



Evaluating Medicaid Block Grant & Per Capita Cap Proposals

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Congress is quickly moving forward with efforts to dramatically transform Medicaid from a program that provides open-ended funding that reimburses states based on actual health costs (what in budget speak is called an “entitlement”) to a program with capped funding. Since the overall goal of Republicans in Congress remains slashing government funding, all states will end up losers in the long run as they face rising health care costs without additional funding from the federal government.

We have created a list of questions to help you assess the potential impact of forthcoming proposals. The “Top Five” list includes issues common to all the state Medicaid programs. But because Medicaid operates differently in every state, you may want to take a deeper dive to identify the potential impact restructuring Medicaid would have on your state, particularly on issues of interest for your state or federal policymakers. Overall, any new proposal that transfers more financial risk to enrollees or states will erode the guarantee of Medicaid as critical safety-net insurance and likely lead to significant cuts in eligibility, services, provider reimbursement, and consumer protections.

Top Five Questions

The top five questions to consider when comparing new Medicaid proposals to existing funding are:

1. Would federal Medicaid funding in your state stay the same in the first year after the proposal goes into effect? What about after five or ten years?
2. Could your state cover the same categories and number of individuals as it currently does?
3. Are the mandatory and optional services the same?
4. Are the current enrollee protections maintained?
5. If your state has expanded Medicaid through the ACA, would it continue to get the higher federal funding indefinitely without any new funding or eligibility restrictions? If your state has not expanded Medicaid, would it be able to do so in the future and still receive the higher match?

If the answers to these questions are all “no” or not ascertainable, it is likely that your state will be worse off under the proposal than current Medicaid funding. But since the devil will be in the details of

the actual legislative proposals (as opposed to policy briefs), the rest of this issue brief provides more detailed questions to help evaluate new proposals.

Background

To effectively evaluate any new proposal for restructuring Medicaid, you will need to gather information about your current Medicaid program.¹ Here is some of the background information you likely will need:

1. How much did your state spend on Medicaid over the past 1, 5 and 10 years?²
2. What was the annual percentage growth rate in Medicaid spending over the past 1, 5 and 10 years?³
3. How many people were enrolled in Medicaid in 2016 (or 2015)?⁴
 - a. How many children?
 - b. How many pregnant women?
 - c. How many people with disabilities?
 - d. How many older adults?
 - e. How many other individuals (and what were their characteristics – parents, working adults, etc.)?
4. How much was spent on each enrollment group?⁵
5. How does the state decide the eligibility category into which an individual fits (*i.e.*, how do you decide which cap applies if you have a child with a disability – child or disability)?
6. How much was spent per enrollee overall and by population group?⁶
7. Which groups does your state cover beyond the mandatory minimum eligibility categories?
8. Can you break down enrollment between mandatory and optional categories?
9. Does your state put limits on mandatory services, *e.g.* 12 inpatient hospital days annually?
10. What “optional” services does your state provide? Limits?
11. Does your state have one or more HCBS waivers? For what population groups? What “waiver” services does your state provide in each of these waivers?⁷

¹ See, *e.g.*, The Kaiser Family Foundation provides state-by-state information on Medicaid and CHIP, available at <http://kff.org/state-category/medicaid-chip/>. See also, Manatt Health, *Data Points to Consider When Assessing Proposals to Cap Federal Medicaid Funding: A Toolkit for States*, available at <http://www.statenetwork.org/resource/data-points-to-consider-when-assessing-proposals-to-cap-federal-medicaid-funding-a-toolkit-for-states/>.

² See Kaiser Family Foundation, [Total Medicaid Spending](#).

³ See Kaiser Family Foundation, [Average Annual Growth in Medicaid Spending](#).

⁴ See Kaiser Family Foundation, [Total Monthly Medicaid and CHIP Enrollment](#).

⁵ See Kaiser Family Foundation, [Medicaid Spending by Enrollment Group](#). See also MACPAC *Trends in Medicaid Spending (Jan 2016)*

⁶ See Kaiser Family Foundation, [Medicaid Spending per Enrollee \(Full or Partial Benefit\)](#), [Medicaid Spending Per Full-Benefit Enrollee](#).

12. Does your state allow premiums? If so, for whom and how much?
13. Does your state allow copayments? If so, for whom and how much?
14. Does your state have a 1115 waiver? If so, what population groups are covered?

