

MEDICAID AND FEDERAL FUNDING CAPS IMPLICATIONS FOR ACCESS TO HEALTH CARE AND LONG-TERM SERVICES AND SUPPORTS AMONG VULNERABLE AMERICANS

By **Benjamin W. Veghte** and **Alexandra L. Bradley***

Any public policy must balance its objectives and budgetary constraints. The task of balancing purpose and constraint is particularly challenging in U.S. health care policy because of the high cost of health care,¹ coupled with the absence of a comprehensive approach to cost management as adopted by other nations.² The effort to balance costs and goals poses an especially complex challenge for a program like Medicaid, in which the federal government and the states share the cost of care. Any curtailment of the federal government's funding commitment to health care and long-term services and supports for the nation's poorest and most vulnerable populations would shift a larger share of the cost burden onto the states and localities where they reside.

Both the American Health Care Act (AHCA) and the Medicaid provisions in the Trump Administration's Fiscal 2018 budget propose massive shifts in fiscal responsibility for Medicaid from the federal government to states and localities. The capacity of states to bear additional responsibility for Medicaid is limited. Their ability to

generate revenue varies widely. Nearly all states are required to balance their budgets, either by constitution or statute, and are constrained from financing government debt.³ Moreover, if one state raises taxes to compensate for a decline in federal funding while its neighbors do not, high-earners in that state could opt to move to a neighboring state. Similarly, if one state chooses not to cut Medicaid coverage or benefits despite the decline in federal funding, but its neighbors do, this could attract new beneficiaries from neighboring states.

This brief will first discuss Medicaid's role in the nation's health care system, as well as its budgetary footprint and financing structure. It will then discuss strategies for containing cost growth, and analyze in depth the strategy of capping federal spending through per capita caps, as proposed in the AHCA. It will conclude with a consideration of the implications of per capita caps for states' ability to provide health care and long-term services and supports to vulnerable Americans.

* **Benjamin Veghte** is Vice President for Policy and **Alexandra Bradley** is Health Policy Analyst at the National Academy of Social Insurance.

Medicaid's Role in the Health Care System

From its beginnings as a small companion to cash welfare,⁴ Medicaid has come to play a substantial role in the U.S. health care system. Today, Medicaid insures roughly 69 million people.⁵ The program finances nearly half of all U.S. births.⁶ Together with its smaller companion Children's Health Insurance Program (CHIP), it covers more than one-third of American children.⁷ Medicaid insures over 1 in 10 working-age Americans,⁸ and 1 in 5 low-income Medicare beneficiaries depends on Medicaid to cover services not covered by Medicare (e.g., long-term services and supports) and to afford Medicare's considerable patient premiums and cost sharing.⁹ Since long-term services and supports are not covered by Medicare or private health insurance plans, and the private long-term care insurance market has been unable to create a product that is priced to attract a meaningful number of consumers, Medicaid has risen to become the dominant insurer for the LTSS needs of individuals with disabilities and seniors.¹⁰ Medicaid is also a critical source of coverage for children with special health care needs,¹¹ and has made it possible for many adults with disabilities to hold jobs while maintaining health care coverage.¹²

Medicaid finances nearly half of all U.S. births, and along with its smaller companion Children's Health Insurance Program (CHIP) covers more than one-third of American children.

Medicaid's size tells only part of the story. The program is the nation's largest social program targeted at low-income Americans, accounting for \$553.8 billion in total spending in 2015, 63 percent of which is federal.¹³ However, Medicaid is less expensive per enrollee, after adjusting for health status, than Medicare or private insurance.¹⁴ Indeed, the Congressional Budget Office (CBO) has estimated that the same service package, when furnished through private insurance, would cost 50 percent more per enrollee.¹⁵ Medicaid's per capita cost growth has been comparable to or lower than other forms of health insurance, and is projected to be lower in the future as well.¹⁶

How is Medicaid Financed?

Since its 1965 enactment, Medicaid has been funded in accordance with a federal formula that entitles states to



be paid for a percentage of their qualifying expenditures for health care and administrative costs. States effectively determine the size and scope of their programs, aside from compliance with certain minimum eligibility and coverage rules, and select from a wide range of program options. The federal government then shares in the cost of health care benefits furnished by state programs up to a percentage inversely related to state per capita income.

