policy makers support capping Medicaid funding, and outlines reasons why these funding arrangements are risky for the more than 17 million children with disabilities, adults with disabilities, and poor seniors who rely on the program for basic health services and LTSS to meet their daily needs. Finally, the report discusses the risk these proposals pose for states.

BLOCK GRANTS

Under block grant proposals, states would receive a lump sum of money from the federal government to

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fund their Medicaid programs, regardless of actual need or program costs.[6] The federal government would determine baseline block grant amounts based on a state's average program spending. The funding would not respond to changes in Medicaid enrollment due to circumstances outside of a state's control—like enrollment increases during recessions, enrollment increases due to epidemics like the current opioid crisis, the need to cover more people during natural disasters like hurricanes Katrina and Sandy, and the development of new prescription drugs and treatment modalities.[7]

PER CAPITA CAP

Under per capita cap proposals, the federal government would give states a fixed dollar amount per enrolled beneficiary. Recent proposals would establish separate caps for different coverage groups—children, adults, people of all ages living with disabilities, and poor seniors. The federal government would determine baseline cap amounts based on average spending for each of the coverage groups. The federal government would pay per beneficiary costs up to the amount of the cap. States would be at risk for all medical and LTSS expenditures that exceed the cap.[8] Unlike a block grant, per capita cap funding increases (or decreases) with changes in Medicaid enrollment.[9] Similar to a block grant approach, per capita caps would not increase in response to pharmaceutical or medical innovation, or other changed circumstances that could affect per enrollee spending.

GOAL OF BLOCK GRANTS AND PER CAPITA CAPS IS TO REDUCE FEDERAL SPENDING

A primary goal of block grants and per capita caps is to reduce federal Medicaid spending. To accomplish this, the federal government would likely set baseline spending for block grants and per capita caps below actual program spending, and would not allow spending to grow at a rate that reflects growth in program costs.[10] As a result, federal funding would not keep pace with actual health care costs. States that want to maintain service levels or provide additional services would have to pick up a growing share of program costs (without additional federal dollars) or cut services or provider rates, both of which would reduce access to care for beneficiaries.

PROPONENT ARGUMENTS FOR CAPPING MEDICAID FUNDING

Proponents of block grants and per capita caps—also called capped funding—generally cite benefits relating to two broad categories:

Save Federal Tax Dollars and Make Federal Spending More Predictable

For some federal and state policy makers, the primary appeal of capped Medicaid funding is to reduce the growth of federal Medicaid spending. In addition, they seek to make federal spending more predictable by shielding federal spending from changes in state economic circumstances, changes in state policy decisions, and the full impact of medical cost growth. Unlike per capita caps, block grants would also shield federal spending from changes in beneficiary enrollment.

Increase Program Flexibility and Cost Savings

Some state and federal policy makers believe that states, not the federal government, should control health policy decisions with respect to their citizens.[11] Those who hold this view also believe that a block grant or a per capita cap, coupled with fewer federal restrictions, would help states operate their programs more creatively and efficiently. Policy makers who hold this view say that giving states more flexibility over how they run their programs, including relief from cumbersome waiver processes and the ability to change eligibility rules and benefit design, would allow states to be more innovative. This, proponents argue, could result in greater program efficiencies at lower cost.[12]

THE RISKS OF CAPPING FEDERAL MEDICAID FUNDING

Capped funding could have negative consequences for vulnerable populations and states.

Risks for Vulnerable Populations Who Need Health Services and LTSS

As mentioned above, the growth in the value of block grants and per capita caps would likely not keep pace with the actual costs of the needed care. Consequently, states would have to find ways to compensate for the loss. Federal law requires states

to cover mandatory benefits. States choose to cover optional benefits. Faced with fewer federal funds over time, states could limit optional benefits like home- and community-based services (HCBS) that help people live independently in their communities. Examples of these important services include help with toileting, bathing, dressing, shopping, and managing money. Although called "optional," these services are vital to keeping people out of costly nursing home settings so that they can remain safe and independent in their homes and communities.[13]

