

Medicaid Financing: Dangers of Block Grants and Per Capita Caps

Lessons from TANF and CCDBG

Introduction

Since 1965, Medicaid has been providing affordable access to health care for children, workers, seniors, and persons with disabilities through a shared state-federal funding arrangement. Medicaid provides health insurance for one in five Americans, including 83 percent of children living in poverty; 48 percent of children with special health care needs; 45 percent of nonelderly adults with disabilities; and more than 60 percent of nursing home residents.¹ Medicaid covers about one-third of the non-elderly Black and Hispanic populations and 15 percent of the white population.² People of color are more likely to be insured by Medicaid because of systemic racism and economic oppression that has denied them access to quality jobs, including those that provide health insurance.³

In 2017, Congress repeatedly rejected proposals to change Medicaid's financing to a block grant structure, which would provide states with a capped amount of federal funds and shift the risk of increased costs to states. Nonetheless, in January 2020, the federal Centers for Medicare and Medicaid (CMS) released guidance to states encouraging them to use waiver authority to apply for per capita caps—which would provide states with a set amount of dollars per Medicaid enrollee—and eventually block grants. To date, CMS has not approved any state to transition to capped funding for Medicaid, and it's likely that any approval will face a legal challenge.

Capping state funding would place severe fiscal pressures on states, threaten patient access to care, and increase racial disparities. Other federal programs that have undergone such drastic restructuring—particularly the change with 1996's "welfare reform" from Aid to Families with Dependent Children (AFDC) to the Temporary Assistance for Needy Families (TANF) block grant—demonstrate that services are greatly diminished, funding fails to keep up with need, and the block grant is unresponsive in times of recession. All of these consequences leave states with untenable choices. The Child Care and Development Block Grant (CCDBG)—which is comprised of both a discretionary funding stream, subject to the annual federal appropriations process, and a mandatory funding stream—similarly demonstrates shortcomings and has been challenged to provide adequate child care assistance to eligible families.⁴ Per capita caps would also undermine the core guarantee of comprehensive medical insurance. The current COVID-19 crisis highlights the dangers of such shifts.

Under a block grant, states receive a set amount of money from the federal government to administer a program. Block grants would be a drastic change from the current Medicaid financing structure, which automatically responds to need and generally guarantees coverage to everyone who meets eligibility criteria⁵. With block grants, states would face difficult decisions that would lead to decreased eligibility and benefits for the people who receive their health care through the program.

In January 2020, CMS issued guidance outlining a new Healthy Adult Opportunity (HAO) waiver that states could apply for. The guidance is the first time CMS solicited waivers from states seeking to implement

capped funding for their Medicaid programs. Under the guidance, states are able to apply for a per capita or an aggregate cap grant, both of which fundamentally alter a state's Medicaid funding and pose risks to enrollees, providers, and state budgets. The guidance would also streamline the approval process for several other ways states may make detrimental changes to Medicaid, including imposing work reporting requirements, increasing out-of-pocket costs for enrollees, and changing benefit packages.

What are block grants and per capita caps?

Under the per capita cap option, states would receive a set amount of federal Medicaid dollars *per enrollee* for the population included in the waiver. If states opt for the aggregate cap, their federal Medicaid dollars for the waiver population would be a set amount and *not variable* based on enrollment numbers. In either scenario states would be asking to limit the federal dollars for Medicaid coming into their states, putting several aspects of the program at risk. We know from other programs that a block grant funding structure simply isn't adequate to provide services to everyone who is eligible.

TANF, currently the largest block grant program at \$16.5 billion a year, is designed to help families with low incomes achieve self-sufficiency. It is also the one example of a program that was converted from an individual benefit—where all people meeting the eligibility criteria were legally entitled to receive assistance—to a block grant. The transition from AFDC to TANF in 1996—and the experience in the more than two decades since—provides key evidence and cautions about how a block grant structure might change Medicaid.