This open-ended approach to federal funding was seen as a significant advance over Medicaid's predecessor, a federal grant-in-aid program that broke with precedent by authorizing direct payments to health care providers rather than cash payments to families.¹⁷ This earlier program provided federal funding to state health care programs for the poor, but this funding was subject to per capita limits. Rather than spurring efficiency and innovation, these federal funding caps—applied on a per-beneficiary basis—meant limited coverage. A dozen states excluded children entirely. Several restricted coverage for hospital care outside of life-endangering emergencies, and some excluded all but a handful of prescription drugs. Overall, less than 2 percent of the population received coverage.¹⁸

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By moving to the current open-ended financing structure, the federal government encouraged not only strong enrollment growth more calibrated to the actual extent of need, but also growth in per-beneficiary spending at a level reflecting the actual cost of a reasonable level of coverage.¹⁹ Today, as with other forms of health insurance, Medicaid coverage spans a broad range of items and services, including comprehensive physical, behavioral, and oral health care for infants and children; preventive primary health care for adults, including women’s reproductive health services and pregnancy-related care; services to manage the health of children and working-age adults with serious and chronic health conditions;²⁰ and health care and long-term services and supports for individuals with disabilities and the frail elderly, principally in home and community-based settings, as well as in institutional settings.²¹

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On the other hand, some policymakers argue that Medicaid’s open-ended, matched financing structure fails to sufficiently incentivize states to develop more efficient ways to deliver care. In theory, capitation would provide greater efficiency incentives. However, examples of cost-reducing efficiency gains in health care for vulnerable populations are scarce, and often require up-front investment and tolerance for a long waiting period before returns on investment materialize. A more likely response by states to capitation of federal funding would be to cut benefits, restrict enrollment, or expand cost sharing.

One unintended consequence of federal matching for state Medicaid spending is that over the years, states may have found ways to shift cost burdens from the states to the federal government. Funds from providers and local governments can be used to inflate state Medicaid budgets, in turn raising federal contributions without any increase to states’ contributions. Indeed, a Government Accountability Office (GAO) survey of all states found that



from 2008 through 2012, funds from providers and local governments had increased as a percentage of the non-federal share, while state funds had decreased.²² The GAO study noted an example in Illinois, where the state had taxed nursing facilities to fund an increase in Medicaid payments to nursing facilities, resulting in an increase in federal matching funds and no increase in state general fund expenditures.

Capping Spending vs. Containing Costs

Health care costs in the United States are by far the highest in the world, and hence controlling them is a perennial challenge of public policy. But controlling overall Medicaid costs and capping federal Medicaid spending are fundamentally different. The former entails health care financing and delivery system reforms that seek to hold down the rate of spending growth in Medicaid (and other payers) by improving quality and efficiency. Federal spending caps eschew initiatives aimed at addressing underlying cost drivers in favor of shifting risk of cost growth to states, localities, other insurers, health care providers, and consumers.

Approaches to Controlling Medicaid Costs

Medicaid spending is driven principally by enrollment.²³ Therefore, to control costs without taking coverage away from millions who depend on it because of poverty, poor health, disability, age, or some combination of factors unrelated to the need for health care, it is necessary to focus on greater efficiencies and, where possible, better price controls. Options pursued actively by states with bipartisan federal support over the past two decades include expanded authority to take steps that help slow the increase in the volume and intensity of care and address high-priced treatments. A full discussion of cost containment strategies goes beyond the scope of this brief, but examples include global budgeting,²⁴ expanded use of managed care and other payment and delivery reforms,²⁵ shifting a greater proportion of long-term care services from nursing homes to community settings, and more active management of high-cost prescription drugs.



Managed care: The Medicaid program allows states to contract with managed care organizations to organize and manage comprehensive health care delivery for a preset fee similar to a health insurance premium. Better and broader use of managed care models for higher-cost beneficiaries thus might yield savings over time, particularly for those beneficiaries who are dually enrolled in both Medicare and Medicaid. These beneficiaries typically have a greater need for both acute and long-term care services—and considerably higher annual per capita costs—than most

others. The same is true for children and adults eligible for Medicaid based on serious and ongoing disabilities, for whom care management can be effective. Slightly under half of all states have implemented or are in the process of developing managed LTSS programs for seniors and individuals with disabilities.²⁶ Other states could elect to adopt these strategies as well, either as a state option or through special demonstrations under Section 1115 of the Social Security Act, to test other strategies for managing costs for dually eligible enrollees. Designing and administering such systems can be complex, but many states have paved the way in developing managed long-term services and supports, and federal law currently provides flexibility in this regard.²⁷

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Price negotiation: Another approach to greater cost containment in Medicaid is to give states greater negotiating leverage over the price of new drugs, devices, and assistive technologies. Because of whom it insures, Medicaid is a large purchaser of extremely costly health care items and services. Current Medicaid policy limits states' power to negotiate drug prices, instead opting for a rebate in exchange for coverage of virtually all FDA-approved non-innovator drugs and biologics.²⁸ Nearly all states negotiate additional supplemental rebates, but some states have pushed to change the rules for coverage of all drugs. Developing such additional authority would, of course, have to be done with care in order to guard against undue restrictions on access to necessary medications, including breakthrough drugs. But Medicaid's purchasing power is considerable, and through the use of well-designed formularies and strategies such as reference pricing, the growth of drug costs could be slowed.

