Medicaid Per Capita Allotments and Block Grants
Implications and Considerations

Under current law, Medicaid provides guaranteed federal matching funds to states. The federal match is determined by a formula set in statute that is based on a state's per capita income. The formula is designed so that the federal government pays a larger share of program costs in poorer states. The federal share, or FMAP, varies by state from a floor of 50% to a high of 74% in 2016.[1] States may also receive higher FMAPs for certain services or populations. Tennessee's FY 2017 FMAP is 64.96%.[2]

Two proposals that have been discussed for reforming Medicaid under the new administration are per capita allotments (or per capita caps) and block grants. Per capita allotments and block grants are designed to reduce federal spending and make federal spending more predictable. However, these mechanisms could also eliminate the guarantee of coverage for all who are eligible and the guarantee to states of federal matching funds. States gain additional flexibility to administer their programs under these proposals, but risk reduced federal funding that could create pressure to shift costs and risk to enrollees (through reduced benefit guarantees) and providers (through reduced payments).

Per Capita Allotments

How Per Capita Allotments Work

Under per capita allotments, the federal government sets a limit on how much to reimburse states per enrollee.

Under this model, a per enrollee cap (either total or by population group) would be determined for a base year. Each year, the cap would be adjusted based on a federally-determined growth limit. A state's total federal Medicaid funding limit for each subsequent year would be determined by multiplying the base year per capita amount, the growth limit percentage, and the number of enrollees. To achieve federal savings, the per capita growth amounts would be set below the projected rates of growth under current law.

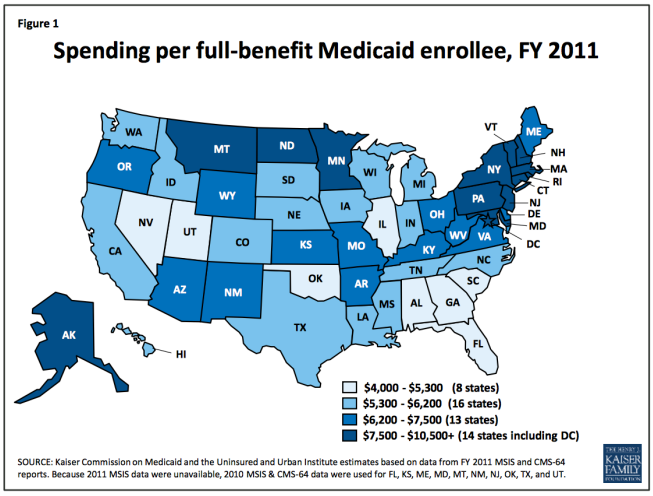
Per capita allotments do allow flexibility for changes in enrollment numbers, but do not take into account that some individuals are much more expensive to cover than others. A per capita allotment would also not account for changes in the costs per enrollee beyond the growth limit.

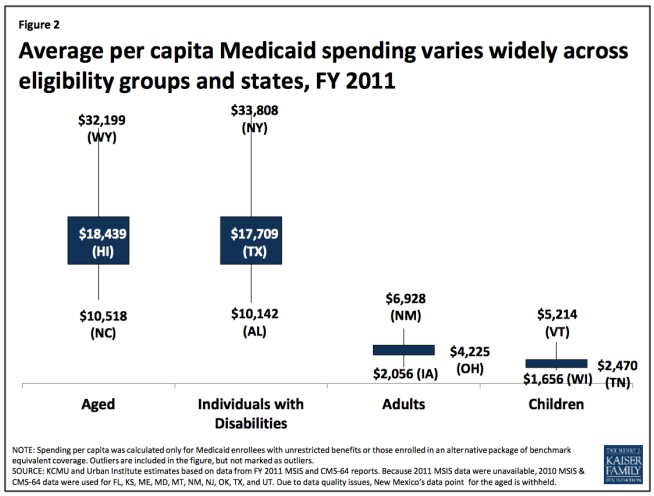
Key Design Challenges

Key challenges in designing a per capita allotment proposal include determining the per enrollee base spending amounts and the allowable growth rate, and making decisions about new state flexibility versus maintaining federal core requirements and state accountability.

