

MEDICAID BLOCK GRANT FINANCING AND PER CAPITA CAPS

AAFP Position

The American Academy of Family Physicians (AAFP) recognizes that health is a basic right for every person and that the right to health includes access to timely, affordable, and quality health care, including for Medicaid enrollees. To satisfy the AAFP's Medicaid core [principles](#), a concrete and supportive Medicaid financing structure is essential to serve the needs of enrollees. Block grants and per capita caps [violate](#) these principles. The AAFP has [concerns](#) about the impacts of alternative Medicaid financing mechanisms, such as block grants and per capita caps, on patient health and the ability of family physicians to continue serving Medicaid patients. A change to block grants would increase financial strain on state governments and physicians, reduce access to care for patients in rural and medically underserved areas, and increase uncompensated care costs.

Healthy Adult Opportunity

On January 30, 2020, the Centers for Medicare and Medicaid Services (CMS) released [guidance](#) outlining its new Healthy Adult Opportunity (HAO) initiative, which would, for the first time, allow states to apply for Section 1115 waivers to exercise more discretion in how they wish to use their Medicaid funds to cover enrollees. Under this initiative, states can experiment with how to finance coverage for any nonelderly adult who does not qualify for Medicaid on the basis of a disability or does not receive long-term services and supports. While a majority of individuals affected would be those with incomes up to 133 percent of the federal poverty level as part of the Affordable Care Act's Medicaid expansion, this new initiative could apply to other individuals included in Medicaid's "mandatory" populations, including parents and pregnant women. As a trade-off, the state can enact changes to the Medicaid program without CMS approval, use a closed prescription drug formulary, alter payments for federally qualified health centers (FQHCs), and use alternative approaches to compliance with managed care organization rules, among other changes.¹

In order to exercise this expanded discretion in eligibility, benefits covered, and oversight requirements, states pursuing a HAO waiver must agree to enact a limit on federal financing of their Medicaid programs in the form of an annual spending cap. This differs from Medicaid's traditional "open-ended" financing structure that doesn't artificially limit the federal government's contribution. States receive federal Medicaid support in the form of a federal matching assistance percentage (FMAP) that is based on the state's average per capita income and may fluctuate from year to year due to demographic changes, the economy, and state health costs. Simply put, as Medicaid demand increases, the federal contribution also increases. By contrast, per capita or block grant funding through the HAO would be determined based on historic Medicaid spending in the state while incorporating medical inflation in determining future spending growth. Under block grants, the state is given one lump sum of money from the federal government for their Medicaid program that is not based on enrollment. Conversely, per capita caps limit how much money from the federal government states are paid per enrollee. In both structures, any additional needed funds beyond the cap must be provided by the state.

Negative Implications

By nature, block grants do not give states the capacity to adequately respond to increased need brought on by any disruption including economic downturn, infectious disease epidemics and

¹ Rudowitz R, Musumeci M, Garfield R, Hinton E. (2020). "Implications of CMS's New 'Healthy Adult Opportunity' Demonstrations for Medicaid." *Kaiser Family Foundation*. Web.

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pandemics, and natural disasters. With the traditional FMAP, the federal government is obligated to increasingly support states that need to spend more to meet enrollees' needs. Without open-ended federal assistance under the current funding mechanism, states with block grants will struggle to meet budget requirements and in turn be forced to reduce eligibility categories or cut benefits to compensate. In addition, HAO initiatives pave the way for states to impose work requirements and additional cost-sharing on beneficiaries, as well as end retroactive eligibility for Medicaid coverage.

A tight financing structure will also make it more difficult for providers to serve patients. If states are forced to cut benefits or eligibility, patients will have difficulty accessing critical care. If parents are having difficulty accessing Medicaid under block grant financing, their children are more likely to lose coverage.² Enrollment of children in Medicaid has already declined in recent years, and block grants risk an even further decline, which can have negative impacts on their health later in life as well.²

Impacts on Physicians

Any HAO exercise has an adverse impact on physicians, because unlike most other Section 1115 demonstrations approved by CMS, HAO initiatives specifically allow states to change provider payment rates without CMS approval. Many providers are reimbursed for Medicaid at already much lower rates than Medicare, employer-sponsored insurance, and private insurance. If states are encouraged to lower provider payments even further for Medicaid, physicians may be unable to continue seeing Medicaid beneficiaries, reducing access to care for already vulnerable individuals across the country.³ This is especially true in rural or underserved areas, where hospitals, practices, and nursing facilities receive a sizeable amount of revenue from Medicaid. If their funds are limited, these already strained providers will risk being unable to serve already vulnerable patients. Additionally, there is concern that changing already agreed upon statutory managed care provisions, will lead to confusion on how plans will pay for, furnish, or cover services, increasing uncertainty and administrative complexity for providers operating with those plans.

State Action

Oklahoma

In March 2020, Oklahoma Governor Kevin Stitt became the first to submit a waiver under the HAO to convert Oklahoma's Medicaid program into a per capita cap financing model, titled [SoonerCare 2.0](#). In addition to per capita caps, the proposal also included work requirements, penalties of revoking coverage for missed monthly premium payments, and eliminated hospital presumptive eligibility and coverage for non-emergency medical transportation.⁴ In August 2020, after the state narrowly passed [State Question 802](#), a ballot initiative to amend the state constitution to fully expand Medicaid as outlined in the Affordable Care Act, Oklahoma [withdrew](#) its HAO waiver request. The ballot measure prohibits any components that would restrict coverage, such as work requirements and per capita caps, and will take effect on July 1, 2021.

Tennessee

Although announced before CMS released the HAO guidance, Tennessee's proposal had a block grant structure. In late 2019, Tennessee drafted, released, then submitted its Medicaid block grant proposal, [TennCare II](#), to CMS, which is still discussing the proposal and its specifics. Along with block grant financing, Tennessee's [proposal](#) also requests the authority to change covered services without federal approval or oversight, eliminate federal standards for Medicaid managed care plans, and exclude coverage of prescription drugs through a closed formulary, among other changes.

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² Wagnerman K. (2018). "Research Update: How Medicaid Coverage for Parents Benefits Children." *Georgetown University Health Policy Institute Center for Children and Families*. Web.

³ McLean R. (2020). "Internists Say Changes to Medicaid Program Will Put Health Care at Risk for Vulnerable Patients." *ACP*. Web.

⁴ Cross-Call J. (2020). "Despite COVID-19, Some States Still Blocking Medicaid Expansion, Seeking Other Restrictions." Web.