In sum, broader use of managed care by states and greater authority to utilize market-based solutions such as competitive price negotiation, combined with other types of flexibility such as value-based coverage and cost sharing design, could hold down Medicaid spending growth over time in a manner that does not put coverage itself at risk.²⁹

Capping Federal Spending

Capping federal contributions to the Medicaid program would shift responsibility for cost containment to the states. The idea of capping federal Medicaid spending is not new. Throughout the course of the program's history, several attempts have been made—in 1981, 1995, and 2003—to change the nature of Medicaid's federal financing structure from an open-ended entitlement to a capped payment, typically in the form of a block grant.³⁰ None of these were enacted into law.

It is important to note that capping federal Medicaid spending is distinctly different from the type of capitation used in managed care or global budgeting in several key respects. First, payments to managed care systems currently functioning under Medicaid in the United States are required by federal law to be actuarially sound.³¹ This means that the payments are guaranteed to be sufficient to compensate managed care organizations for providing quality care for all required benefits. In fact, these capitation rates are adjusted annually to adjust for changes in expected health and long-term care costs. Second, the health care systems of other countries that use global budgeting strategies also ensure virtually universal coverage for citizens and typically have established a floor for benefits covered. While there are currently mandatory populations³² and benefits³³ that must be covered under Medicaid, there are also many that are optional. In an environment of federal capitation, states could opt to remove people or benefits that fall into an optional Medicaid category.

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How Would Block Grants or Per Capita Caps Work?

In contrast to strategies aimed at reducing health care costs overall, block grants and per capita caps are designed simply to limit federal Medicaid spending. Block grants and per capita caps each work somewhat differently, but both aim to accomplish the same task of reducing federal spending.

Block Grants

Under a block grant approach, the federal government allocates a fixed, aggregate sum to states annually based on a pre-determined formula. The annual allocation may reflect historic state spending, trended forward. Alternatively, the aggregate formula can reflect a national average across all state programs, either for the Medicaid population as a whole or broken down by sub-populations (e.g., rates based on the proportion of children, working-age adults, people with disabilities, and the elderly in a given state). The federal allotment, however calculated, would be adjusted annually by some measure of inflation, but not to reflect population growth due to a recession, the volume and intensity of care, or advances in technology such as the introduction of new and costlier drugs and devices.³⁴ The choice of base allocation determines whether states are locked in place at current spending levels or whether dollars are shifted across states, and the choice of indexation measure determines the degree to which program funding lags (or keeps pace with) actual cost growth.

Current federal program requirements could be greatly scaled back under a block grant. Instead of detailed eligibility, benefit, and cost sharing rules, federal law might simply require that states uphold some maintenance of effort (MOE) through coverage of certain populations (e.g., children) or services (e.g., hospitalization), and that funds be spent on medical care.

In a block grant, states might not be required to expend their own funds in order to qualify for federal contributions. Thus, a block grant could reduce overall spending on health care for vulnerable populations not only by the amount of federal funding lost, but also by the amount of cuts in state expenditures.

Under current policy, the federal government pays states a portion of what they expend on covered services furnished by participating providers to enrolled beneficiaries. In a block

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Per Capita Caps

As with a block grant, a per capita cap would place a fixed limit on the amount of program funding paid by the federal government and could eliminate the need for state spending as a condition of federal funding. The difference is that the limits would be expressed in per-enrollee terms, meaning that as program enrollment grows, the overall amount of federal funding a state receives also would rise. The per capita payment can be calculated by sub-population or as a single average payment across all enrollees. As with a block grant, a per-enrollee cap would be set by a base year and adjusted annually through a formula fixed in law. In the absence of specific adjustments, the

Table 1. Changes to Key Medicaid Features in Block Grant or Per Capita Cap Funding

