AARP Public Policy Institute
CELEBRATING 25 years

# The High Cost of Capping Federal Medicaid Funding

**The use of block grants (or other capped funding arrangements) to limit federal Medicaid spending may help balance the federal budget and provide states with more flexibility, but the price is high: Millions of Americans could lose access to basic health services, including long-term services and supports.**

Medicaid is the major source of coverage for low-income children and the 16 million low-income older adults and persons with disabilities who need long-term services and supports.[1] The program was designed so that financing is shared between the federal government and the states.[2] Medicaid rules require states to spend their own funds in order to receive federal matching funds for covered services provided to qualified individuals.[3] Under the current federal-state partnership, the federal government pays well over half of state Medicaid costs. Recent proposals have sought to change this long-standing financial arrangement that, over the years, has ensured that the Medicaid program is there for people when they need it.

Recent proposals would block grant, or otherwise cap, federal funding for Medicaid and give states additional flexibility over how they run their programs. Under a block grant (or some variation of capped funding), states would receive a predetermined allotment of funds, regardless of actual need or program costs. Under the current financing structure, the federal government shares the costs of medically necessary health and long-term care services for low-income people, whether those costs rise (or fall) due to state policy decisions (e.g., raising or lowering provider payment rates), or whether they rise (or fall) due to factors outside of the state's control (e.g., growth in the eligible population, health care inflation, or natural disasters).[4]

This Fact Sheet discusses reasons why some state and federal policymakers prefer capping Medicaid funding and why this type of funding arrangement is not good for beneficiaries. According to an analysis by the Congressional Budget Office, if total funding for Medicaid (including funding for the Medicaid expansion under health reform) is converted into a block grant, states would be required to provide less extensive coverage or pay a larger share of program costs.

## The Appeal of Capping Medicaid Funding

### Capped Funding Limits Federal Responsibility for Medicaid

In the current deficit reduction environment, the primary appeal of capping Medicaid funding is to limit federal spending to a defined amount. Limiting federal exposure to changing state economic circumstances and/or state policy choices means that federal responsibility for Medicaid expenditures is stable and predictable, even if the price of such stability results in diminished access to needed health and long-term cares services by our nation's most vulnerable citizens—young children, older adults, and persons with disabilities who have extremely low incomes.

AARP®

### Capped Funding Holds the Promise of Limiting the Role of the Federal Government in State Affairs

This view holds that states, rather than the federal government, should control health policy decisions with respect to their own citizens. Without federal restrictions, states would be free to manage their Medicaid programs in ways that reflect the unique needs and preferences of their residents.[5] The trade-off for capped funding would be less federal involvement in how states run their Medicaid programs.[6]

### Capped Funding Encourages Program Efficiency, Leading to Savings

According to this view, fewer federal restrictions provide opportunities for creativity that would lead to the development of innovative and less costly programs. Giving states more flexibility over how they run their programs—including relief from eligibility rules, basic benefit package requirements, and a host of other rules—would free states to be more creative and innovative in how they run their programs, which, in turn, could lead to greater program efficiencies at lower cost.[7,8]

## The Price of Capping Federal Medicaid Funding

There are significant risks associated with capping Medicaid financing that can undermine the program's traditional function as a safety net for people who turn to it as a last resort—including those who have exhausted their own resources and need long-term services and supports. Some of these risks are described below.

### Capped Funding Shifts Financial Risk to States

As a deficit reduction strategy, a capped funding arrangement would limit the federal government's contribution to Medicaid, transferring more and more financial burden to states over time—whether or not they are prepared to shoulder that burden.[9] According to the Congressional Budget Office, under a recent Medicaid block grant proposal, federal funding for Medicaid would fall 35 percent by 2022—and 49 percent by 2030.[10] In response, states would be forced to raise taxes to meet the need (which often proves politically untenable) or employ measures to reduce program spending that could hurt the most vulnerable—those who are poor, including over a million impoverished older adults and persons with disabilities who rely on Medicaid to stay out of costly nursing homes.[11] Faced with economic downturns, epidemics, or emerging new medical treatments (which, while beneficial, tend to be costly), federal funds would not increase and states would be pressured to find ways to meet these new financial challenges by raising taxes, shifting more costs to the poor, or making cuts to their programs in ways that compromise quality and hurt beneficiaries.[12]

### Capping Funding Hurts People Who Rely on Medicaid for Long-Term Care

In return for limiting its financial exposure, the federal government could give states the flexibility to restructure Medicaid, which could include diminishing and/or freezing enrollment, establishing waiting lists for eligible people, cutting nursing home and other provider rates to a point that compromises quality, or increasing beneficiary cost sharing. States could also receive flexibility to limit access to services such as long-term care.