- **Base Spending Per Enrollee.** Per capita allotments could be based on per enrollee spending for each state or nationally. Similarly, there could be one per enrollee spending base or separate base amounts for each eligibility group – aged, blind and disabled, children, and adults. If the cap were to use a historical spending per enrollee by state as the base, states effectively would be fixed into their current policy choices, and inequalities between the different Medicaid programs could become permanent. On the other hand, implementing a uniform per capita cap across states would likely result in large changes in the distribution of funds for states.

  Based on current flexibility in the Medicaid program, there is considerable variation in per enrollee costs across eligibility groups and across states, as demonstrated in the figures below. Spending for the elderly and individuals with disabilities may be more than four times the spending for an adult and more than seven times spending for an average child covered by the program. In addition, even within a given state and eligibility group, per enrollee costs may vary significantly, particularly for individuals with disabilities. [3]





Reliable data to determine the base per enrollee spending may be significantly lagged. Currently, the latest administrative data to examine per enrollee spending in Medicaid is from FY 2011. More recent data from Tennessee estimates that the average annual cost per TennCare enrollee is $3,656.39. [4] Data from the Urban Institute on the cost of TennCare enrollees by category is in the table below. [5]

Medicaid Federal Expenditures per Enrollee by Eligibility Group, 2017

State	Total	Aged	Aged ranking	Disabled	Disabled ranking	Adults	Adults ranking	Children	Children ranking
Tennessee	5,614	5,450	(38)	10,708	(39)	5,825	(3)	2,737	(10)

- **Growth Rates.** To achieve federal savings, most proposals for a per capita allotment set the amount of growth in per enrollee spending below current projections. Applying uniform growth

rates across states in per enrollee spending could have different implications for states since per enrollee growth varies widely by state.

- **Core Requirements.** Medicaid financing reform proposals are often tied to changes in core requirements for Medicaid, which could give states additional flexibility. Proposals may include changes to minimum standards for eligibility or benefits, or changes in the maximum eligibility or benefits wherein the federal government would not reimburse for coverage or benefits beyond those specified in the law (compared to current law where states have the option to provide coverage and benefits beyond core requirements and still receive federal match). Key questions arise over the requirements for state spending and how states would be held accountable for use of federal Medicaid funds under a per capita allotment.

Implications of a Per Capita Allotment

A per capita allotment could control federal outlays while giving states additional flexibility. However, implementing a per capita allotment could be administratively difficult and could maintain current inequities in per enrollee costs across states. Further, if costs are above per enrollee amounts, costs could be shifted to states, providers, and enrollees. To prevent this, states may have incentives to reduce Medicaid payment rates and restrict benefits. Low reimbursement rates can contribute to issues around access to care and provider participation, which could be especially detrimental for people who need specialized treatment and long-term care. If federal spending updates lag rising health care costs, states might reduce payments below actuarially sound levels, triggering the demise of managed care plans. Alternatively, states might narrow eligibility to control costs, perhaps eliminating coverage for more costly individuals. [6]

Block Grants

How Block Grants Work

A second approach to reforming Medicaid is block grants. Under block grants, the federal government determines a base year financing amount for each state and then specifies a fixed rate of growth for federal spending. Because the federal funds available are fixed amounts, they grow at a predictable rate from one year to the next – or not at all if Congress does not appropriate funding increases.

A Brief History of Block Grants

Proposals to fund Medicaid through block grants have a long history. In 1981, President Ronald Reagan proposed state-specific block grants based on historical levels of spending in each state. Congress rejected the proposal but did temporarily tighten the federal funding formula. This temporary spending reduction was repealed in 1984 through bipartisan budget legislation.

A little more than a decade later, in 1995, both the House and Senate passed a bill that would have funded Medicaid through block grants to states based on historic average levels of spending nationally, coupled with a complex growth formula that would set future spending levels well below the expected rate of growth in Medicaid. President Clinton vetoed the legislation due to concerns over its adverse financial impact on state Medicaid programs and underlying state economies. Before vetoing the block grant legislation, President Clinton proposed per capita allotments, but Congress rejected that proposal.

Since that time, block grant proposals have appeared intermittently. Most recently, in 2015, Senators Richard Burr of North Carolina, Orrin Hatch of Utah, and Congressman Fred Upton introduced bills to repeal the Affordable Care Act (ACA). The bills would have ended the ACA's Medicaid expansion funding for low-income adults and created block grants to states based on levels of spending prior to 2014.