	Current Medicaid	Block Grant	Per Capita Cap
Coverage	Guaranteed coverage for people who are eligible under a state plan; state waiting list flexibility limited to services under waivers (e.g., home and community based services)	No guaranteed coverage for eligible people; federal payments not tied to number of people who qualify for help; states can use waiting lists and cap the number of people who receive services	People who are eligible receive some level of coverage; federal payments tied to actual enrollment
Federal Funding	Funding reflects federal share of total state expenditures per federal funding formula; no cap Responsive to changes in enrollment, volume, intensity, and technological advances Annual growth rates vary over time	Subject to an aggregate cap not adjusted for enrollment, volume and intensity of care, or changes in technology or innovation Annual aggregate spending caps that grow in accordance with a formula set in law	Subject to a per-enrollee cap, or multiple caps for different categories of enrollees; no adjustments for volume and intensity; no adjustment for changes in technology or innovation Annual per capita growth rate in accordance with a set formula defined in law
State Expenditures	A condition of federal payment Federal payments cover a portion of state spending	State expenditures may or may not be required as a condition of federal funding	State expenditures may or may not be required as a condition of federal funding
Core Federal Standards	Minimum federal requirements as a condition of participation with respect to both the level of coverage and permissible patient cost sharing, coupled with extensive state options	Minimal requirements, typically limited to a requirement that funds received be spent on health care (and possible mandatory populations and benefits)	Requirements that spending be on covered health care services, with broad state latitude over what services must be covered and what cost sharing can be charged ³⁶

Source: Authors’ analysis of key features of block grants and per capita cap proposals.

Note: At the time of writing, the contours of reform proposals currently under consideration by Congress and the Administration are not final.

federal payment rate would not alter in relation to changes in the volume and intensity of care, the introduction of new technologies or innovative pharmaceuticals, or demographic changes such as the aging of the Boomer generation into years of higher care needs.

The purpose of a block grant or per capita cap is to produce federal savings. These savings are generated by growing the federal contribution at a slower rate than is projected to be necessary under the current financing system. Both a block grant and per capita cap represent a fundamental departure from longstanding Medicaid law and policy. Because states likely would experience a growing gap over time between the cost of maintaining their existing programs and what they receive in federal funding,³⁵ they would likely also want additional flexibility to eliminate coverage for populations and benefits that are currently mandatory.

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Medicaid Spending Caps in the American Health Care Act

The American Health Care Act—which passed the House of Representatives on May 4, 2017—would introduce an Affordable Care Act repeal and replace strategy that includes a fundamental change to the structure of Medicaid from an open-ended entitlement to per capita caps, in addition to a state block-grant option.³⁷ As of mid-June 2017, the Senate has not yet introduced its own version of a repeal and replace bill. The Trump Administration’s budget would also give states the choice between a per capita cap and a block grant, while designing the per capita caps in such a way as to achieve far steeper cuts to Medicaid than proposed in the AHCA.³⁸

The AHCA would reduce the special enhanced federal funding rate for the Affordable Care Act’s adult Medicaid expansion group (adults ages 18-64 not otherwise eligible for coverage under Medicaid rules). In accordance with the fast-track legislative “reconciliation” process that is expected to be used in the Senate, which limits the range



of modifications to existing tax and entitlement laws that can be included in a bill, the House bill would make only minimal changes in Medicaid program requirements. Populations whose coverage is mandatory (poor children and pregnant women; exceptionally poor parents and caretakers; and people who qualify for Supplemental Security Income, such as seniors and individuals with disabilities) would remain entitled to Medicaid in all states, and optional populations would retain their entitlement to coverage in any state that elects to continue offering coverage for that optional beneficiary group. The minimum benefit package for mandatory populations would also remain in place, as would Medicaid’s current cost sharing rules. That said, it is not clear how such requirements could be sustained if federal contributions fail to keep pace with actual costs. The AHCA would also give states the option to impose work requirements on adult beneficiaries who are not elderly, disabled, or pregnant.

The House-passed measure includes a state block grant option for the coverage of low-income children and/or most low-income, working-age adults. States taking this option, which would grow only at the rate of general inflation, would be able to bypass virtually all federal program requirements related to eligibility, benefits and coverage (with the exception of mandatory eligibility for children), standards for provider participation, other program management requirements, and federal rules regarding state expenditures.

The per capita caps would begin in 2020. In 2019, per capita caps would be set for each of five beneficiary categories

