

Medicaid Block Grants – by Any Name – Would Mean Massive Cuts, Costs Shifted to Texas

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The U.S. House is reportedly preparing to file a bill based on the policy brief on Repeal and Replacement of the Affordable Care Act (ACA) and major Medicaid Restructuring. When lawmakers file that bill, it will be possible to share estimates of the specific impact on Texans’ access to health care and on federal health care funding for Texas.

This policy brief is designed to help Texas consumers, stakeholders and decision-makers identify the most critical elements of Congressional health care proposals. The focus is on a funding mechanism that goes by several names -- Medicaid block grants, per capita caps or per beneficiary allocation proposals. How Congress chooses these elements will determine whether leaders cut state Medicaid funding below current amounts, whether the Texans covered today in private coverage or in Medicaid-CHIP will be covered in the future, and whether the health benefits they can receive today will be reduced.

CPPP joins health advocates across Texas and the U.S. in calling on Congress to ensure that changes to Medicaid and the ACA meet this simple test:

- Cover at least as many people as the ACA and Medicaid do today, with pathways to coverage for today’s uninsured;
- Provide health benefits that are at least as comprehensive;
- Provide health coverage that is at least as affordable – that means both premiums and out-of-pocket costs like deductibles and copays –and
- Cut red tape barriers to enrolling and using health coverage.

The principles apply equally to Medicaid-CHIP changes and to ACA Repeal/Replace proposals. As lawmakers file bills in the weeks and months to come, we will analyze them and explain how they perform on the key elements explained in this brief.

Proposals to convert Medicaid from its current form into a block grant or per capita cap program have been brought forward multiple times in the last 30 years. For most Texans, even lawmakers, the concepts are rarely explored beyond talking points. We must consider the complex reality of the potential losses for Texas, as well as the monumental formula struggles among the states, to avoid real harm to vulnerable Texans, the Texas health care infrastructure, and the state economy, of which health care is a major component.

INSIDE

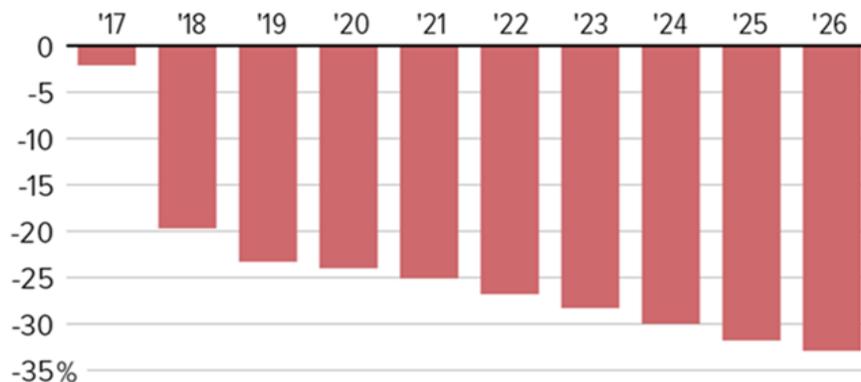
- Key Findings
- Block Grant and Per Capita Cap/Per-Beneficiary Allocation Basics
- Cuts Would Go Deeper than Texas Legislature’s
- What Texans Covered by Medicaid Could Lose
- Texas Medicaid Block Grant/Per Capita Cap Check-List

Key Findings

- All recent U.S. Congress block grant *and* per capita cap proposals have included large federal Medicaid funding cuts – to *below* current funding levels. This message is very important, because many Texas leaders who do not routinely work on Medicaid believe that a Medicaid block grant or per capita cap would *increase* Texas’ federal Medicaid dollars. It would not.
- Congress’ track record of funding block grants has allowed most to fall further and further behind population and inflation growth.
- A switch in focus from block grant to Per-Capita Cap or Per-Beneficiary Allocation is *not* a panacea for these concerns. The *ONLY certain* difference from block grant to Per-Capita Cap/Per-Beneficiary Allocation is that federal funding will include some kind of allowance for enrollment growth. To illustrate:
 - Last summer’s (2016) House Republican budget proposal from newly-confirmed US Health and Human Services Secretary Price and House Speaker Ryan would have made the *same deep cuts* in fed Medicaid spending, regardless of whether a state chose a block grant or per capita cap.
 - The Congressional Budget Office scored the 2016 budget proposal as cutting Medicaid spending over \$1 trillion in 10 years, or a reduction of 25 percent in states like Texas that had not expanded Medicaid (and even more in states losing expansion funds).