A key benefit lost in the creation of TANF was a guarantee for access to child care assistance. Because Congress expected women with low incomes to go to work, they initially provided a large increase in funding for CCDBG. Those dollars however have eroded over time, and states have been left to balance the needs of serving families receiving TANF and other working families with low incomes by using limited TANF and CCDBG dollars.⁶

Five consequences of changing Medicaid's financing structure:

1. Funding will not keep up with need, burdening state budgets.

If Medicaid financing is changed to a block grant or per capita cap, states are at significant risk of not receiving enough funding to keep pace with the rising cost of health care while simultaneously continuing to provide the same coverage, benefits, and payments to providers. As a result, state policymakers would be forced to decide how to make up the difference and/or Medicaid recipients would lose services or eligibility. Erosion in Medicaid funding is detrimental not only to those without other affordable health care options, but also to doctors, other health care providers, hospitals, nursing homes, and managed care organizations that all receive Medicaid funding to provide services.

Such an erosion is exactly what has happened with TANF, which has been flat funded since it was block granted over 20 years ago and not adjusted for either inflation or population growth over time. As a result of inflation alone, the value of the block grant has fallen by more than one-third since its creation. States that have experienced growth in the number of children living in families with incomes under the poverty level are forced to spread fewer dollars across a larger number of children. Fifteen states receive less than half as much per poor child as they did when TANF was created.⁷ States have responded by both cutting benefits and serving fewer families in need.

While funding for CCDBG grew in the early years after lawmakers created it (as part of the same law that created TANF), it later remained flat and then experienced minimal increases in baseline funding until 2018. In that year, CCDBG received a \$2.4 billion increase⁸ in federal appropriations to support state implementation of enhanced quality, safety, health, and accessibility requirements included in the 2014 CCDBG Act reauthorization. This was the largest increase in funding in the program's history. Although the 2018 CCDBG increase began to fill the gap of years of underinvestment, the number of eligible children receiving CCDBG assistance has continued to decrease, with 463,000 fewer families served in 2017 than 2006.⁹

Eroding federal funds will significantly impact state budgets. Total Medicaid spending (state and federal combined) comprises about one-quarter of state budgets, and federal dollars account for over half of this spending. Therefore, a reduction in federal Medicaid funding over time through block grants will place pressure on state budgets, causing ripple effects throughout other areas of state budgets and jeopardizing their fiscal stability.¹⁰

2. Medicaid will no longer respond automatically to economic downturns or health crises.

Shifting financial risks to states is especially damaging during economic downturns. Unlike the federal government, which can run a deficit, nearly all states are legally required to balance their budget each year. When state tax revenues drop during recessions or crises like the COVID-19 pandemic, federal dollars can help alleviate state budget crises. Without federal support that responds to increased need, states would be forced to cut eligibility and/or benefits at a time when more people are in need.

Medicaid's response to the Great Recession was exactly what we expect of the safety net. The program responded by providing health care for millions of Americans who lost employment and often their access to employer-provided insurance. Between December 2007 and December 2009, Medicaid enrollment grew by 14 percent and, because Medicaid spending can fluctuate as enrollment and costs increase, expenditures also increased. This increase happened because the long-standing successful funding formula allows for fluctuations in enrollment and health costs and does not cap spending. The ability of Medicaid to respond to economic pressures preserves not only access to health care for those most in need, but also jobs at every level of the health care industry.

The ability of Medicaid to respond to economic pressures preserves not only access to health care for those most in need, but also jobs at every level of the health care industry.

During the Great Recession, Congress provided additional Medicaid dollars to states through a higher federal match (also known as the Federal Medicaid Assistance Percentage or FMAP). The FMAP boost provided over \$100 billion to states to offset increased Medicaid costs, and state spending on Medicaid *declined* during fiscal years 2009 and 2010 due to the increased FMAP.¹¹

Unlike Medicaid, TANF did not respond during the recession to the increasing needs of American families by providing a basic safety net. In fact, TANF caseloads did not immediately grow along with the sharp increase in national unemployment, and the program only played a marginal role in lifting families out of deep poverty during the recession. In three states—Georgia, Indiana, and Rhode Island—TANF caseloads actually decreased during the recession.¹²

As the country currently grapples with the COVID-19 pandemic and economic downturn, a strong Medicaid program that responds to the public health crisis and state fiscal problems will be a critical component of our country's exit out of the crisis. As a health insurer, Medicaid will provide payment for enrollees' COVID-19 testing and treatment. It will also serve as a safety net to millions of people who lost their employer insurance due to job loss. States will receive fiscal relief through enhanced federal dollars for Medicaid during the public health emergency, as they did during the Great Recession. If a state was operating part of its Medicaid program under an HAO waiver, both of these crucial responses by Medicaid would be in jeopardy. States would be incentivized to keep enrollment low and, depending on their waiver terms with CMS, would likely not benefit from enhanced federal Medicaid dollars.