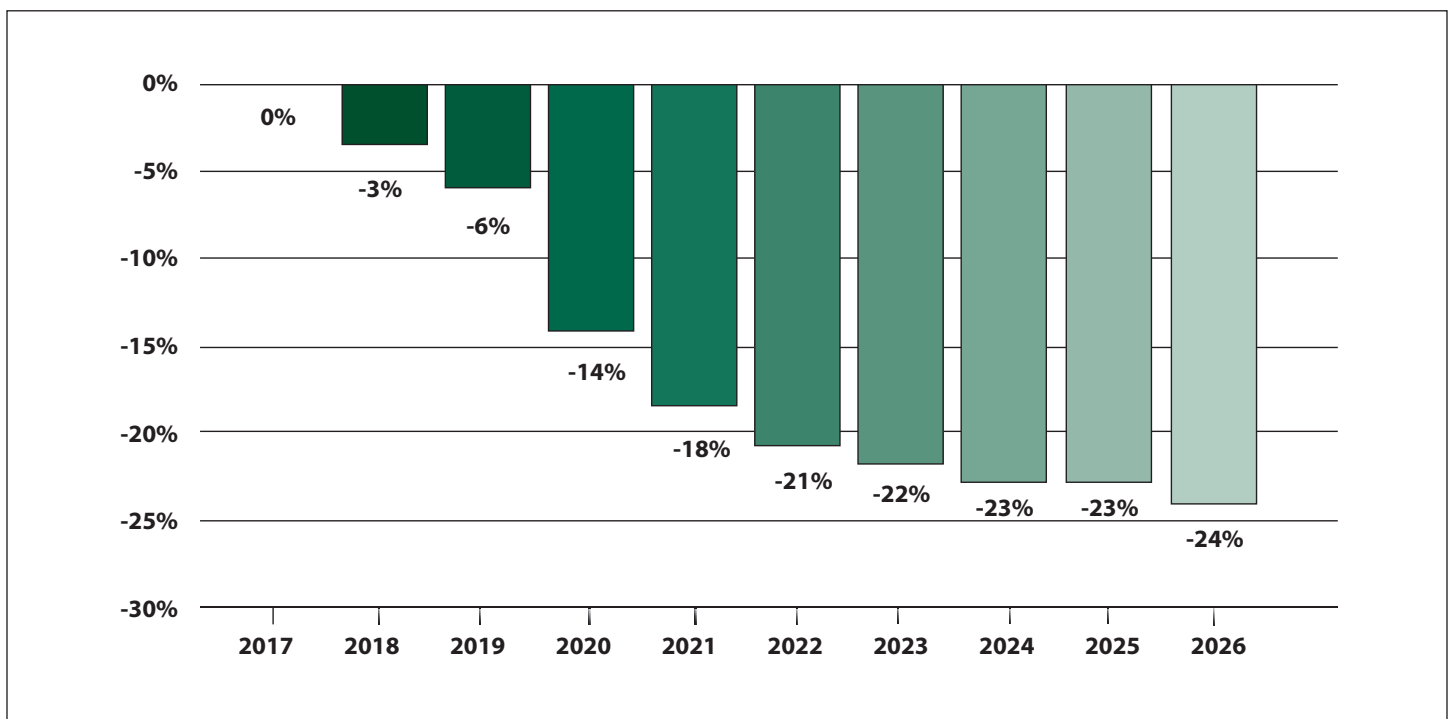
(children, seniors, people with disabilities, low-income childless adults covered by the ACA's Medicaid expansion, and other adults eligible prior to the ACA expansion—mostly low-income pregnant women and parents). These caps would be based on the sum of actual per-capita spending in 2019 in each of these five categories. If each state's 2016 per capita spending across all categories, trended forward through 2019 to account for inflation using the Consumer Price Index for Medical Care for All Urban Consumers (CPI-M), is lower than the caps based on actual 2019 spending, then the latter would be adjusted downward proportionally.³⁹

Upon implementation in 2020 and beyond, states would be subject to an aggregate cap equal to the sum of each specific cap multiplied by enrollment in that category, with the cap adjusted based on changes in the share of enrollees in each of the five categories. The growth rate of the aggregate caps would depend on the composition of enrollees. The per capita cap component for seniors and people with disabilities would grow with the CPI-M plus 1 percentage point, while the other three components

would continue to grow at the rate of the CPI-M.⁴⁰ States would have discretion to reallocate spending across these five groups within the aggregate caps. The CPI-M measures out-of-pocket consumer spending on health care, which is growing more slowly than the Congressional Budget Office projects Medicaid costs overall will grow.⁴¹ It should be noted that at any future point in time, Congress could lower the growth rate in order to achieve further federal budgetary savings. Indeed, the Trump Administration already assumed this in its FY18 budget.⁴²

The Congressional Budget Office estimates that the Medicaid reforms in the AHCA would reduce the federal contribution to Medicaid by \$834 billion from 2017-2026. CBO determines these cuts by comparing the reduced federal Medicaid payments under the AHCA to what the government would have contributed under current law, according to CBO assumptions. This analysis reveals that the magnitude of the reductions in percentage terms would be less than 10 percent in years 2017-19, but would rise to 24 percent by the end of the ten-year window (Figure 1).

Figure 1. AHCA Cuts in Federal Medicaid Payments to States, 2017-2026



Source: CBO, 2017.

The Trump Administration's FY18 budget uses a slower growth rate for the per capita caps. Its Medicaid cuts would be much steeper than those in the AHCA, totaling as much as \$1.3 trillion between 2017 and 2026.⁴³

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How Could Reductions in Federal Funding Affect Access to Care?