The cumulative effect of giving states these options could cause millions of poor—as well as formerly middle-class people who have exhausted their life savings and rely on the Medicaid program—to lose access to the long-term care services that Medicare does not provide.

Capped funding could also undermine the positive—and innovative—trend

toward providing long-term services and supports in home and community-based settings that people prefer. For example, faced with fewer federal funds over time, states might have to limit or eliminate state plan services that are the backbone of home and community-based care, such as personal care, adult day care, or chore services.

### Capped Funding Hurts Medicare Beneficiaries

Medicare beneficiaries who are poor enough to qualify for Medicaid represent some of the poorest and sickest older adults in the country. They rely on the Medicaid program to help them pay their Medicare cost sharing and to provide services not covered by Medicare, such as long-term services and supports, including home and community-based services. Because these low-income beneficiaries are responsible for a significant portion of Medicaid expenditures—representing 15 percent of Medicaid enrollment and 39 percent of program spending—they could be an obvious target for cuts if states' capped allotments are exhausted, leaving the most vulnerable Medicare beneficiaries without access to needed long-term services and supports.[13]

### Capped Funding Can Discourage Innovation

Medicaid programs are able to innovate because the federal government provides financial support for states to implement new approaches designed to improve the program. For example, the federal government allocated $1.75 billion over five years for state Medicaid programs to develop creative approaches to transitioning people out of costly nursing homes back into community settings. This initiative—called the Money Follows the Person Rebalancing Demonstration—was scheduled to end in FY 2011.[14] The program has been extended for five more years (from FY 2011 to FY 2016), with an additional $4.45 billion in federal funding.[15]

Because block grants lock states into point-in-time payments (albeit typically with adjusters), they do not provide enough financial flexibility (in the form of increased federal dollars) to finance the cost of program innovation. This is especially the case for states with very lean programs that will be locked into lower baseline allotments.[16] It is unlikely that these states will have the financial resources to allocate funds to the start-up costs needed to bring innovative programs on line, and, under a capped funding arrangement in the context of deficit reduction, it is not likely that these states will have access to increased federal funding to finance innovation.

### The Public Supports Continued Funding for Medicaid as a Safety Net Program

A 2005 survey conducted by the Kaiser Family Foundation found that the majority of respondents support Medicaid as a safety net program for the most vulnerable. Even during state budget crises, a majority of those polled (52 percent) were reluctant to cut Medicaid. The survey also found that nearly three-quarters (74 percent) of respondents said Medicaid is a "very important" government program.[17] Well over one-half (56 percent) had personally received Medicaid-financed long-term care (16 percent) or had a friend or family member who had received such care (40 percent).[18]

A more recent poll reaffirmed public commitment to Medicaid, finding that more than two-thirds (87 percent) of those polled were not willing to see major reductions in Medicaid as a way to reduce the federal deficit; and close to one-half (47 percent) were opposed to any reductions in Medicaid. A significant majority of those polled (59 percent) realized the personal importance of the program as one that provides access to

health insurance and long-term care for those who are in need.[19]

Federal law establishes a *floor* with regard to program eligibility, covered services, and beneficiary contributions. Giving states the flexibility to alter minimum requirements—by dropping people from the rolls, establishing waiting lists for coverage, increasing cost sharing, cutting services, or restricting access to providers—represents a retreat from a national commitment to a health care safety net for the country's most vulnerable citizens.

## Where AARP Stands

AARP public policy strongly supports maintaining the current financial structure of Medicaid because it is one that best supports all low-income people getting the care they need when they need it. It also holds the best promise for ensuring that older adults and persons with disabilities have access to long-term care, including home and community-based long-term services and supports.

## Conclusion

It is important to take the country's responsibility to reduce the federal deficit seriously. However, a basic set of principles should guide policymakers in their deliberations. One is to do no harm to our nation's most vulnerable: low-income children, older adults, and persons with disabilities. Another is to ensure the robustness of the Medicaid long-term care system for those for whom the program is a last resort for access to services. Finally, federal policymakers should take seriously what leading experts across the political spectrum have said: growth in Medicaid spending cannot be substantially slowed without addressing the growth in private sector health spending. Failure to address growth in private sector spending would result in the creation of a two-tiered health system, shifting costs and risk to states, beneficiaries, and providers.[20]

States already enjoy considerable flexibility in how they operate their Medicaid programs. Hence, the familiar saying: "If you've seen one Medicaid program, you've seen *one* Medicaid program." In spite of the program variation among states, program flexibility is constrained by minimum standards and rules that apply uniformly across states. Federal policymakers should not consider giving states the opportunity to back away from these minimums in return for limited federal Medicaid funds.