While it is too early to have data about the role of TANF and CCDBG in response to the COVID pandemic, it's reasonable to assume the programs will not be able to successfully meet the need. As a historic number of families face unemployment and wage loss, those eligible and in need of TANF and CCDBG will grow. Due to the capped funding structure, however, the programs will simply not be able to respond to meet the increased need.

3. States will be under pressure to cut benefits and reimbursements.

If a block grant limits federal funding of Medicaid, states would struggle to cover the same number of people with a limited pool of funding. This would put pressure on them to cut their Medicaid budget by instituting higher co-payments or other cost-sharing arrangements, or by dropping or reducing coverage for certain benefits (e.g., early intervention therapies for young children). The current Medicaid structure for matching federal dollars requires states to meet minimum standards for benefits, which includes such services as developmental screenings for children and nursing care for seniors who are unable to be cared for at home. Under the CMS guidance, states would be allowed to impose higher cost sharing through increased premiums and other out-of-pocket costs and suspend Medicaid eligibility for unpaid premiums.

Another option for states is reducing provider payments, which could lead to fewer doctors being willing to care for Medicaid patients and, in turn, limit access to health care – and increase health disparities for people of color. One study found that a bump in Medicaid reimbursements increased the likelihood of a Medicaid patient being able to access a primary care appointment.¹³

The inflexibility of the block grant funding structure has prevented CCDBG payments from keeping pace with inflation and rising child care costs. This reduction in payment rates has left providers weighing the costs and benefits of accepting families using CCDBG subsidies. The additional costs of maintaining CCDBG provider requirements and the deficit between subsidies and actual provider rates has translated to fewer providers accepting CCDBG payments¹⁴ and fewer families accessing child care. Since 2006, the number of providers accepting CCDBG subsidies has declined by 60 percent (nearly 423,000 providers).

A decrease in assistance is exactly what happened with TANF. The value of cash assistance awarded to families has substantially decreased over the last 24 years, during which 36 states have allowed TANF benefits to decline by 20 percent in purchasing power, and 15 states have not adjusted their nominal benefit amounts. As a result, recipients have had to bear inflation-adjusted declines in assistance of more than 37 percent. Every state's TANF benefit level for a family of three with no other income was at or below two-thirds of the federal poverty line as of July 2018. Another consequence of not adjusting TANF for inflation is that states must cover the full cost of any increases in benefits, including during an economic downturn.¹⁵

CCDBG also demonstrates that block grants lead to reduced benefits and payments. While the recent reauthorization of CCDBG established additional rules for the program, states retain flexibility to set many key policies. Restrictive eligibility policies are one way of controlling costs in a capped program. As of 2019,

state-determined income eligibility for CCDBG was lower as a percent of poverty in 28 states, and 23 states required higher parent co-payments as a percentage of household income when compared to 2001.¹⁶ Payment rates to providers—an important indicator of whether families can access quality child care—have been most affected by stagnant funding. In 2001, 22 states set payment rates at the federally recommended level compared to just 4 states today.¹⁷ Low payment rates disproportionately impact women of color, who are especially likely to work in the child care field.¹⁸