States could respond in a number of ways to legislation that withdraws significant federal funding, with or without additional flexibility to reduce the program's size and scope further than what is already permissible under federal law. (As of June 6, the Senate Parliamentarian has not yet ruled on what types of additional state program flexibility provisions related to eligibility, benefits and coverage, and other requirements would be permissible to include in the fast-track reconciliation process.)

States that desire to maintain their existing programs in the face of per capita caps would need to begin to make additional payments beyond the amounts required under the federal funding formula. To fully make up the difference between current levels of funding and the capped federal funding under the American Health Care Act, states would need to increase their spending by over a third or more by 2022 and beyond.⁴⁴ Such an added demand on state funding would further burden state budgets already stressed by the current cost of Medicaid and indigent health care spending.

Since most states already do a great deal to control Medicaid spending and face the substantial roadblock of annual balanced budget requirements, there would be little room for savings from increased efficiency of the program.⁴⁵ Therefore, options are limited for where further funds could be sourced. On the one hand, states could raise funds by increasing taxes, cutting funds from other programs (e.g., education, infrastructure, public safety, public assistance programs, etc.), and/or increasing cost sharing for beneficiaries to make up the difference.

Alternatively, or in conjunction, states could scale back on Medicaid coverage either by restricting enrollment, cutting benefits, or cutting already very low payments to providers, which in turn could reduce access to care.⁴⁶ States could also opt to decrease their own expenditures in proportion to federal funding losses, resulting in hundreds of billions of dollars in additional Medicaid cuts.

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Health Care and Long-Term Services and Supports

If the AHCA is enacted, states would come under tremendous fiscal pressure to reduce eligibility and services when federal Medicaid cuts begin to fully take hold in the early 2020s. States would be likely to focus on making cuts to the populations and services that are most costly on a per capita basis. Examples of Medicaid investments most likely to face reduction or elimination include coverage for seniors and people with disabilities with income above Supplemental Security Income levels who require long-term services and supports, and coverage for adult benefits such as dental care, vision care, or home and community-based services.⁴⁷ Alternatively, non-mandatory populations could be placed on wait lists for Medicaid coverage, in addition to the many currently eligible individuals in optional categories who are already on a wait list for care.⁴⁸ Other expensive optional services that could be cut to reduce costs include personal care and rehabilitative services.

More generally, those requiring long-term services and supports—namely people with disabilities and frail seniors—are expensive to serve, and therefore could be targeted for cuts. Seniors and individuals with disabilities currently represent one-quarter of Medicaid enrollees, yet account for a disproportionate share (two-thirds) of total Medicaid spending.⁴⁹ As Boomers age, the growth rate of the proposed per capita caps (M-CPI + 1) for these populations may prove insufficient to keep pace with the needs of those eligible for Medicaid LTSS. The first cohorts of Boomers are now in their 70s. As they age, their per capita health care and LTSS costs will increase, putting pressure on states.

In light of capitated federal funding, states could choose to reduce LTSS services, particularly for groups with less well-developed advocacy structures, such as people with physical disabilities. Medicaid’s Section 1915(c) authority currently provides states with tremendous flexibility to develop home and community-based services waivers to meet the needs of people who prefer to get LTSS in their home or community rather than in an institutional setting. However, these services could be a target for state cuts, since they are optional, while institutional care is a mandatory benefit. Furthermore, given the deep budget cuts to Medicaid under the AHCA, states could argue that meeting *Olmstead* obligations to accommodate the right of people with disabilities to live in the most integrated setting appropriate to the individual’s need⁵⁰ would require them to “fundamentally alter” their system of services to other Medicaid beneficiaries. State Medicaid programs’ obligation under *Olmstead* to provide services in the most integrated setting is not unlimited,⁵¹ and some states might seek and find relief in the courts.



These choices also have the potential to produce unintended consequences for state budgets in the long term. For example, forgoing appropriate long-term services and supports at earlier stages of need in lower-cost settings such as the home and community can drive frail seniors into greater utilization of higher-cost care as unmet health needs compound and LTSS needs rise.⁵²

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Dual-Eligibles and Medicare’s Finances

