Medicaid Per Capita Caps and Block Grants: Devastating for People with Disabilities

Capping the Medicaid program would be devastating to people with disabilities. Medicaid provides health care services and long-term services and supports that maintain the health, function, independence, and well-being of 10 million enrollees with disabilities and, often, their families. For many people with disabilities, being able to access timely needed care is a life or death matter. Block grants or per capita caps place arbitrary limits on federal support for Medicaid, limits unrelated to beneficiaries' actual health care needs. The $840 billion reduction in federal support for what is already a lean program would force states to cut services and eligibility that put the health and wellbeing of people with disabilities at significant risk.

Federal funding caps would shift huge costs onto states and consumers. The Consortium for Citizens with Disabilities strongly opposes any block granting or per capita caps, or significant cuts to the Medicaid program. Per capita caps are "one-sided," meaning states can only lose under this provision. Either a state exceeds the cap and has to fund all care above the cap with no federal support, or it does not reach the cap (often by cutting services or eligibility), gets no more federal funding than it would under current law, and still has the burden of administering the cap.[1] As the population ages and care needs increase, the cap will not keep up. In the event of an expensive new treatment, like the breakthrough Hepatitis C medications, the cap would not adjust and the state would have to pay all the added costs alone. Already in difficult financial circumstances, many states would be forced to cut such services or limit eligibility for our growing and aging population.

Funding shortages would get worse over time. Block grants and per capita caps both cut federal funding, primarily by growing the payments to states slower than the average growth in health care costs. Even if the caps grew at exactly the rate of actual care costs – which they are not designed to do – federal support for Medicaid would still drop because the states above the average cost would lose federal support due to the cap, while states under the average gain nothing.[2] Over time, the gap between actual costs and available federal funding would steadily increase, putting states in an ever tighter bind to cover the difference or cut eligibility or services. And since the caps are based on aggregate costs, cuts can come from any part of the program. Because people with disabilities and older adults have the most extensive care needs and rely on a lot of optional Medicaid services, they will likely be disproportionately impacted as budget shortfalls grow.

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Reduced federal funding will likely lead to cuts of Medicaid services that are optional for states to provide, but critical to people with disabilities – such as Home and Community-Based Services (HCBS). Medicaid's HCBS programs provide critical services that help children and adults with disabilities live and participate in the community, including nursing and personal care services, intensive mental health services, specialized therapies, special education services, and employment supports. Cuts to these cost-effective and successful optional services may lengthen waiting lists for HCBS and force people out of their homes and communities and into more expensive institutions which states are required by Medicaid law to provide. Tight state budgets will stifle integration – states will not be able to expand and develop better community-integrated services and supports for people with disabilities.

Federal funding caps would threaten the Medicaid expansion, which is a lifeline for millions of people with disabilities and chronic conditions and many of their caregivers. These are often people who previously fell through gaps in our coverage safety net, such as people with disabilities in a mandatory waiting period before their Medicare coverage begins or individuals who did not meet Medicaid's strict definition of disability but still suffer from debilitating or chronic conditions. As one example, over one in five enrollees in Ohio's Medicaid expansion reported treatment needs that indicated a disability, including many with mental or behavioral health conditions.[3] Nearly 40% had a chronic condition before enrolling, and 25% received a new diagnosis *after* they enrolled.[4] Other expansion states show similar findings. Also, millions of family caregivers who take care of a child or older adult with a disability gained coverage through the Medicaid expansion. That coverage helps them stay healthy for this important work. The AHCA dramatically reduces federal matching funds for the Medicaid expansion, forcing states into an impossible dilemma of either: 1) terminating adult coverage and disenrolling the millions of people with disabilities and caregivers who have gained coverage through the expansion; or 2) dramatically cutting funding and eligibility in other areas of the program, such as coverage for older adults, people with disabilities, pregnant women, and children.

Federal funding caps would stifle innovation. States already have numerous options to innovate using Medicaid waivers and state options, particularly for people with disabilities and older adults. But many of the cutting edge innovations in health care require up front investments in care management and preventive care that generate overall savings down the road. As per capita caps shift more and more costs to states, those initial investments would become steadily harder to pay for. The likely result: long term investments in primary care and care coordination would lose out to short term demands to fill budget holes.

Medicaid is already a lean, responsive program that is less expensive per beneficiary and growing slower than private employer coverage, despite being the nation's default long term care system. Medicaid's spending growth per beneficiary has typically grown slower than both Medicare and private insurance.[5] Medicaid administrative costs ran under 5% of total outlays in 2015, less than half the rate that is typically seen in the private sector.[6] Long term supports and services are already highly managed in order to meet the basic needs of as many beneficiaries as possible. There is simply no extraneous fat to cut; a reduction in Medicaid funding will mean a reduction in valuable services, eliminating eligibility for individuals with disabilities or cutting payments to providers who may stop participating in the program. This is particularly true in states that currently spend less on their Medicaid programs; but analyses of the AHCA suggest that low-spending states would also be the states most negatively impacted by per capita caps.[7]

Endnotes

[1] Loren Adler et al., THE BROOKINGS INST., *Effects of the Medicaid Per Capita Cap Included in the House-Passed American Health Care Act*, 5 (May 2017), https://www.brookings.edu/research/effects-of-the-medicaid-per-capita-cap-included-in-the-house-passed-american-health-care-act/.
[2] *Id.* at 16.
[3] Ohio Medicaid Assessment Survey, *The Changing Landscape of Healthcare Coverage Across Ohio*, 17 (August 19, 2015).
[4] OHIO DEPT. OF MEDICAID, OHIO MEDICAID GROUP VIII ASSESSMENT: A REPORT TO THE OHIO GENERAL ASSEMBLY, 3, 28 (2016).
[5] MACPAC, *Trends in Medicaid Spending*, 8 (June 2016). This data is through 2014. Growth projections from 2014-2023 also predict Medicaid to grow slower (3.6%) than Medicare (4.2%) and private insurance (4-6%).
[6] CMS OFF. OF THE ACTUARY, *2016 Actuarial Report on the Financial Outlook for Medicaid*, 6 (Jan. 2017). In 2015, net costs (administration, profits, etc.) of private insurance ran above 12%. See, CMS, *National Health Expenditures Accounts NHE Tables*, Table 04, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip, (last visited May 16, 2017).
[7] Loren Adler et al, CTR. FOR HEALTH POL'Y AT BROOKINGS, *Effects of the Medicaid Per Papita Cap included in the House-Passed American Health Care Act*, 12 (May 2017), https://www.brookings.edu/research/effects-of-the-medicaid-per-capita-cap-included-in-the-house-passed-american-health-care-act/.