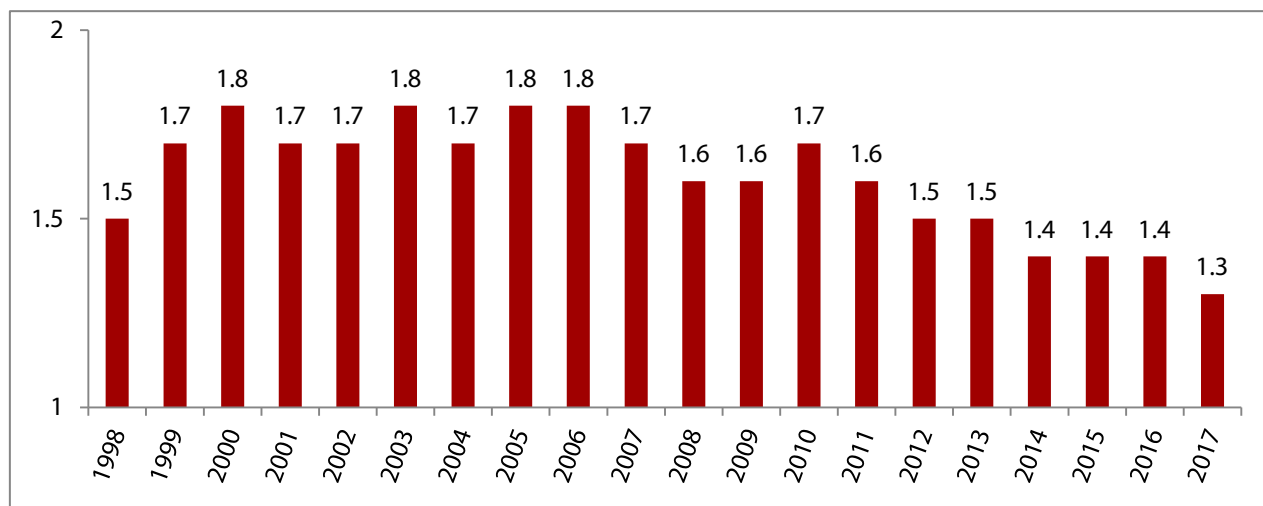
4. States may cut eligibility, pitting populations in need against each other.

Converting Medicaid to a block grant would likely undermine the basic eligibility requirements of the program. The current Medicaid structure requires states to cover certain populations with low incomes, such as pregnant women, children, seniors, and persons with disabilities. Under a different financing structure, these minimum standards would likely be eroded or left entirely to states' discretion. For example, states may be allowed to deny coverage for some populations or establish waiting lists.

While the CMS guidance is limited to certain Medicaid populations, increasing state fiscal pressures for one group will inevitably cause harm to all Medicaid groups. When a state faces a funding shortfall for the waiver population, it will likely look to other Medicaid spending to reduce expenses and cover the shortfall. Other areas states could consider reducing or eliminating include non-essential benefits (e.g., prescription coverage) and provider payments across all Medicaid populations. They could also explore cutting eligibility for populations that they currently cover above the federal requirement. For example, many states cover pregnant women at income levels above the federal requirement. The same is true of children in many states. Within the block grant population, states could take steps to limit enrolment by adding red tape and bureaucracy.

Figure 1. Average Monthly Number of Children Served in CCDBG in the United States

Federal FY 1998-2017, (in millions)



Source: "Administration for Children and Families, Office of Child Care administrative data, 1998-2017"

CCDBG and TANF have no guarantee to serve all eligible children. The share of children who live in poverty receive cash assistance has declined dramatically since TANF replaced AFDC. Today, a little less than one in five children living in poverty receives cash assistance.¹⁹ Due to declining federal and state investments,

CCDBG is currently reaching the smallest number of children in its history (see Figure 1). Total CCDBG funding declined by 12 percent in constant dollars from 2006 to 2017.²⁰ Since 2006, nearly 463,000 children have lost access to CCDBG-funded care due to insufficient funding and the block grant funding structure's inability to appropriately respond to states' needs.²¹ Today, only 15 percent²² of eligible children are able to get help, and Latinx and Asian American families are particularly underserved.²³ As child care investments have not kept pace with rising costs, subsidy values have declined by about 20 percent.²⁴

5. The safety net will be inconsistent across states, increasing racial disparities.

Medicaid programs are not identical across states now, but should Medicaid block grants become a reality, the difference in access to health care among states could become even greater. Current law requires Medicaid to cover certain minimum benefits as well as certain populations. Under the CMS guidance, more decisions will be left to states. As funding erodes and states continue to make choices about limiting eligibility or coverage, the differences in Medicaid coverage among states will be amplified.

One result of leaving decisions to states will be an increase in racial disparities. After the Supreme Court deemed Medicaid expansion to be a state choice, most states that delayed expansion, or have still not expanded, are in the South, which has high concentrations of people of color. As a result, nonelderly Blacks are more likely than whites to fall in the coverage gap.²⁵

The financing structure of TANF has created such inconsistencies across states. The TANF block grant is based on how much states received under AFDC in the years prior to the creation of TANF. This has locked into place sharp disparities in how much states receive on a per-child basis for those children who are poor, based on historical choices that were often driven by a racist lack of concern about the wellbeing of Black children and fear that cash assistance would allow Black mothers to reduce their paid domestic labor for white households.²⁶ These gaps have gotten even larger due to differences in population growth among states. The funding inconsistencies over the 20-plus years of TANF have been particularly alarming: in 1996, some states received as much as 8 times more per child in a family with income under the poverty level than others; today this gap has increased to 10 times more.²⁷ In 2018, Nevada and Texas received the fewest TANF dollars per child in poverty for the year (\$352.92 and \$366.4, respectively).²⁸ This means that even if today's policymakers in Nevada and Texas wanted to increase cash assistance benefits, they would have less ability to do so than states with larger per capita grants.