Medicaid Cuts Would Grow Over Time Under House Budget Committee Block Grant

Percent cut in federal Medicaid funds, relative to current law



Source: CBPP analysis using Jan. 2016 Congressional Budget Office Medicaid baseline and House Budget Committee documents.

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- Texas would lose around \$4.8 billion in federal Medicaid funds (20 percent) by the second year of either a block grant or a per capita cap under the House Republican budget proposal for 2017 (using 20 percent of 2016 actual Texas Medicaid spending).
- The House budget report proposed that the block grant option would give states sole discretion over eligibility requirements, benefits, and provider reimbursement rates, while there would be some minimum eligibility requirements under the per-capita option.

- Harm to Texas will not be avoided, unless Texas leaders demand changes from the summer 2016 model. **Congress' intent in that bill was to shift Medicaid spending growth to states, not to make it easier for states to oversee a health care safety net within predictable growth.**

Quick Block Grant and Per Capita Cap/Per-Beneficiary Allocation Basics:

Current Medicaid law

- **States** are entitled to federal Medicaid matching dollars for all costs, even when enrollment or prices spike.
- **Individuals** are entitled to be covered under the state's official eligibility standards and benefits, without caps or wait list.

Congress is proposing to dramatically change this foundation.

Block Grant

- A block grant would disconnect federal funding from the number of Medicaid beneficiaries and the cost of providing care. The Federal contribution would grow only according to a preset formula, no matter how large the population in need becomes, or how much a state actually must spend on health care and long-term care for Medicaid recipients.
- Congress has allowed most health and social services block grants to decline in value, not keeping up with population growth or inflation. For example, the Temporary Assistance for Needy families (TANF) block grant that Congress established in 1996 has lost 44 percent of its buying power. The Children's Health Insurance Program (CHIP) block grant is the exception, not the rule; Congress has intervened eight times since CHIP was created to keep its funding adequate to prevent caps and waiting lists.

Per Capita Cap or Per-Beneficiary Allocation

- Limits the amount the federal government will pay per person in Medicaid, but guarantees some funds for each person, probably in four groups: children, pregnant women and other adults, seniors, people with disabilities. It may not allow states to add or expand new groups like parents, other adults, or Texans on waiting lists for community care.

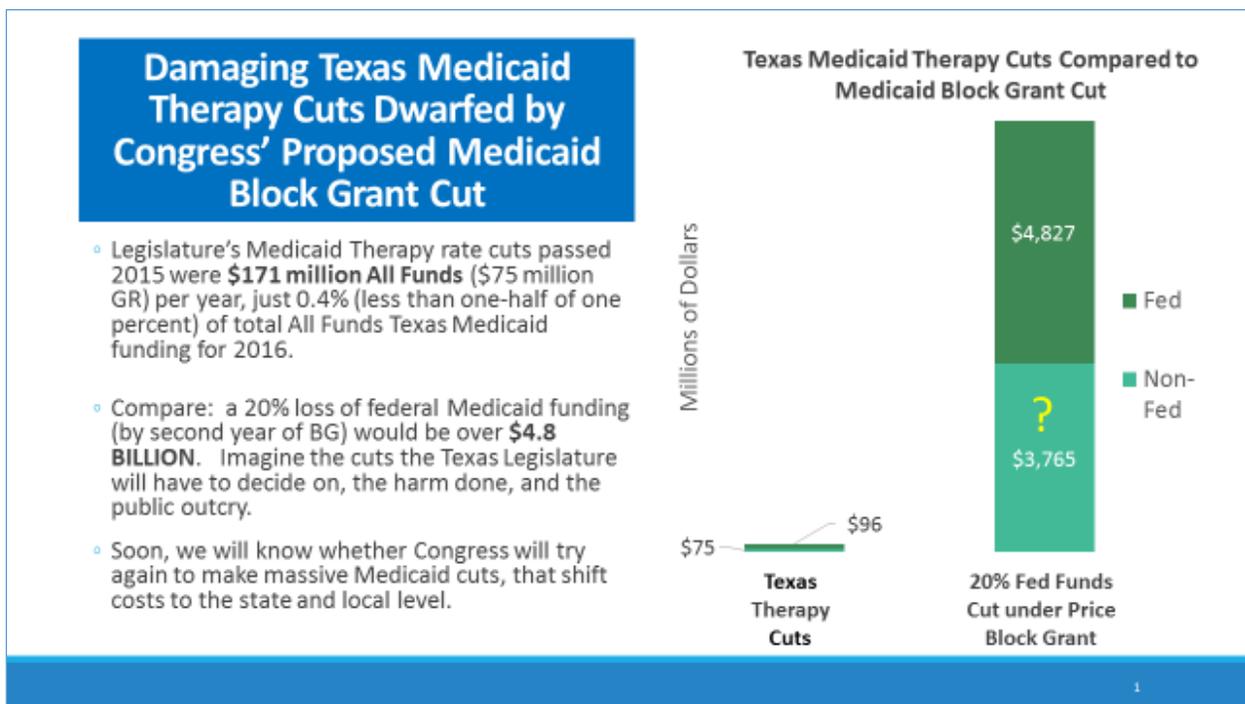
Recent Federal proposals Would Cut Texas Medicaid Far More Deeply than State Legislative Cuts in last 20 Years