Risks Associated with Establishing Baseline Spending

It is unclear how the federal government would set baseline dollar amounts for block grants or for per capita caps by enrollment category. There is considerable variation in spending for children with disabilities, adults with disabilities, and poor seniors.[14] Tying baseline amounts to average state spending or average per person spending would not account for this variation and would likely result in baseline spending that, at the outset, is too low to meet the needs of the entire population. Establishing an unrealistic growth factor—one that does not keep pace with health care cost growth—makes the problem worse and threatens to leave many people of all ages with disabilities with unmet needs. As for poor seniors, by 2026, when boomers start to turn age 80 and older, they will likely need higher levels of service—including home and community-based services and nursing home care—moving them into the highest cost group of all seniors. Locking in baseline spending at a time when per beneficiary spending for seniors is much lower than it will be in future years would result in an underfunded safety net for this population.

Financial Risks for States Budgets

For reasons mentioned above, block grants and per capita caps would place considerable stress on state budgets over time. There would be pressure on states to find ways to meet these new financial challenges. Examples of actions states could take include raising taxes, eliminating eligibility groups or services, reducing provider payments, and shifting more costs to beneficiaries through enforceable cost-sharing policies. Medicaid spending already accounts for almost 20 percent of the state-funded portion of states' budgets.[15] Given competing tensions on their budgets to fund education and other essential state functions, it is not likely that states would raise sufficient taxes to compensate for significant loss of federal Medicaid dollars. If states eliminate eligibility categories, many enrollees would lose access to coverage and needed services. In states that eliminate benefits, low-income enrollees would have to pay out of pocket for those needed services or forgo them entirely. Medicaid beneficiaries in states that reduce provider payments may find it more difficult to find providers willing to serve them, and thus lose access to needed services.[16]

Risks for State Innovation

Medicaid programs have flexibility to be creative in how they operate their programs to meet the unique needs of their citizens. Such flexibilities have led states to improve service delivery, to test different models of care, to improve program efficiencies, and to make home- and community-based LTSS more widely available.[17] Placing caps on Medicaid funding—either through a block grant or a per capita cap—without allowing for growth rates that reflect actual health care costs may not provide states with the funding they need to support innovation.

CONCLUSION

As policy makers consider changing Medicaid financing, a basic set of principles should guide their deliberations. One is to do no harm to the nation's most vulnerable—millions of low-income people, including children with disabilities, adults with disabilities, and poor seniors. Another is to ensure a Medicaid LTSS system that meets the needs of those for whom these services are a last resort. Policy makers should also consider that the majority (90 percent) of seniors want to remain in their homes and communities as long as possible.[18] The same is true for people of all ages living with disabilities. To do so, these individuals need access to health care, as well as the home- and community-based services and supports that Medicaid currently provides. Finally, it is important for policy makers to keep in mind that Medicaid pays nearly

three times as much per person in institutional settings as it does for each individual receiving LTSS in the community. This is true across populations, including older people, adults with physical disabilities, and people with intellectual disabilities.[19]

States already enjoy considerable flexibility in how they operate their Medicaid programs. They have the freedom to decide eligibility and benefit options, set provider rates, and administer the daily operation of their programs. Under the current financing structure, many states have elected to provide optional eligibility and optional services because these choices best meet the needs of their residents, including those who require LTSS. Changing Medicaid financing policies in ways that shift costs to states could lead them to make cuts to important services and supports that millions of people rely on.

1 LTSS are defined as assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) provided to older people and other adults with disabilities who cannot perform these activities on their own due to a physical, cognitive, or chronic health condition that is expected to continue for an extended period of time, typically 90 days or more. ADLs refer to basic personal activities that include eating, bathing, dressing, toileting, and transferring from a bed or chair. IADLs refer to routine household tasks needed for independent living, which includes using the telephone, taking medications, managing money, housework, preparing meals, laundry, and grocery shopping. Susan Reinhard, et al., *Raising Expectations 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* (Washington, DC: AARP Public Policy Institute, The Commonwealth Fund, and The SCAN Foundation, June 2014), accessed at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2014/raising-expectations-2014-AARP-ppi-ltc.pdf

2 This number includes people with disabilities who qualify for Medicaid through a disability pathway. There are additional adults and children with disabilities receiving Medicaid who qualify through other eligibility pathways.