The combination of disparate state funding and high state flexibility has created vast inconsistencies in cash assistance programs across the country. For example, the share of children who are poor receiving cash assistance ranges from almost 62 percent in California to 3 percent in Texas.²⁹ States choose how much each family can get in monthly TANF cash assistance benefits and this also varies dramatically on a state by state basis. The amount a family of three receives in TANF monthly cash assistance benefits varied from \$1,039 in New Hampshire to \$170 in Mississippi in 2018.³⁰ Black children are disproportionately likely to live in states where TANF reaches few families, and thus are less likely to have access to cash assistance when their families are in need.³¹

Similarly, state flexibility has created huge variation in states' child care subsidy programs and policies related to health, safety, quality, and access. Twenty-eight states have reduced their average monthly

number of children served by more than a quarter since 2006, including seven states that are now serving 50 percent (or more) fewer children.³² In a study of racial and ethnic differences in access to CCDBG, CLASP found great variation by state across racial and ethnic groups—with eligible Asian and Latinx children having the least access.³³

Per capita caps are not a viable alternative

Previous congressional debates and the recent CMS guidance have proposed Medicaid per capita caps as an alternative to a full aggregate cap. Both approaches are dangerous and raise all the concerns listed above. In the first waiver to be submitted to CMS under the HAO guidance, Oklahoma requested a per capita cap, and the funding projections were identical for four out of five years. Simply put—the state requested the same amount of money for four consecutive years. Because the state also estimated the same level of enrollment for the four years, the fiscal projections depend on the unrealistic assumption that there will be no increases in medical expenditures.

Consequences to States and Enrollees	Block grants	Per capita caps
Funding will not keep up with population growth	X	
Funding will not keep up with rising costs of health care	X	X
Funding will not respond to economic downturns	X	Likely
States will be under pressure to cut benefits and reimbursements	X	X
States may cut eligibility, pitting vulnerable populations against each other	X	Likely
Communities of color will be disproportionately harmed	X	X
States' safety-net programs will vary widely	X	X

Block grants and per capita cuts do not provide true flexibility

Proponents of structural changes to Medicaid argue that they are needed to give states more flexibility. This is a flawed argument, particularly because states currently have flexibility in their Medicaid programs. States can apply for waivers from CMS to cover more benefits, increase eligibility limits, or try innovative models for care. Any waiver must be deemed “budget neutral,” meaning that it will not increase federal spending. Waivers are evaluated by CMS on four criteria: increasing access to care, increasing and stabilizing provider networks, improving health outcomes, and increasing program efficiency. Given the latitude states already have, the current use of the term “flexibility” by those pursuing significant structural changes to Medicaid should be viewed with caution.

"Flexibility would really mean flexibility to cut critical services for our most vulnerable populations..."

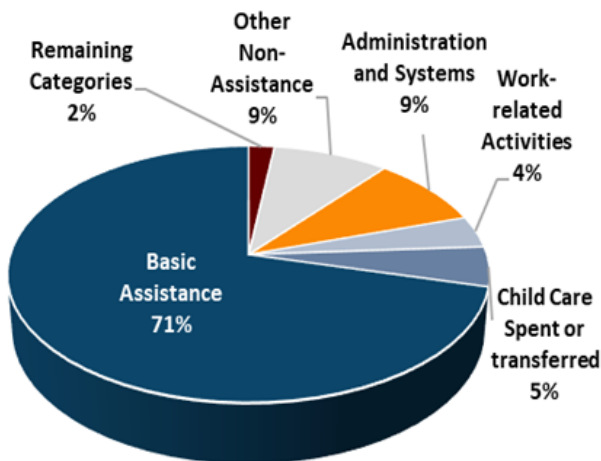
— Governor John Bel Edwards (D-LA)

As Governor John Bel Edwards (D) of Louisiana explained, "Under such a [block grant] scenario, flexibility would really mean flexibility to cut critical services for our most vulnerable populations, including poor children, people with disabilities and seniors in need of nursing home and home-based care."

