

State Health Reform Assistance Network

Charting the Road to Coverage

A Robert Wood Johnson Foundation program

ISSUE BRIEF

December 2016

Capping Federal Medicaid Funding: Key Financing Issues for States

Prepared by *Cindy Mann, Deborah Bachrach, Patti Boozang, Jocelyn Guyer, and Anne Karl, Manatt Health*

President-Elect Donald Trump and Republican congressional leadership have called for a repeal of the Affordable Care Act (ACA) and a fundamental overhaul of the Medicaid program by imposing caps on federal funding to states. If adopted, capped funding would replace the central feature of Medicaid's financing structure—the federal government's legal obligation to share all allowable state Medicaid costs. While capped funding proposals vary in important ways, they all aim to allow the federal government to achieve budget certainty and reduce federal Medicaid spending. Drawing from a review of past proposals, this brief explores financing issues that arise in the design of capped federal funding.

1. How would capped funding change Medicaid financing?

Capped funding makes two key changes in financing. First, in contrast to current law where the federal government shares fully in the cost of the program, capped funding places a pre-set limit on the amount of federal dollars available to states to finance coverage. Second, the proposals to cap funding are explicitly designed to reduce the amount of dollars that the federal government will provide to finance the program. For example, the Medicaid block grant proposal included in the House Budget Committee proposal for 2017 advanced by Committee Chairman and nominee for Secretary of Health and Human Services (HHS) Tom Price would have reduced federal Medicaid spending by nearly a trillion dollars over 10 years.¹

2. What kinds of caps are under consideration?

Two different types of capped Medicaid funding have been advanced over the years: block grants and per capita caps. They differ in important ways, but both approaches reduce federal spending by divorcing the amount of federal financing provided to states from the actual cost of coverage and setting the caps below the level states are expected to need under current program projections.

Block grants impose a national cap on federal Medicaid funding and an aggregate cap for each state—the funding available to states would not vary based on health care costs or the number of people served. Under a per capita cap, federal funding is capped on a per person basis. The amount of the cap typically varies by enrollee group. For example, a higher cap might be set for the elderly and a lower cap for children. Like block grants, per capita caps do not account for the actual cost of

ABOUT STATE NETWORK

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.statenetwork.org.

ABOUT MANATT HEALTH

Manatt Health is an interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP, one of the nation's premier law and consulting firms. Manatt Health helps clients develop and implement strategies to address their greatest challenges, improve performance, and position themselves for long-term sustainability and growth. For more information, visit www.manatt.com/ManattHealth.aspx.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working with others to build a national Culture of Health enabling everyone in America to live longer, healthier lives. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at [www.rwjf.org/twitter](https://twitter.com/rwjf) or on Facebook at [www.rwjf.org/facebook](https://www.facebook.com/rwjf).

For more information, please contact Cindy Mann at cmann@manatt.com or 202.585.6572, or Deborah Bachrach at dbachrach@manatt.com or 212.790.4594.

¹ House Budget Committee, FY 2017 Budget Proposal, Appendix IV, Table S-4, Available online at: http://budget.house.gov/uploadedfiles/fy2017_a_balanced_budget_for_a_stronger_america.pdf. Figures in table include some savings due to changes to CHIP.

care, but funding would adjust based on the number of people served. However, per capita caps may also be subject to a national, aggregate cap on federal Medicaid funding, in which case states would be at risk both for higher health care costs and enrollment as they are with a block grant.² President-Elect Trump and HHS nominee Price have supported block grants, and House Speaker Paul Ryan's "Better Way" proposal would offer states the choice of a block grant or a per capita cap.

3. Would capped funding apply to all Medicaid populations, including the elderly and people with disabilities, or just to the ACA expansion group?

Medicaid refinancing proposals all have a broad reach; they are not limited to the ACA expansion group.

While the scopes of the proposals vary to some degree, in most of the proposals virtually all Medicaid spending, including higher-cost care for the elderly and people with disabilities, would be subject to caps. The Republican Patient CARE Act proposal, advanced by Senators Orrin Hatch and Richard Burr and Representative Fred Upton ("CARE Act"), excludes acute care but not long-term care for the elderly and disabled from caps, while other capped funding proposals do not distinguish between acute and long-term care.³ Some proposals would keep outside of the caps smaller, separate streams of funding for Disproportionate Share Hospital (DSH) payments, for beneficiaries that receive partial benefits (e.g., dual eligibles), or for services provided through Indian Health Services or tribal facilities.