Restrictions to coverage for individuals with long-term care needs could affect not only state budgets, but also Medicare’s finances. One-fifth of Medicare beneficiaries rely on support from Medicaid. This population, known as “dual-eligibles,” consists of low-income seniors and younger people with disabilities. They receive Medicaid support either through coverage of direct services (e.g., long-term services and supports) or through assistance with Medicare premiums and cost sharing.⁵³ While dual-eligibles make up only 15 percent of Medicaid beneficiaries, they account for one-third of Medicaid spending.⁵⁴ If cuts are made to eligibility and benefits for low-income seniors and individuals with disabilities who have LTSS needs, or if cost sharing for these populations is increased, it is likely that many would delay or forgo necessary care. While this would save money for Medicaid in the short term, it would likely not only worsen health outcomes but also increase preventable hospitalizations and emergency care, driving up Medicare costs in the long term.⁵⁵

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Responsiveness to Population Health Threats

Another potential effect of per capita caps would be its impact on states’ ability to ramp up quickly and with more intensive services in the face of population health threats. The adaptability and responsiveness of an open-ended entitlement has facilitated Medicaid’s role as a “first responder” for the health care system. The lack of capped funding restrictions has allowed the program to respond quickly to a variety of population health needs and public health crises, from the Zika virus and Hurricane Katrina to HIV/AIDS and the September 11th attacks.⁵⁶ For example, in the face of the opioid epidemic, many states have expanded and intensified the range of health



services that beneficiaries can receive in order to add both intensive inpatient and outpatient rehabilitation as a covered service. Medicaid's uncapped structure has also helped the program adapt to sudden spikes in health care costs due to innovative (but expensive) technological and medical advancements, such as the recent pharmaceutical treatment for Hepatitis-C. These types of costs are simply not anticipated or accounted for in a per capita cap, and the years ahead will undoubtedly bring other unpredictable health crises that would benefit from "first responder" support from Medicaid.

Innovation and the Flexibility Paradox

The future of opportunities for state flexibility and innovation is uncertain under a block grant or per capita cap financing structure. On the one hand, innovation is challenging in the current environment. The process of applying for waivers and demonstrations can be burdensome for states, and requires substantial administrative commitment. There is also a long time lag time between the formulation of an idea and the actual implementation of a program, if the waiver is approved by the Centers for Medicare and Medicaid Services at all.⁵⁷ On the other hand, many delivery system reforms and innovative health care programs designed to improve health outcomes require up-front investment,⁵⁸ which is harder to come by if federal funding and partnership decline.

A case study of this flexibility paradox can be found in Oregon. In order to be able to implement delivery system reforms designed to improve both the efficiency and the quality of care in its Medicaid program, the state had to undergo the process of applying for a federal waiver. The waiver was approved in merely four months. The state

was then able to set targets for spending and quality while providing flexibility to locally directed Coordinated Care Organizations (CCOs) as they designed health care delivery systems tailored to the health care needs of local communities. With the waiver came additional federal funding, without which the health system transformation would likely not have been possible.⁵⁹

The return on investment from innovations that improve health outcomes, such as those that combat the social determinants of health, do not often materialize significantly in the short term. Given that nearly all states are required to balance their budgets annually, innovations designed to improve health outcomes over the medium-to-long term could be shortchanged in a capitated environment.

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Furthermore, increased flexibility for states in an environment of austerity could also lead to reductions in coverage or increased burdens on beneficiaries, who are already financially and often medically vulnerable. Some states are currently looking to increase cost sharing for beneficiaries, institute work requirements, or tighten restrictions on eligibility.⁶⁰ A block grant or per capita cap structure would give states significant freedom to go further in this regard, particularly for the newly eligible adult population. For low-income individuals with significant health care needs, cost sharing can obstruct access to care, which in turn can lead to adverse health outcomes. Even cost sharing in the range of \$1 to \$5 is associated with reduced use of care, including necessary services.⁶¹ Moreover, research suggests that premiums and cost sharing can lead to greater utilization of more expensive services such as emergency room care, while also increasing pressures on safety net providers, such as community health centers and hospitals.⁶²

CONCLUSION

Policymakers are always seeking strategies for lowering health care costs while maintaining or improving the quality of care. In the case of Medicaid, cost growth is predominately driven by increases in enrollment among covered populations. Hence, reductions in federal Medicaid spending are likely to lead to reductions in access to care by restricting either benefits or coverage.

Medicaid's great strength as a foundational element of the American health care system is rooted in its demonstrated ability to grow in response to a range of often unpredictable factors such as economic downturns, elevated poverty, an ongoing labor shift leading to the loss of employer-sponsored coverage for low-wage workers, demographics, the greater survival of children and adults with disabilities, advances in medical technologies and pharmaceuticals, increases in the volume and intensity of care, and population health threats, for which the program reacts as a public health first responder. Medicaid possesses these characteristics because of its ability to grow over time as state and local conditions change, and as federal policy responds to these changes with new options and flexible financing.

In the case of Medicaid, cost growth is predominately driven by increases in enrollment among covered populations. Hence, reductions in federal Medicaid spending are likely to lead to reductions in access to care by restricting either benefits or coverage.