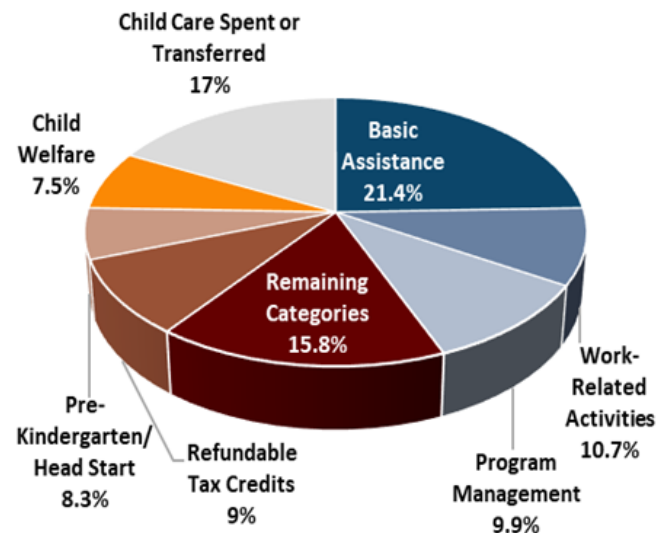
Massachusetts Governor Charlie Baker (R) feels similarly and said, "We are very concerned that a shift to block grants or per capita caps for Medicaid would remove flexibility from states as the result of reduced federal funding. States would most likely make decisions based mainly on fiscal reasons rather than the health care needs of vulnerable populations."³⁴

Second, without protections for recipients, flexibility only increases the competing demands on a limited pool of funding. Under the guise of "state flexibility," states have used TANF block grant dollars and the required state "maintenance of effort" (MOE) contribution to meet other state needs. Because the uses of TANF are so broad, some states have capitalized on the program's flexibility to redirect funds to a wide variety of activities, including some that have limited or no benefit to people with low incomes, such as college scholarships for middle-income students. TANF funds are also commonly used to pay for programs with real benefits to families with low incomes like child care subsidies and child welfare programs. While these are crucial supports for families, in many cases states have supplanted other funding sources that would otherwise have paid for these programs. As a result, significantly fewer dollars go directly to families as cash assistance that they can use to purchase necessities. In fiscal year (FY) 1997, 71 percent of TANF/MOE spending was dedicated to cash assistance for families. In FY 2018, only 21 percent of TANF/MOE spending went to cash assistance for families.³⁵

FY 1997 TANF MOE spending



FY 2018 TANF MOE spending



Note: Refundable tax credits includes EITC and non-EITC spending; Child Welfare includes foster care spending from basic assistance, Authorized Under Prior Law (AUPL), and Non-AUPL. See [TANF 101 Block Grants](#) for more information on AUPL.

It is sometimes suggested that "flexibility" offered by capped funding would allow states to expand funding to address social determinants of health, such as housing or other anti-poverty efforts. The experiences of TANF and CCDBG serves as a cautionary tale and refutes this message. Given limited funding, states are highly unlikely to support such activities, and if they did, they would need to cut in other areas such as eligibility, benefits, or payments.

Moreover, CMS does not have the authority to grant the waivers it has offered states under the HAO guidance. The Medicaid statute is clear that the purpose of the program is to furnish medical assistance to individuals whose incomes are not enough to meet the costs of necessary medical care and to furnish such assistance and services that helps these individuals attain or retain the capacity for independence and self-care. States are allowed in limited circumstances to request to "waive" provisions of the rule but the Secretary of Health and Human Services (HHS) may only approve a project that is "likely to assist in promoting the objectives" of the Medicaid Act.³⁶ A waiver that does not promote the provision of affordable health care would not be permissible.

Conclusion

After Congress rejected block grants for Medicaid, CMS still provided guidance to states outlining such an option. To date, CMS has not approved any state to implement a block grant, and any future approval will likely face a legal challenge. The consequences of such a drastic change to Medicaid would be far reaching and cause significant damage to a vital program for children, seniors, and persons with disabilities. Cuts to Medicaid would disproportionately affect communities of color, especially Black people, for whom Medicaid significantly reduces the coverage gap left by private insurance. Access to care for vulnerable populations would be diminished, states would be left holding the bag for increasing medical costs, and providers and other health industry jobs would be at risk.