4. Could Congress exempt certain groups of beneficiaries or certain services from capped funding?

Yes. However, Congress—particularly the Congressional Budget Office (CBO)—would likely be concerned that states could cost shift from the capped program to the uncapped program. For example, if people with disabilities were in the uncapped program, CBO might assume that states would make it easier for adults to qualify under the disability category. That concern (and the added federal cost that would result) might work against partial caps proposals or, if not, lead to new rules and requirements for states aimed at minimizing this type of cost shift.

5. If federal Medicaid payments to states were capped, would states still have to cover all groups of individuals or all services they are now required to cover?

Probably not. Capped funding is typically coupled with greater flexibility with respect to coverage and benefits requirements. States would almost certainly be able to roll back eligibility or cap enrollment for at least some groups of people.

With limited federal funding and fewer rules on who and what must be covered, states can expect greater competition across beneficiary groups and providers (e.g., nursing homes versus hospitals versus primary care or specialty providers) to play out at the state level.

6. Would states that want to continue to cover their current Medicaid enrollees—or new populations—be able to do so?

Maybe. Some capped funding proposals limit the populations states can cover with the federal payments (e.g., people below 100% of the federal poverty level),⁴ and some critiques of the ACA Medicaid expansion object to Medicaid coverage of "able-bodied" adults. The ACA repeal legislation passed by Congress but vetoed by President Barack Obama in early 2016 would have repealed the new coverage expansion for adults without restoring pre-ACA state options for covering low-income parents.

Whether or not states have robust coverage options, a central question will be whether they have the funding needed to take advantage of the coverage options that are available. Proposals to cap federal Medicaid funding are structured to result in lower funding for states; as noted, the House Budget Committee proposal for fiscal year 2017 would have resulted in the loss for states of nearly a trillion dollars over 10 years.⁵

² The Patient CARE Act proposed by Senators Orrin Hatch and Richard Burr and Representative Fred Upton includes an aggregate cap. House Energy and Commerce Committee, Patient Choice, Affordability, Responsibility, and Empowerment Act. Available online at: <http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/20150205-PCARE-Act-Plan.pdf>.

³ Health Accessibility, Empowerment and Liberty Act of 2016, discussion draft legislation. Available online at: http://www.goodmaninstitute.org/wp-content/uploads/2016/05/SESSIO_007_xml.pdf.

⁴ For example, the CARE Act.

⁵ House Budget Committee, FY 2017 Budget Proposal, Appendix IV, Table S-4. Available online at: http://budget.house.gov/uploadedfiles/fy2017_a_balanced_budget_for_a_stronger_america.pdf. Figures in Table S-4 include some savings attributable to CHIP.

7. How would capped payments be set?

Typically, the proposals base each state's capped funding on the state's historical Medicaid spending. For example, a state's block grant might be set equal to the amount of federal Medicaid payments it received in a designated base year. Similarly, under a per capita cap structure, capped payments for children, the elderly, or people with disabilities would likely be set based on the amount of funding that state received for that group of individuals in the base year. While caps could be flat over time (as they are, for example, under the Temporary Assistance to Needy Families block grant), the Medicaid proposals generally allow the capped payments to grow over time, but not based on actual costs or state-specific trend rates. Growth is tied to national trend rates, such as growth in the gross domestic product (GDP) or the Consumer Price Index (CPI).

8. What funding would be counted in setting the caps? How do capped funding proposals treat states that have expanded Medicaid versus states that have not done so?

One of the most challenging and contentious issues for the design of capped funding proposals is how they address the stark differences in federal Medicaid funding levels across states. Federal Medicaid funding reflects in large part state decisions as to who they cover, how much they pay providers, and the breadth of the benefits covered for both acute care and long-term services and supports. Caps based on historical spending freeze in those decisions, leaving states that have limited coverage, narrower benefits, and lower plan or provider rates little or no ability to make different decisions in the future, at least not without making significant tradeoffs, such as by financing new coverage through reductions in benefits or plan/provider payments.

Medicaid expansion funding is probably the most striking example of how these disparities might play out under capped funding: if the capped payments include expansion funding for those states that did expand under the ACA (see the questions raised about whether that funding will actually be available in [Repeal of the ACA Medicaid Expansion: Critical Questions for States](#)), the 31 states that expanded would collectively receive an additional \$56 billion in their annual capped allotments.⁶ Those states may or may not be able to afford to maintain that coverage over time with capped payments, but the other 19 states will almost certainly not be able to afford to extend coverage in the future, at least not without sharply reducing other coverage or provider payments or absorbing the cost with state funds.