The Congressional Budget Office (CBO) estimated that the proposed block grant legislation would reduce federal spending by $1 trillion over 10 years; however, much of the savings came from reductions in eligibility thresholds that would lower enrollment relative to levels under current law. Although the House bill offered no details regarding the level of flexibility states would have in order to absorb the significant reductions in federal funding, it had enough support to be incorporated into the 2017 fiscal year budget that was released in 2016. [7]

Implications of Block Grants

Using block grants to fund state Medicaid programs disconnects the level of funding from the number of enrollees and the cost of providing care. To permit states to manage Medicaid with a fixed amount of federal funding, the entitlement to coverage would need to be eliminated, and federal rules regarding eligibility, coverage, and payment would need to be substantially restructured.

Any program spending that exceeded the federal amount provided to the state would have to be financed by the state. Conversely, the funding provided to states would not be reduced if they found ways to reduce Medicaid costs. Any savings that a state was able to achieve would remain within that state.

Other Considerations

Capping federal Medicaid spending could have several advantages relative to current law. It could generate savings for the federal budget if the caps were set below current projections of federal Medicaid spending. Setting an upper limit on spending would also make federal costs for Medicaid more predictable. Finally, if spending limits were accompanied by significant new flexibility for states such flexibility might give states the opportunity to develop their own strategies for reducing program costs.

Caps on federal Medicaid spending could also have several disadvantages. If the limits on federal payments were set low enough, they would shift additional cost—perhaps substantial costs—to states and cause state Medicaid budgets to become less predictable than under current law. In response, states would have to commit more of their own revenues to Medicaid or reduce services, restrict eligibility or

enrollment, cut payment rates for health care providers, or, to the extent feasible, develop ways to deliver services more efficiently, each of which would raise various concerns.

Further, depending on the structure of the caps, Medicaid might no longer serve as a countercyclical source of federal funds for states during economic downturns (a state might not automatically receive more federal funding if a downturn caused more state residents to enroll in Medicaid). In addition, because states differ significantly in the size of their Medicaid programs—and because spending varies widely and grows at varying rates for different types of enrollees within a state—policymakers could find it difficult to set caps at levels that accurately reflect states' costs. Finally, it might be difficult to set caps that balanced the competing goals of creating incentives for program efficiency and generating federal budgetary savings while providing enough funding that states could generally maintain the size of their current Medicaid programs.

If spending caps were coupled with new state flexibility, states could be given more discretion over a number of program features, such as administrative requirements, ways to deliver health care, cost-sharing levels, and covered eligibility categories and medical services. New flexibility could make it easier for states to adjust their Medicaid spending in response to a limit on federal funds. The degree of new flexibility that states received would be particularly important if the federal spending caps were significantly lower than projections of Medicaid spending under current law.

Alternatively, federal spending caps could include a "maintenance of effort" requirement that would prevent states from changing the eligibility categories and medical benefits they covered before the caps took effect. That approach would ensure that key characteristics of the program in the base year—such as eligibility criteria, covered services, and the amount, duration, and scope of those services— would continue, preventing states from significantly curtailing their Medicaid programs after caps had been set.[8] Such requirements have been included with federal block grants in the past.

Remaining Questions about the Form Block Grants or Per Capita Allotments Might Take

- Will states have a choice between a per capita allotment or block grant?
- Will block grants cover the entire Medicaid program, or just expansion populations?
- How will the base year be calculated?
- How will growth rate be calculated?
- Will core requirements change – affecting state flexibility and accountability and/or enrollee access to coverage and care?
- Will states have a "maintenance of effort" requirement?
- If waivers are grandfathered in, will states be able to make changes to those waivers afterwards
- Will states still be required to provide state matching dollars to draw down federal dollars up to per capita cap? Or just after reaching the cap?
- What will count as state spending for purposes of qualifying for federal funds?