2016 Price/Ryan Block Grant/Per Capita Cap would cut Texas Medicaid \$4.8 billion in Second Year

As the graphic below illustrates, a cut of \$4.8 billion in federal Medicaid funds (i.e., for a single year, in the second year of the Price-Ryan block grant/per capita cap bill), would be many times larger than any previous Texas Medicaid cut in the last 25 years. To illustrate:

- The disastrous Texas Medicaid pediatric therapy rate and policy cuts adopted in 2015 cut \$171 million each year in Medicaid services, of which just under \$100 million was federal funding.

- Texas' most extreme health care budget cuts in recent decades were imposed by the Legislature in 2003, cutting maternity coverage, eliminating benefits for seniors and adults with disabilities, cutting CHIP enrollment by over 200,000 children, eliminating over 2,300 state jobs, and slashing provider payments.
 - After several cuts were reversed within the first year, major cuts to Medicaid and CHIP eligibility, benefits, and rates were scored as cutting total spending for 2004-2005 by about \$1.6 billion, or about \$1 billion in federal Medicaid dollars (\$620 million General Revenue).ⁱ
- A \$4.8 billion cut in federal Medicaid funds would be 48 times larger than the \$150 million 2015 pediatric therapy cuts, and four to five times the size of the massive 2003 Medicaid cuts** (\$500 million federal funds annually was just under 5% of total federal Medicaid funding for 2004).



The Human Face: What Texans Covered by Medicaid May Lose

Beyond concerns over the potential massive funding loss posed by the 2016 Congressional Medicaid Block Grant/per capita cap proposals, there are over 4 million Texans who access health care and long-term services and supports from Medicaid today—and [millions more who remain uninsured](#). Converting Medicaid to a block grant or per capita cap opens to question whether hundreds of minimum standards set in 50 years of Medicaid law will be retained. Every aspect of Medicaid could be on the table for cuts, from who is covered, what health care they can get, and how much they can be charged, to whether they can choose their own doctor.

From the point of view of the Texans getting care and the providers who serve them, here are major categories of Texas Medicaid that could change under *either* a block grant or per capita cap.

Benefits

- Children: Today kids can't be denied medically necessary care by Medicaid, or face arbitrary limits like numbers of prescriptions or therapy visits.
- Adults have fewer required minimum benefits under current law, and strict limits are allowed. Even this minimum benefit standard may be eliminated under either block grant or per capita cap.

Affordability

- Children and pregnant women are exempt from co-payments, premiums, or denial of care for non-payment in Medicaid today.
- Adults today have upper limits on cost-sharing, and no denial of care for non-payment has been allowed in Medicaid for those below poverty. Use of premiums, and denial of care for non-payment have been allowed only for those above poverty. These limits likely eliminated under block grant or per capita cap.