Congress could even out the funding or reallocate funding when it sets the caps, using a formula other than state historical spending to distribute the payments. The Republican Patient CARE Act contemplates a redistribution approach: it would set an aggregate cap based on historical national spending, and allocate those dollars based on the number of people in each state with incomes below the federal poverty level.⁷ Evening out the funding—or redistributing funding through a new formula—would either take funding away from the expansion states that are counting on those funds to maintain coverage or require an increase in federal spending to provide more funding to the non-expansion states. None of the capped funding proposals, however, contemplate additional federal investments. Indeed, as noted above, they contemplate less federal spending.

9. Would Congress fold into the capped funding other ACA funds, waiver funds, or supplemental payments into the capped allotments?

The answer to this important question is not clear; most of the proposals do not address this level of detail. States that have funding for Medicaid initiatives created by the ACA—like health homes, Community First Choice, and the Balancing Incentives Program—will want to understand how these funds are considered in the calculation of the capped payments. Many states (and hospitals and nursing homes) rely heavily on supplemental payments that leadership in Congress has criticized, raising the question as to whether these funds will remain available to states in or outside capped funding. It is also not clear how capped funding proposals will treat delivery system transformation and uncompensated care payments authorized by section 1115 waivers. The Ryan proposal would include some—but not all—waiver funding in the base funding, and also constrain new waiver funding.

10. How do capped funding proposals accommodate advances in medical care or events beyond states' control that can drive up state costs?

Neither block grants nor per capita caps automatically adjust federal spending to share the cost of higher-than-anticipated health care costs. Block grant funding does not adjust for higher costs due to an aging population, enrollment increases that result from economic downturns, breakthrough drugs, or unanticipated health care costs such as the current opioid crisis. Similarly, block

⁶ Manatt analysis of data reported by states on Form CMS-64 as of November 2016. Available online at: <https://www.medicaid.gov/medicaid/financing-and-reimbursement/state-expenditure-reporting/expenditure-reports/index.html>.

⁷ House Energy and Commerce Committee, Patient Choice, Affordability, Responsibility, and Empowerment Act. Available online at: <http://energycommerce.house.gov/sites/repUBLICANS.energycommerce.house.gov/files/114/20150205-PCARE-Act-Plan.pdf>.

grants do not accommodate upticks in health care spending such as those that occurred in connection with 9/11 or natural disasters, such as Hurricane Katrina and Hurricane Sandy.

A per capita cap similarly would not accommodate increased health care costs (e.g., new drug costs, new technologies), although it might respond to added costs associated with growing enrollment or changing demographics. However, if per capita caps were set below costs or were subject to an aggregate national cap, those accommodations might be more theoretical than real.

11. Would states still be required to spend state funds as a condition of receiving federal capped payments?

Again, the answer is not clear. Some proposals require a state match,⁸ others are silent on the issue. The Ryan proposal appears to require state spending under existing matching rules if a state opts for the per capita cap approach, but it is not clear whether a match would be required if the state chooses a block grant. Federal block grants for Temporary Assistance to Needy Families, mental health, or other services and benefits vary in terms of whether states have an obligation to spend their own dollars as a condition of receiving federal funds. The Children's Health Insurance Program (CHIP) is the one capped federal program that has a matching requirement, mirroring the rules that apply to Medicaid today.

If state spending is required in one form or another, another key question is whether the current rules on how states raise their funds will be maintained. Will provider taxes and donations, as well as financing contributions from local governments, continue to be permitted? And if so, will they be subject to existing (or new) regulations and oversight? A 2016 proposal advanced by Representative Pete Sessions and Senator Bill Cassidy would have maintained state-spending requirements, but prohibited the use of intergovernmental transfers to meet those requirements.⁹

Regardless of whether the new rules would modify state spending requirements and the funding sources that would count toward those requirements, states will have to consider whether the total funding available under the new capped structure would be sufficient to support state health care priorities. To the extent that federal funding falls short of costs, additional state dollars will be needed.

12. What can states learn from CHIP, which caps federal funding?

CHIP is financed with a fixed federal amount with federal funds provided as matching payments up to that capped amount. States are not guaranteed to receive the total allotted amount as they are under some block grants. As in Medicaid, federal funds are available as a match to state spending. But unlike Medicaid, the funds available are subject to a cap; each state's CHIP allotment serves as a ceiling on the amount of federal matching dollars available to a state. In the early years of CHIP, the capped funds proved too low, forcing some states to close enrollment and establish waiting lists. In the last reauthorization of CHIP, Congress significantly increased state allotments to more accurately reflect state spending with adjustments for child population growth, health care inflation, and other mechanisms to address shortfalls. In short, although CHIP is a capped program, in recent years Congress has assured that states always had sufficient federal matching funds, to the point where in some years total spending on CHIP has grown more rapidly than Medicaid.¹⁰

State experience has been that CHIP has worked well when allotments are sufficient to cover the state costs of covering CHIP-eligible children; when funding is insufficient, it has worked less well, requiring states to limit coverage through enrollment caps and waiting lists. In addition, it is also important to note that relative to Medicaid, CHIP is a small program. CHIP finances coverage for approximately 8.9 million children in low-income families, most of whom are healthy.¹¹ By contrast, Medicaid provides coverage as well as long-term services and supports to 81 million children and adults, including children with special needs, adults with disabilities, and low-income seniors.¹² Coverage for high-cost, high-needs children is typically financed through Medicaid, not CHIP.