The new health care reform law includes a range of options for states and the federal government to implement innovation into the program and realize savings. These include demonstration programs to test new, more efficient ways to deliver care; opportunities to avoid costly nursing home care by expanding home and community-based services; requirements that will rein in costs associated with program fraud; and programs aimed at addressing the needs of high-cost users of services.[21] These opportunities should be given a chance to work.

---

[1] Center on Budget and Policy Priorities (CBPP), Off the Charts: Ryan's Rx for Medicaid Means Millions More Uninsured or Underinsured Seniors, People with Disabilities, and Children (Washington, DC: CBPP, April 4, 2011). Accessed at http://www.offthechartsblog.org/ryan%E2%80%99s-rx-for-medicaid-means-millions-more-uninsured-or-underinsured-seniors-people-with-disabilities-and-children/.

[2] The federal share of Medicaid spending is determined according to a formula—called the Federal Medical Assistance Percentage or FMAP—under which the poorest states (based on average per capita income) receive a higher federal matching rate. By law, a state's FMAP cannot be lower than 50 percent or higher than 83 percent. T. A. Coughlin and S. Zuckerman, *States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences* (Washington, DC: Urban Institute,

June 2002). Accessed at http://www.urban.org/UploadedPDF/310525_DP0209.pdf.

[3] Ibid.

[4] C. Mann, *Medicaid and Block Grant Financing Compared* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2004). Accessed at http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf publications/federal medicaid policy/medicaid and block grant financing compared.pdf.

[5] J. Holahan and A. Weil, Block Grants are the *Wrong Prescription for Medicaid*. (Washington, DC,: Urban Institute). Accessed at http://www.urban.org/UploadedPDF/900624_HP Online_6.pdf.

[6] J. M. Lambrew, "Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals," *The Milbank Quarterly* 83, no. 1 (2005):1–23.

[7] Holahan and Weil, *Block Grants are the Wrong Prescription*.

[8] C. Edwards, *Downsizing the Federal Government: Medicaid Reforms* (Washington, DC: Cato Institute, September 2010). Accessed at http://www.downsizinggovernment.org/hhs/medicaid-reforms.

[9] For a more complete discussion of the impact of a Medicaid block grant on states, see E. Park and M. Broaddus, *Medicaid Block Grant Would Produce Disparate and Inequitable Results Across States* (Washington, DC: Center on Budget and Policy Priorities, March 10, 2011).

[10] This does not count the loss under the Ryan plan of the additional resources that the federal government would spend for Medicaid to cover more of the uninsured under the health reform law. Congressional Budget Office, "Long-Term Analysis of a Budget Proposal by Chairman Ryan" (April 5, 2011).

[11] Numbers as of 2004. E. Kassner et al., *A Balancing Act: State Long-Term Care Reform* (Washington, DC: AARP Public Policy Institute, July 2008).

[12] Holahan and Weil, *Block Grants Are the Wrong Prescription*.

[13] Kaiser Commission on Medicaid and the Uninsured (KCMU), *Dual Eligibles Share of Medicaid Spending* (Washington, DC: KCMU, 2007). Accessed at http://www.statehealthfacts.org/comparemaptable.jsp?ind=299&cat=6.

[14] L. Flowers and W. Fox-Grage, *How Does the Health Reform Law Create Opportunities for States to Save Medicaid Dollars?* (Washington, DC: AARP Public Policy Institute, forthcoming).

[15] Ibid.

[16] For a more complete discussion of the impact of a Medicaid block grant on states, see Park and Broaddus, *Medicaid Block Grant Would Produce Disparate and Inequitable Results*.

[17] The Kaiser Family Foundation, *National Survey of the Public's Views About Medicaid* (June 2005). Accessed at http://www.kff.org/medicaid/7338.cfm.

[18] Ibid.

[19] The Henry J. Kaiser Family Foundation (KFF). Pulling it Together: a Public Opinion Surprise (Menlo Park, CA: KFF, April 2011). Accessed at http://kff.org/pullingittogether/A-Public-Opinion-Surprise.cfm.

[20] P. N. Van de Water, *Rivlen-Ryan Plan Would End Guaranteed Medicare, Shift Medicaid Costs to States and Beneficiaries* (Washington, DC: Center on Budget and Policy Priorities, revised March 22, 2011). Accessed at http://www.cbpp.org/cms/index.cfm?fa=view&id=3429.

Fact Sheet 219, April, 2011

Written by Lynda Flowers
AARP Public Policy Institute,
601 E Street, NW, Washington, DC 20049
www.aarp.org/ppi
202-434-3910, mailto:ppi@aarp.org
© 2011, AARP.
Reprinting with permission only.

The author thanks her AARP colleagues, Donna Folkemer (Hilltop Institute), and Andy Schneider (Independent Consultant) for their very helpful comments, which improved the final product.

Fact Sheet