Who Is Covered

- Current federal Medicaid law requires all kids in families with incomes up to 138 percent of the federal poverty income level (FPL), (about \$34,000 annual income for a family of four in 2017) be allowed to get Medicaid coverage (kids 138-206 percent FPL can get CHIP). Seniors and individuals with disabilities with incomes below about 75% of the FPL (about \$735 a month) and pregnant women to 203 percent FPL (about \$33,000 annual income for a pregnant mother) must be covered.
- Under a block grant, states could reduce these minimum standards and decide who to cover, and/or have capped enrollment and waiting lists. Under a per capita cap/per-beneficiary allocation, every proposal differs, and states may be allowed to cover fewer of the populations covered today.
- With a block grant or per capita cap, there is, so far, no pathway in proposals to improve coverage of uninsured Texans, including those with disabilities on today's wait lists for long term services and supports under Medicaid "waivers." Every proposal differs, and it is also not clear whether there will be a pathway to coverage for more of Texas' working poor uninsured under per capita cap/Per-Beneficiary Allocation bills.

Red Tape

- Current federal Medicaid law prevents states from cutting back on kid's coverage by lowering the income thresholds, or by creating other eligibility barriers.
- Today Medicaid Managed Care plans are subject to many consumer protections: network adequacy, due process, and more.

Provider Choice and Payment

- Today, Medicaid enrollees must be allowed to choose among qualified Family Planning providers. Cost-based pay is required for Community Health Centers (FQHCs), which is a primary reason they are able to provide care not only to large numbers of Texas Medicaid enrollees, but also can still serve uninsured Texans at reduced costs.

It will not be safe to simply assume that any current part of federal Medicaid law will automatically be saved under either block grant or per capita cap. Medicaid advocates and stakeholders will have to specify—and verify—which protections, policies, or benefits will be retained in a radically restructured Medicaid.

Caveat: Per Capita Cap Carries Most of the Same Risks for Texas as Block Grant

It is important to understand that any block grant or per capita cap bill can require a cut in federal Medicaid funds to states—or not. To illustrate, the March 2016 U.S. House Budget Resolution called for a transition to “State Flexibility Funds,” or a block grant for Medicaid. However, later language adopted in the House Budget Report indicated that states could choose between a single lump sum (block grant) or a per capita-cap methodology, **but with the same \$1 trillion spending cut over 10 years**. In other words, regardless of which choice a state selected, federal Medicaid funds for the state would have been reduced by the same amount.

The U.S. House February 2017 Repeal and Replace policy brief provides no specific information on either the basis for allocating funds to states, or the targeted reduction in federal Medicaid funding to states. Only when an actual bill is filed will we know what the U.S. House ins now proposing.

Medicaid Block Grant/Per Capita Cap Check-List

The checklist below notes key issues Texas leaders must fight for in any federal legislation altering Medicaid, to avoid serious human and fiscal harm to Texans. Without these protections, federal changes will amount to a massive cost-shift to state and local governments, or a massive loss of health and long-term care for Texans.

1. Does the block grant or per capita cap include growth factors that will ensure federal cost-sharing responds to these real-world needs?

- Population Growth
- Increases in poverty/unemployment/economic downturns. (i.e., there must be allowances for enrollment needs that exceed population growth)
- Epidemics/public health crises (e.g., Zika);
- Natural Disasters (e.g., Katrina and Rita);
- Medical advances (e.g., Hep C life-saving cure)

2. Key question for every block grant or per capita cap proposal: how much in federal savings are anticipated from it?

Last summer’s House Republican budget had a \$1 trillion, 10-year Medicaid spending reduction assumption built in. The bill did not simply reduce the growth rate in Medicaid, it actually reduced it below first-year spending levels.

If a similar reduction target is used in future proposed law, that target may actually override other key factors such as what’s in the funding base, and what is the growth factor. For example, Texas must consider whether the additional flexibility in the summer 2016 House Republican budget proposal would be valuable enough to justify a 20% federal spending cut by year #2? Would a cut of the size proposed allow Texas to maintain coverage?ⁱⁱ

3. Does Medicaid-CHIP funding become subject to frequent Congressional struggles?

A critical question: will a block grant or per capita cap move Medicaid funding from its current status and into periodic Congressional budget squabbles, and require periodic reauthorization? It's no accident: Congress has established Social Security, Medicare, Medicaid as entitlements in part to avoid these funding fights, and promote stability.

If yes, Texas would trade the current state-budget uncertainty over future Medicaid enrollment growth and cost growth, for periodic uncertainty over whether Congress will continue to fully fund our Medicaid block grant or per capita cap allocation.