⁸ See CARE Act. Available online at:

<http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/20150205-PCARE-Act-Plan.pdf>;

Health Accessibility, Empowerment and Liberty Act of 2016, discussion draft legislation. Available online at:

http://www.goodmaninstitute.org/wp-content/uploads/2016/05/SESSIO_007_xml.pdf.

⁹ Health Accessibility, Empowerment and Liberty Act of 2016, discussion draft legislation. Available online at:

http://www.goodmaninstitute.org/wp-content/uploads/2016/05/SESSIO_007_xml.pdf.

¹⁰ Jocelyn Guyer, Martha Heberlein, and Joan Alker, "CHIP Not a Model for a Medicaid Block Grant," Center for Children and Families, June 2011. Available online at: http://ccf.georgetown.edu/wp-content/uploads/2012/03/Federal%20medicaid%20policy_CHIP-not-a-model-for-block-grant.pdf.

¹¹ Medicaid and CHIP Payment and Access Commission, MACStats: Medicaid and CHIP Data Book, Exhibit 1: Medicaid and CHIP Enrollment as a Share of the U.S. Population, 2015 (millions). Available online at:

<https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-1.-Medicaid-and-CHIP-Enrollment-as-a-Share-of-the-U.S.-Population-2015.pdf>.

Note that many of the "CHIP" children are enrolled in Medicaid but their coverage is financed with CHIP funds. CHIP finances otherwise uninsured children either in Medicaid or in a separate CHIP program whose family income is above levels in place in March 1997.

¹² *Id.*

13. What other Medicaid financing-related rules might be affected?

States will want to understand which of the existing Medicaid payment and matching rules will continue if Medicaid is restructured with capped federal financing. The proposals advanced to date largely leave these and other important questions unanswered:

- Will state Medicaid programs continue to be responsible for paying the premiums and cost-sharing for low-income Medicare beneficiaries?
- Will the current 90 percent matching rate for new IT investments remain available? What about the 75 percent match rate for IT and eligibility system operating costs?
- Will states still be required to pay federally-qualified health centers based on costs?
- Will the rules that require states to pay health plans actuarially sound rates or ensure an adequate network of providers stay in place?
- How will a block grant address Medicaid requirements regarding prescription drugs? Will existing rules that require broad coverage of drugs be maintained? And if not, will Congress drop the federal rebate requirements on drug manufacturers, increasing the cost of drugs for states?

States will also need to consider how they will manage costs that are indirectly driven by other federal laws that presumably will stay in place regardless of Medicaid financing changes; these include the Americans with Disabilities Act (ADA), civil rights, and mental health parity laws. The ADA requirements that people with disabilities be provided long-term care options in the most integrated setting appropriate to their needs, for example, has been one reason states have moved aggressively to expand home and community-based long-term services and supports. Medicaid financing has been instrumental in helping states finance their ADA obligations.

14. Will new flexibility allow states to manage their programs within reduced, capped federal funding?

This is a key question states will need to consider within the context of the expected level of available funds. States already have considerable authority to design their delivery system and payment rates but they are likely to gain new flexibility to reduce coverage and benefits. At the same time, states may be subject to new Medicaid reporting or oversight requirements, which could add to administrative costs. States may also be precluded from using federal Medicaid funds for certain populations or certain services, such as for family planning or end of life counseling. States would bear the full cost if they continued to provide coverage or services that could no longer be supported with federal funds.

Added flexibility may help states looking for new opportunities to improve care and lower costs by investing in population health-related initiatives. For example, states might be able to use Medicaid funds for housing-related services that might lower health care costs for people who are homeless. But while states may gain programmatic flexibility, this flexibility may be illusory if the capped funding does not support new investments. In addition, to the extent that greater flexibility opens up new ways to spend funds, that could lead to intense competition for the capped funds: for example, with new flexibility there may be new demands to use the capped Medicaid funding to supplant state or local funding for Institutions for Mental Diseases or for health care services provided in correctional institutions.