Simply put, neither turning Medicaid into a block grant nor initiating per capita caps on spending will provide states with choices that improve access to care. Rather, such changes will shift all the financial risk to states, which would be forced to respond to rising needs without additional assistance from the federal government. The current structure has worked for more than 50 years by sharing the responsibility between states and the federal government. This system allows Medicaid to respond to economic downturns without jeopardizing state budgets while also ensuring that states are held accountable for minimum eligibility and benefits criteria. Medicaid is a successful program with a proven record of improving lives. Any changes to Medicaid should build on this current successful foundation rather than threatening states' financial stability and patients' health and wellbeing.

Thanks and acknowledgements to Elizabeth Lower-Basch, Ashley Burnside, Alycia Hardy, and Katherine Gallagher Robbins for their assistance with data collection and content review.

Endnotes

¹ Robin Rudowitz, Rachel Garfield, and Elizabeth Hinton, "10 Things to Know about Medicaid: Setting the Facts Straight," Kaiser Family Foundation, March 2019, <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/>.

² Kaiser Family Foundation, Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity, 2018, <https://www.kff.org/medicaid/state-indicator/rate-by-raceethnicity-3/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.

³ Kaiser Family Foundation, Employer-Sponsored Coverage Rates for the Nonelderly by Race/Ethnicity, 2018.

⁴ The Child Care and Development Block Grant (CCDBG) is also known as the Child Care and Development Fund or CCDF. CCDBG's structure is unusual because it is comprised of multiple funding streams: mandatory, matching, and discretionary. Each state receives a Mandatory allotment based on a formula set in 1996, and may draw down Matching funds up to a cap if it contributes required state Match and Maintenance of Effort fund. Discretionary funding is subject to the annual federal appropriations process and does not require a state match.

⁵ Medicaid is an entitlement program, but some states do maintain waiting lists for Home and Community Based Services (HCBS) waivers, which provide care in home and community settings in place of long-term care facilities.

⁶ Karen Schulman and Abbie Starker, "Temporary Assistance For Needy Families and Child Care Assistance: A Weakened Safety Net For Families," National Women's Law Center, 2016, <http://nwlc.org/wp-content/uploads/2016/11/TANF-Child-Care-Fact-Sheet-11.4.16.pdf>.

⁷ U.S. Department of Health and Human Services Office of Family Assistance, "TANF Financial Data," 1997-2015, <https://www.acf.hhs.gov/ofa/programs/tanf/data-reports>. U.S. Census Bureau Current Population Survey March Supplement, "Related Children Under Age 18," 1997-2015. Elizabeth Lower-Basch, "TANF 101: Block Grant," CLASP, December 2019, <http://www.clasp.org/resources-and-publications/publication-1/TANF-101-Block-Grant.pdf>.

⁸ "Child Care in the FY 2018 Omnibus Spending Bill", Center for Law and Social Policy, March 2018, <https://www.clasp.org/sites/default/files/publications/2018/03/Child%20Care%20in%20the%20FY%202018%20mnibus.pdf>.

⁹ CLASP Analysis of U.S. Department of Health and Human Services, Administration for Children and Families Administrative Data, 2006 and 2017, <https://www.acf.hhs.gov/occ/resource/fy-2017-final-data-table-1> and <https://www.acf.hhs.gov/occ/resource/ccdf-data-06acf800-final>.

¹⁰ Medicaid and CHIP Payment and Access Commission, "Medicaid's Share of State Budgets," <https://www.macpac.gov/subtopic/medicaids-share-of-state-budgets/>.

¹¹ Robin Rudowitz, COVID-19: Expected Implications for Medicaid and State Budgets, April 2020, <https://www.kff.org/coronavirus-policy-watch/covid-19-expected-implications-medicaid-state-budgets/>.

¹² Elizabeth Lower-Basch, "TANF 101: Cash Assistance," CLASP, March 2019, <https://www.clasp.org/publications/report/brief/tanf-101-cash-assistance>.