Appendix A
Current Proposals

"A Better Way" (June 2016) Speaker Ryan	Under Ryan's proposal, states could choose between a per capita allotment or a block grant to finance their Medicaid program. <u>Per Capita Allotment:</u> Beginning in 2019, states would receive a federal allotment that would be based on the product of the state's per capita allotment for the four major categories—aged, blind and disabled, children, and adults—and the number of enrollees in each of those four categories. The allotments would be determined based on each states' total Medicaid spending for each group for full-year enrollees in 2016, adjusted for inflation. States would draw down federal dollars up to the allotment based on the traditional FMAP rules. Under Ryan's plan, states that choose per capita allotments and have not expanded Medicaid as of January 1, 2016 would not be able to do so. States that have already expanded Medicaid under the ACA would be able to retain those dollars, but would be given flexibility to shift dollars to other populations. Beginning in 2019, the enhanced FMAP for the expansion population would be phased down to match the states' traditional match rate. This proposal would also give states the flexibility to charge higher premiums than currently allowed, implement a work requirement, provide premium assistance for commercial or employer coverage, implement wellness incentives, offer a limited benefit package, use waiting lists and enrollment caps for non-mandatory populations, reduce income eligibility thresholds for the expansion population, or phase out expansion by freezing enrollment. This proposal would also grandfather in managed care waivers if they have already been renewed twice. Finally, this proposal also expands the Weldon Amendment, which prohibits any government from discriminating against health care entities on the basis that they do not provide, pay for, provide coverage of, or refer for abortions. <u>Block Grant:</u> States that opt for a block grant would receive a set amount of funds to finance their programs determined by a base year. Ryan's plan currently offers no formula for how block grants would be calculated or trended forward, or what growth factors would be considered, except to say that funding would be determined using a base year that would exclude the Medicaid expansion population (these enrollees would be transitioned to other coverage – either commercial coverage or employer-sponsored coverage if available). The designation of how such funds are spent for these populations would rest with the state.

	States would be required to provide coverage to elderly and disabled individuals who are described as mandatory populations under current law. While designed to reduce federal spending, the Ryan's plan does not specify any set budget targets.[9] More information on Ryan's proposal can be found here.
House Budget Resolution (Spring 2016) Under Rep. Tom Price's chairmanship of House Budget Committee	The House Budget Resolution would allow states to choose between a block grant and a per capita allotment. Under the per capita allotment option, per enrollee spending amounts would be set for the four eligibility groups – elderly, blind and disabled, adults, and children. A payment amount would be established to account for the average cost of per enrollee care in each of the four eligibility groups, and would be indexed to a predetermined growth rate. The federal government would then provide Medicaid funds to the states based on the total number of enrollees in each category. It is not specified if the per enrollee amounts would vary across states and what the growth rate would be. Overall, the House proposal seeks to achieve $3 trillion in savings from the repeal of the Affordable Care Act (ACA) and the Medicaid financing reforms. [10] More information on the resolution can be found here.
Health Accessibility, Empowerment and Liberty Act (HAELA) Bill (2016) Rep. Sessions (R-TX) and Sen. Cassidy (R-LA)	The legislation specifies four enrollee categories – elderly, blind and disabled, children (to age 21), and adults. Per enrollee amounts would be set for each category for each state and increased by inflation in the first year, then by projected changes in gross domestic product plus one percentage point. In years 4 through 10, the proposal would transition states to a corridor around a national average per enrollee amount by allowing for higher growth for low spending states and lower growth for high spending states for each category. Federal payments would be limited to cover only expenditures for individuals up to 100% FPL. The federal government would pay the higher of 75% or the traditional FMAP.[11] More information on the details of the legislation can be found here (bill) and here (analysis).

[1] http://files.kff.org/attachment/Issue-Brief-Overview-of-Medicaid-Per-Capita-Cap-Proposals
[2] http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0
[3] http://kff.org/report-section/overview-of-medicaid-per-capita-cap-proposals-issue-brief/
[4] https://www.tn.gov/assets/entities/tenncare/attachments/leg0416.pdf
[5] http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000912-Block-Grants-and-Per-Capita-Caps-the-Problem-of-Funding-Disparities-among-States.pdf
[6] http://files.kff.org/attachment/Issue-Brief-Overview-of-Medicaid-Per-Capita-Cap-Proposals
[7] http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2016/nov/1913_rosenbaum_medicaid_block_grants.pdf
[8] https://www.cbo.gov/budget-options/2013/44889
[9] http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf
[10] http://files.kff.org/attachment/Issue-Brief-Overview-of-Medicaid-Per-Capita-Cap-Proposals
[11] http://files.kff.org/attachment/Issue-Brief-Overview-of-Medicaid-Per-Capita-Cap-Proposals