3 Medicaid and CHIP Payment and Access Commission (MACPAC), "Exhibit 14. Medicaid Enrollment by State, Eligibility Group, and Dually Eligible Status, FY 2013," in *MACStats*, Section 3: Program Enrollment and Spending–Medicaid Overall (Washington, DC: MACPAC, https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-14.-Medicaid-Enrollment-by-State-Eligibility-Group-and-Dually-Eligible-Status-FY-2013.pdf.

4 Among all Medicaid beneficiaries, about 5 million poor seniors individuals of all ages with disabilities use LTSS. Steve Eiken, *Medicaid Long-Term Services and Supports Beneficiaries in 2012* (Truven Health Analytics, September 2016) accessed at: https://www.medicaid.gov/medicaid/ltss/downloads/ltss-beneficiaries-2012.pdf.

5 Vic Miller and Andy Schneider, *The Medicaid Matching Formula: Policy Considerations and Options for Modification* (Washington, DC: AARP Public Policy Institute, September 2004).

6 Lynda Flowers, *The High Cost of Capping Federal Medicaid Funding* (Washington, DC: AARP Public Policy Institute, April 2011).

7 Congressional Budget Office (CBO), *Options for Reducing the Federal Deficit 2014–2023* (Washington, DC: CBO, November 13, 2013).

8 Edwin Park and Judith Solomon, *Per Capita Caps or Block Grants Would Lead to Large and Growing Cuts in State Medicaid Programs* (Washington, DC: Center on Budget and Policy Priorities, June 2016).

9 U.S. Government Accountability Office (GAO), *Medicaid: Key Policy and Data Considerations for Designing a Per Capita Cap on Federal Funding* (Washington, DC: GAO, August 2016).

10 CBO. *CBO Options for Reducing the Deficit 2017–2026* (Washington, DC: CBO, December 2016).

11 Republican Governors Public Policy Committee, *A New Medicaid: A Flexible, Innovative and Accountable Future* (Republican Governors Public Policy Committee, Health Care Task Force, August 30, 2011).

12 Republican Governors Public Policy Committee, *New Medicaid*.

13 Medicaid pays nearly three times as much per person served in institutional settings as per person served in the community. This is true across populations, including older people and adults with physical disabilities as well as people with intellectual disabilities. Ari Houser, Wendy Fox-Grage, and Kathleen Ujvari, *Across the States: Profiles of Long-Term Services and Supports*, 9th ed. (Washington, DC: AARP Public Policy Institute, 2012).

14 Katherine Young, et al., *Medicaid Per Enrollee Spending: Variation across States* (Washington, DC: The Henry J. Kaiser Family Foundation, January 2015), http://kff.org/medicaid/issue-brief/medicaid-per-enrollee-spending-variation-across-states/.

15 The almost 20 percent is from state fiscal year 2014. MACPAC, *Medicaid Share of State Budgets: Spending* (Washington, DC: MACPAC, https://www.macpac.gov/subtopic/medicaids-share-of-state-budgets/.

16 CBO, *Reducing the Federal Deficit 2014–2023*.

17 Flowers, *High Cost of Capping*.

18 Nicholas Farber and Jana Lynott. *Aging in Place: A State Survey of Livability Policies and Practices* (Washington, DC, AARP Public Policy Institute and the National Conference of State Legislatures, December 2011),accessed at https://assets.aarp.org/rgcenter/ppi/liv-com/aging-in-place-2011-full.pdf

19 Ari Houser, Wendy Fox-Grage, and Kathleen Ujvari. *Across the States: Profiles of Long-Term Services and Supports* 9th Ed. (Washington, DC, AARP Public Policy Institute, 2012), accessed at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf

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