4. What is in the block grant or percapita cap base? This is as critical as the growth factor—or more!

CHIP block grant financing has been modified by Congress 8 times from 1997-2010.

a) Does the funding base lock in all of Texas Medicaid provider payment history? Do we want to be locked into that?

If a block grant or per capita cap is based on historical Texas spending in a recent year, it can have the effect of locking in place all Texas Medicaid policy, including choices that create access barriers, like inadequate primary care provider payments.

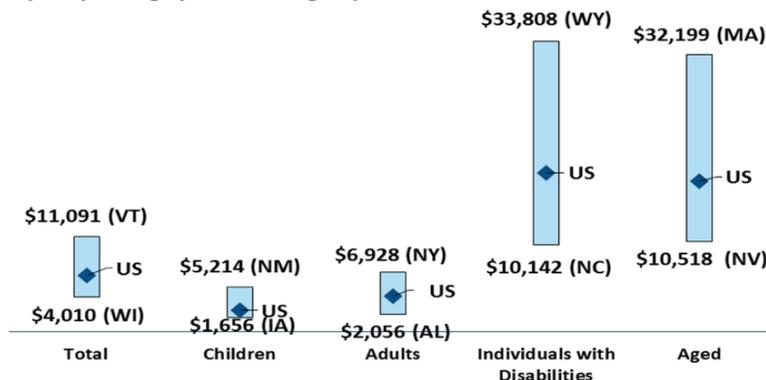
Texas Medicaid physician payments have not had annual updates for over 20 years. Annual updates were stopped in 1993, and never resumed. Since then, there have been 3 legislative increases (99, 2001, 2007) and 4 cuts (2003, 2010, 2011, 2012). Hospital payments are far more complex, but like physician rates they stopped getting regular updates in the 1990s and pay significantly less than actual costs (average 55 percent for inpatient, 72 percent for outpatient).

In contrast, Texas Medicaid Managed Care plans cleared strong profits, even after “Experience Rebates” paid back to HHSC. Multiple different formulas are used for long-term care providers. The transparency of provider payments is declining as Medicaid Managed Care plans may declare what they pay doctors and others to be “proprietary” information. Only a small number of provider types are paid 100 percent of their allowable costs.

Figure 5

A per capita cap could lock in historical state differences or redistribute federal funds across states.

Per capita spending by enrollment group



NOTE: Spending per capita was calculated only for Medicaid enrollees with unrestricted benefits or those enrolled in an alternative package of benchmark equivalent coverage. Outliers are included in the figure, but not marked as outliers.
SOURCE: KCMU and Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports.



Rigid use of a retrospective base year will lock Texas and other states into permanent inadequate provider networks. Texas is certainly not the only state where some Medicaid provider types profit, while others cannot cover costs.

Per capita cap proposals of recent years have not specified whether each state would have its own historically-based per capita allowance, or whether all the 50 states' spending would be aggregated and averaged in some way.

As this graphic shows, there is extreme variation in state per-capita Medicaid spending. Per capita cap/per-beneficiary allotment formulas have the potential to lock in wild state variations in payments and benefits—and the stakes of settling for too little for Texas are high.

b) Will Texas get to build our untapped Medicaid expansion funds (~\$6 to \$8 billion a year in additional federal funds) into base?

- January 2014-September 2015, 31 Medicaid expansion states claimed \$93 billion in federal dollars (so, likely double that by now).
- Will states that have not adopted the expansion be locked into that decision, resulting in a lower spending base than expansion states?

c) Will Texas get to keep special hospital supplemental payments (DSH and 1115 waiver federal funds) in base, even though there are almost no state dollars involved (virtually all matched with IGT from local county governments).

Texas has already shifted half of the state's share of Medicaid hospital payments to local government.ⁱⁱⁱ

d) Will the base for a Texas block grant or per capita cap allow for inclusion of ~ 200,000+ on Medicaid Community Care waiver waitlists?

e) Will the base include all our "Medicare savings program" enrollee costs (Medicaid helps pay out-of-pocket Medicare costs for over 500,000 low-income seniors and adults with disabilities)?