Comparing New Proposals to Current Medicaid Programs

The following sections outline a number of high-level questions that you may need to answer to quantify the likely losses in eligibility, services, and consumer protections that would arise if Medicaid funding was changed to a block grant or per capita cap. Depending on the current Medicaid program in your state, you may need to answer additional questions.

A. Funding

One of the defining features of the current Medicaid program is that federal funding is tied to actual costs incurred by the state for services provided to enrollees. For each new enrollee, service covered, or provider paid, states can receive federal reimbursement at a pre-determined FMAP (Federal Medical Assistance Percentage). Past proposals to convert Medicaid into a block grant or per capita cap have abandoned this shared responsibility for actual costs and shift financial risk to the states. With a capped federal contribution, states would shoulder the responsibility for extra costs, be they from increased enrollment, development of costly new health care services or medications, or increases in provider reimbursement.

Many proposals are structured to delay the larger cuts in the later years. This may be done, in part, to lessen the initial impact and undercut opposition. For example, some states may see fewer negative effects in the initial years (especially if states that expanded Medicaid can continue receiving the enhanced match for a transition period). Thus, it is important to look beyond the first few years and particularly examine the impact in the later years of a proposal.

Some of the questions that need to be answered to evaluate how much federal funding a state may lose include:

1. What is the growth rate or “index”⁸ used in the new proposal?
2. How does the “index” compare to your state’s current year-over-year increases?⁹

⁷ If your state has any waivers under § 1115 or § 1915 of the Social Security Act, you should evaluate what services are provided to whom and the overall budget.

⁸ The current proposal is likely to use the “chained” CPI as the inflation index plus 1%. The regular CPI usually rises slower than health care costs and the chained CPI is often lower than CPI. For example, see Kaiser Family Foundation, *How has Health Spending Increased Over Time?* <http://www.healthsystemtracker.org/chart-collection/how-has-health-spending-changed-over-time/?slide=19>.

⁹ See Kaiser Family Foundation, [Average Annual Growth in Medicaid Spending](#)

3. How much will the state receive in the **first** year after implementation? How does this compare to current spending?
4. How much will the state receive in the **fifth** year after implementation? How does this compare to projected spending (use your current growth rate to compare)?
5. How much will the state receive in the **tenth** year (and subsequent years) after implementation? How does this compare to projected spending (use your current growth rate to compare)?
6. Is the enhanced match still available for family planning services and supplies?
7. Is the enhanced match still available for language services?
8. Is the enhanced match still available for Community First Choice Option if your state took up that option?
9. Do states still receive at least 50% reimbursement for administrative costs?
10. Is the enhanced match still available for transforming computer systems?
11. How does the cap incorporate DSRIP funding or funding for other demonstration projects?

B. Per Capita Caps

A per capita cap proposal would limit federal contributions based on a predetermined amount of funding per person. Unlike a block grant, this allows federal funds to vary to accommodate changes in enrollment (due, for example, to an economic downturn), but may not respond to other common cost drivers (for example, medical advances and an aging population).¹⁰

1. How many caps are there (*e.g.*, 1 for children, 1 for elderly individuals, 1 for people with disabilities, 1 for adults)?
2. Are there sufficient caps to address the variation in your Medicaid population?
3. Is the cap less than your state currently spends on the relevant populations?
4. Does the cap adjust for any factors (*e.g.*, economic recession, natural disaster, epidemics, new prescription drugs, or other medical technology)?
5. How would enrollees be sorted under different enrollment caps/groups? How would states identify individuals who might fall under multiple caps?
6. What would be the administrative burden of sorting people by different caps each month?
7. What would be the reimbursement for someone enrolled for only part of a month?
8. Would the cap(s) put your state at risk financially if certain enrollees cost more to provide care than the caps provide?
9. Would the cap permit your state to expand enrollment by adopting a new optional eligibility category and still receive federal funding for those new enrollees?
10. Would children with disabilities or chronic conditions have a cap based on all children, all people with disabilities, or something else? Would the cap be sufficient to provide essential care to these children that would allow them to remain in their homes and communities?

¹⁰ See NHeLP's [Fact Sheet: Per Capita Caps vs. Block Grants in Medicaid](#).