Limiting and capping federal funding for Medicaid and moving away from a flexible federal partnership to one of defined contributions, divorced from the real world of health and health care, would fundamentally alter the program. Over time, it would eliminate a significant share of funding from health care for the most vulnerable populations and communities, threaten the most vulnerable beneficiaries with the highest health care needs, and dampen the program's ability to respond to population trends and health crises or to invest in delivery system reforms and innovative programs designed to achieve long-term returns on investment. Each state would have to decide how to pass on these federal funding cuts to taxpayers, providers, and beneficiaries. They would face difficult choices with few viable options: either come up with the funds needed to maintain existing programs and fill the gap created by federal funding limits, or substantially scale back funding for health care—a choice that carries major implications for state and local economies, beneficiaries, the health care system, jobs, and population health.

ENDNOTES

- 1 Squires & Anderson, 2015.
- 2 Ibid.
- 3 The National Conference of State Legislatures (NCSL) reports that all states but Vermont must balance their budgets; some experts consider Wyoming, North Dakota, and Alaska to be exceptions as well. NCSL, 2010.
- 4 Stevens & Stevens, 1970.
- 5 CMS, 2017a.
- 6 Markus, Andres, West, Garro, & Pellegrini, 2013.
- 7 MACPAC, 2016b (Exhibit 2).
- 8 Ibid.
- 9 Kaiser Commission on Medicaid and the Uninsured, 2011a.
- 10 Long-Term Care Financing Collaborative, 2016.
- 11 Musumeci, 2017.
- 12 MACPAC, 2012.
- 13 Truffer, Wolfe, & Rennie, 2016.
- 14 Clemans-Cope, Holahan, & Garfield, 2016
- 15 CBO, 2012.
- 16 MACPAC, 2016a.
- 17 Stevens & Stevens, 2003.
- 18 Goodman-Bacon & Nikpay, 2017.
- 19 Ibid.
- 20 CMS, n.d.
- 21 Among seniors who use Medicaid long-term services and supports, 50 percent are in a home and community-based setting and 50 percent are in institutions. Among non-elderly adults with disabilities, the shares are 79 and 21 percent, respectively. Reaves & Musumeci, 2015.
- 22 GAO, 2014.
- 23 MACPAC, 2016a.
- 24 Zemel & Riley, 2016.
- 25 Kaiser Family Foundation, n.d.
- 26 Watts, Musumeci, & Ubri, 2017.
- 27 Ensslin & Kruse, 2016; Solomon, 2017.
- 28 CMS, 2017b.
- 29 Holahan & McMorrow, 2012.
- 30 Lambrew, 2005.
- 31 American Academy of Actuaries, 2017.
- 32 For a list of mandatory and optional eligibility criteria, see: MACPAC, 2017.
- 33 For a list of mandatory and optional benefits, see: MACPAC, 2017.
- 34 Rudowitz, 2017.
- 35 CBO, 2017; Rudowitz, 2017.
- 36 This is not true under the AHCA, because the budget reconciliation process does not allow changes that do not directly affect the federal budget. Such changes could come in a subsequent stage of health care reform.
- 37 HR 1628, 115th Cong. 1st sess.
- 38 OMB, 2017.
- 39 Holahan, Buettgens, Pan, & Blumberg, 2017.
- 40 House GOP, 2017.
- 41 Rudowitz, 2017.
- 42 Park, 2017.
- 43 Ibid.
- 44 Smith, 2017.
- 45 Rosenbaum, Schmucker, Rothenberg, & Gunsalus, 2016.
- 46 Rudowitz, Garfield, & Young, 2016.
- 47 Jacobson, Neuman, & Musumeci, 2017.
- 48 Anderson et al., 2016.
- 49 MACPAC, 2016b.
- 50 *Olmstead v. L.C.*, 527 U.S. 581, 1999.
- 51 Westmoreland & Perez, 2000.
- 52 Flowers, 2017.
- 53 Jacobson, Neuman, & Musumeci, 2017.
- 54 Mann & Orris, 2017; Kaiser Commission on Medicaid and the Uninsured, 2011b.
- 55 Jacobson, Neuman, & Musumeci, 2017.
- 56 Rosenbaum, Schmucker, Rothenberg, & Gunsalus, 2016.
- 57 Rosenbaum, Riley, Bradley, Veghte, & Rosenthal, 2017.
- 58 Ibid.
- 59 Mann, 2017.
- 60 Rudowitz, 2017.
- 61 Kaiser Commission on Medicaid and the Uninsured, 2013.
- 62 Artiga, Ubri, & Zur, 2017.

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