Other Medicaid for Texans and funds of concern: "Duals" pilots (Medicaid and Medicare combined Medicaid Managed Care); Graduate medical education reimbursements; the "Community First Choice" Medicaid benefit users (seniors and Texans with disabilities); Former Foster Youth up to age 26; and the current 92 percent federal match rate for CHIP (which also applies to all the kids moved from Medicaid to CHIP under the ACA's "leveling")?

f) Will the base Congress adopts also lock in spending that's inadequate, based on benefit limits in Texas Medicaid? Examples:

Texas Medicaid still has not fully implemented access to life-saving Hepatitis C cure medication.

No dental care is covered for most adults in Texas Medicaid (some exceptions in Long Term Care waivers). This is especially short-sighted for pregnant women.

Children: For example, despite current-law protections against arbitrary benefit limits for kids under EPSDT, Texas Medicaid still has not allowed coverage of the current U.S. standard of care for many children on the autism spectrum.

Will our history of limited benefits make our Medicaid funding allocation too low to allow us to adopt best treatment practices and standards of care?

5. What are the requirements about state matching dollars or maintenance of effort (MOE)?

Many recent federal proposals do not specify the rules for state matching payments. That means we really do not know whether Texas will be required to keep up its state-budget share or not.

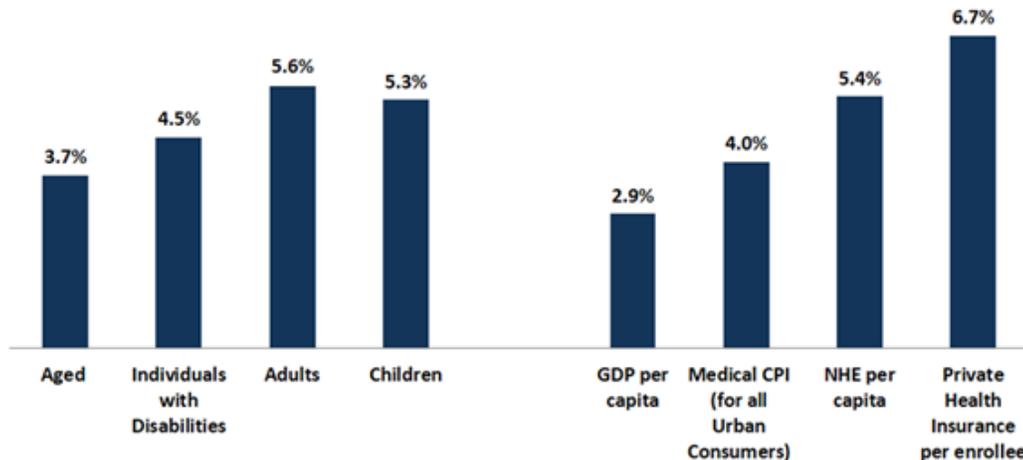
Reductions of Medicaid spending below the current Texas All Funds level would force cuts almost certain to yield harm and significant public outcry, like the current Texas therapy rate cut debate.

Texas advocates and health care providers are equally concerned about either the federal OR state government reducing current Medicaid funding.

Figure 3

Average annual spending varies across Medicaid and other benchmarks, 2000-2011

Average Annual Growth Rates



NOTE: Growth rates by Medicaid eligibility groups are for fiscal years 2000-2011.
 SOURCE: Growth rates by eligibility group from KCMU and Urban Institute estimates based on data from FY 2000, 2001, 2010, & 2011 MSIS and CMS-64 reports. GDP per capita from The World Bank National Accounts Data, available at <http://data.worldbank.org/indicator/NY.GDP.PCAP.CD/countries>. NHE per capita & Private Health Insurance per enrollee from the National Health Expenditure Accounts, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>. Medical CPI-U growth from Bureau of Labor Statistics, available at <http://www.bls.gov/cpi/>



6. What is the proposed growth factor, and how would that factor have affected per capita and aggregate Texas Medicaid spending had it been applied over last 15 years?

Most recent Congressional per capita cap proposals cap growth at CPI.

Some proposals would tie per-enrollee caps to gross domestic product (GDP) or inflation. GDP would be a poor choice, as it measures national economic activity; therefore, *during economic downturns, GDP may grow slowly or not at all*, preventing Medicaid from stepping up to fill the need in a “counter-cyclic” fashion.