11. Would the cap apply to HCBS waiver programs? Or only to medical services for HCBS waiver participants? Would the funding be sufficient to provide people with disabilities the full range of supportive services and home and community based services currently provided in your state?
12. Would the cap be sufficient to cover the costs of nursing home care for all eligible individuals, particularly as the population ages and more individuals become eligible for these services?
13. Would the cap improve or worsen institutional bias in Medicaid?
14. Would the cap be sufficient to provide care for pregnant women with high-risk pregnancies or who give birth prematurely?
15. Does the cap account for inflation sufficient to ensure provider participation across general and specialty care provider groups?
16. If your state gets additional DSH funding, would it sufficiently compensate for loss of funding under the per capita cap?

C. Eligibility

Eligibility for Medicaid is complex due to the number of different eligibility categories as well as the income (and sometimes asset) limits. While reducing eligibility complexity would be a worthwhile endeavor, new proposals likely would only do so by restricting eligibility. Some of the questions to consider regarding eligibility include:

1. Are there mandatory eligibility categories? If yes, are they the same as current law or are some populations left out?
2. Are there optional eligibility categories the same? If yes, are they the same as current law or who is left out?
3. Does the “medically needy” category still exist?
4. Does Transitional Medical Assistance still exist?
5. Are there any limits that reduce your state’s ability to expand eligibility beyond mandatory categories? If not, how many people could lose coverage?
6. Does the new proposal allow your state to continue enrolling all populations it currently covers?
7. Are there optional eligibility groups that typically cost more than the applicable cap who might be subject to termination?
8. Are CHIP enrollees included in the proposal? If yes, are there any changes to eligibility?
9. Are there any new barriers to eligibility such as work requirements, premiums, or cumulative time limits?
10. Are there any lock-out periods for any individuals?
11. Are immigrants still eligible to the same degree they are currently?
12. Does the “reasonable opportunity period” still apply for immigrants who have to document their immigration status (such that lawfully present immigrants can get provisional eligibility while verifying immigration status)?

13. Does the state have the option to cover lawfully present immigrant pregnant women and children during the five year bar?
14. Can states implement presumptive eligibility for all/some groups?
15. Can states provide continuous eligibility?
16. Can a state begin to place enrollment restrictions on individuals with pre-existing conditions?

D. Medicaid Expansion¹¹

As of January, 2017, 31 states have expanded their Medicaid programs pursuant to new authority in the ACA. States initially received 100% federal reimbursement for the costs of these new enrollees. Over time, the federal share will drop to 90%. Discussions in Congress have focused on reducing the federal share for the Medicaid expansion population and proposals may reduce the federal funding below 90%.

If your state has expanded Medicaid, here are some questions to consider:

1. Does the new proposal allow your state to continue enrolling those populations or are there eligibility restrictions?
2. Under which cap will the medically frail and people with disabilities currently covered under the Medicaid expansion be categorized?
3. Will states continue to be required to screen expansion eligible enrollees for medical frailty, including disabilities, mental health conditions, and other serious chronic conditions? How much would such a screening cost?
4. Does the new proposal provide the same funding as the ACA to cover those additional populations?
5. Does the new proposal permit enrollment caps on this or any other population?
6. Are there limits on the scope of services provided to these enrollees?
7. Are there any limits – time limits, spending limits, other – on covering the expansion population?

If your state has **not** expanded Medicaid, here are some questions to consider:

1. If your state decided to expand Medicaid, would it get funding to cover these new enrollees?
2. Would there be any limits on the ability of your state to expand?
3. Would there be limits on the scope of services provided to these enrollees?
4. Would preventive services still provided at no cost?
5. Would there be any limits – time limits, spending limits, other – on covering the expansion population?

¹¹ See NHeLP's [50 Reasons Medicaid Expansion is Good for Your State](#).

Other Issue Areas

Given that current efforts by Congress focus on changing the financing and are limited by what is permissible through the budget reconciliation process, we are not including questions about Medicaid services and consumer protection provisions. These changes may be attempted at a later date, especially if states seek more flexibility to live within new financing limits. We can provide additional questions as needed to continue evaluating proposals to change the Medicaid program.

Conclusion

When the ultimate goal is to decrease federal funding rather than identify ways to effectively and efficiently provide care, any attempts to undermine the existing guarantees of Medicaid will put the health and care of 74 million individuals at risk. States will bear an increasing share of the risk for maintaining basic levels of eligibility, services, and payments to providers. Careful analysis of any proposals to change Medicaid's financing and structure must be undertaken to identify who stands to be harmed and left worse off than under current law.