For Texas, a starting point for analysis of the growth factor should start with examination of the per capita growth rates 2002-2017 by major eligibility categories, with and without 1115 and DSH included, to determine how a CPI based inflator (or others under consideration) would have affected receipt of federal Medicaid funding.

It's important to remember that an acceptable growth factor is not a substitute for an adequate base, or for the ability to improve coverage of the uninsured in and near poverty, or to respond to the 5 real-world factors listed in #1 above.

Next Steps to Protect Texans' Health Care

The human and economic consequences for Texas will be severe if Congress succeeds in cutting Medicaid funding to our state. Our U.S. Senators and Congresspersons, and our Statewide elected officials and Legislators must hear from Texans across the state:

- That we object to these cuts, and
- That we will hold them accountable for protecting access to care and for the return of federal taxpayer dollars to our state.
- That any ACA repeal and replace or Medicaid restructuring must meet this test:
 - Cover at least as many people, with paths to coverage for today's uninsured;
 - Health benefits that are at least as comprehensive;
 - Health coverage that is at least as affordable—that means both premiums and out-of-pocket costs like deductibles and copays—and
 - No red tape barriers to enrolling and using health coverage.

Remind our officials in Austin and Washington, D.C. that:

- All block grant and per capita cap/Per Beneficiary Allocation proposals to date have cut Texas Medicaid funds below current levels, which is unacceptable.
- Congress shifting Medicaid costs and risk to the states, and ending the historical guarantee of sharing costs with states when the economy tanks, or a natural disaster occurs, is unacceptable.
- If this happens, state lawmakers will be forced to make terrible decisions that hurt people, far more damaging and costly than the Texas Legislature's 2003, 2011, and 2015 Medicaid cuts.

To get involved and stay up-to-date:

- Follow [CPPP's Blog](#) and join our [email list](#).
- Signup for emails and activities with the [Cover Texas Now coalition](#), of which CPPP is a member.

For more information, contact Anne Dunkelberg, dunkelberg@cppp.org.

ⁱ *Truth and Consequences: The State Budget for 2004-2005 and its Impact on Texans*; July 2004 <http://library.cppp.org/files/6/budgetimpact04-web.pdf> ; p. 21; *Texas' State Budget for 2004-05 Implications for Health Care for Vulnerable Texans*, October 2003, <http://library.cppp.org/research.php?aid=434&cid=3&scid=4>; *Federal Medicaid Relief Funds Could Stop the Elimination of Medicaid Mental Health Services, Other Services*, July 2003 <http://library.cppp.org/files/3/PP199.pdf> ; *Children's Medicaid and SCHIP in Texas: Tracking the Impact of Budget Cuts*, July 2004, <http://library.cppp.org/research.php?aid=25&cid=3&scid=4>.

ⁱⁱ See conclusions of HB 497 report (December 2010) https://hhs.texas.gov/sites/hhs/files/hb-497_122010.pdf.

"If Texas opted out of the federal (Medicaid) program, the full impact from the loss of federal Medicaid dollars would depend on legislative policy decisions:

- *Texas would lose \$15 billion (SFY 2009) in federal matching funds for client services and hospitals.*
- *At the same time, Texas residents and businesses would continue to pay federal taxes in support of other states' Medicaid spending.*
- *Up to 2.6 million Texans could become uninsured.*
- *Hospitals still would be required by federal law to treat medical emergencies of uninsured former Medicaid and CHIP clients, potentially adding billions to uncompensated care costs each year.*
- *The Legislature could preserve benefits for some current Medicaid and CHIP clients using the state share of funding while shielding the state budget from significant losses, but it will be difficult to accomplish these two goals without shifting costs to county governments and public hospitals."*

ⁱⁱⁱ Texas Health and Human Services Commission Evaluation of Uncompensated Care and Medicaid Payments in Texas Hospitals and the Role of Texas' Uncompensated Care Pool <https://hhs.texas.gov/sites/hhs/files//91316-hma-uc-study-report.pdf>; Presentation to the House Appropriations Subcommittee on Article II: Overview of Texas Medicaid Hospital Finance and the Section 1115 Demonstration Waiver, July 2016, <https://hhs.texas.gov/sites/hhs/files//hospital-finance-hac.pdf>.

For more information or to request an interview, please contact Oliver Bernstein at bernstein@cppp.org or 512.823.2875.

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