¹³ Diane Alexander and Molly Schnell, The Impacts of Physician Payments on Access, Use and Health, October 2019, <https://www.ipr.northwestern.edu/documents/working-papers/2019/wp-19-23.pdf>

¹⁴ Monica Rohacek and Gina Adams, Providers in the Child Care Subsidy System, Urban Institute, November 2017, <https://www.urban.org/sites/default/files/publication/95221/providers-and-subsidies.pdf>

¹⁵ Ibid.

¹⁶ Karen Schulman, "Early Progress: State Child Care Assistance Policies 2019", National Women's Law Center, <https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2019/11/NWLC-State-Child-Care-Assistance-Policies-2019-final.pdf> (table 1b and 3a) * Virginia is divided into four regions with each region having its own income eligibility limits. One of the four regions in Virginia lowered income eligibility limits as a percent of poverty. This report analyzes data at the state level, therefore, the entire state is included in the number of states that lowered income eligibility as a percent of poverty.

¹⁷ Karen Schulman, "Early Progress: State Child Care Assistance Policies 2019", National Women's Law Center, <https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2019/11/NWLC-State-Child-Care-Assistance-Policies-2019-final.pdf> (table 4b).

¹⁸ Lynette M. Fraga and Renee Boynton-Jarrett, The Forgotten Essential Workers: Women of Color in Child Care, Real Clear Policy, May 2020, https://www.realclearpolicy.com/articles/2020/05/12/the_forgotten_essential_workers_women_of_color_in_child_care_491313.html.

¹⁹ Bernadette D. Proctor, Jessica L. Semega, and Melissa A. Kollar, "Income and Poverty in the United States: 2015," U.S. Census Bureau, September 2016, <http://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-256.pdf>. Office of Family Assistance, "TANF Caseload Data 2015", Administration for Children and Families, U.S. Department of Health and Human Services, <https://www.acf.hhs.gov/ofa/resource/tanf-caseload-data-2015>. Elizabeth Lower-Basch, "TANF 101: Block Grant," CLASP, December 2019, <http://www.clasp.org/resources-and-publications/publication-1/TANF-101-Block-Grant.pdf>.

²⁰ House Committee on Ways and Means, "Table 9-2: CCDF Funding History, FY 1997-FY 2018," U.S. House of Representatives, 2018, <https://greenbook-waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/Chapter%209%20Child%20Care%20-%20Additional%20Tables%20and%20Figures.pdf>

Note: Total CCDBG funding includes federal and state mandatory funds, CCDBG discretionary funds, and TANF transfer funds."

²¹ U.S. Department of Health and Human Services, Administration for Children and Families, FY 2017 Final Data Table 1 "Average Monthly Adjusted Number of Families and Children Served", <https://www.acf.hhs.gov/occ/resource/fy-2017-final-data-table-1> and U.S. Department of Health and Human Services, Administration for Children and Families, FY 2006 Final Data Table 1 "Average Monthly Adjusted Number of Families and Children Served", <https://www.acf.hhs.gov/occ/resource/ccdf-data-06acf800-final>.

²² Nina Chen, "Factsheet: Estimates of Child Care Eligibility & Receipt for Fiscal Year 2016", Office of the Assistant Secretary for Planning and Evaluation, 2019, <https://aspe.hhs.gov/system/files/pdf/262926/CY2016-Child-Care-Subsidy-Eligibility.pdf>.

²³ Rebecca Ullrich, Stephanie Schmit, and Ruth Cosse, "Inequitable Access to Child Care Subsidies," Center for Law and Social Policy, 2019, https://www.clasp.org/sites/default/files/publications/2019/04/2019_inequitableaccess.pdf

²⁴ U.S. Department of Health and Human Services, FY 2017 Administration for Children and Families Justification of Estimates for Appropriations Committees, 2016, https://www.acf.hhs.gov/sites/default/files/olab/final_cj_2017_print.pdf.

²⁵ Samantha Artiga, Kendal Orgera, and Anthony Damico, "Changes in Health Coverage by Race and Ethnicity since the ACA, 2010-2018", March 2020, <https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/>.

²⁶ Elisa Minoff, "The Racist Roots of Work Requirements," Center for the Study of Social Policy, February 2020, <https://cssp.org/wp-content/uploads/2020/02/Racist-Roots-of-Work-Requirements-CSSP-1.pdf>

²⁷ Office of Family Assistance, TANF Financial Data for years 1997 through 2015; Current Population Survey March Supplement, "Related Children Under Age 18" for years 1997-2015.

²⁸ Elizabeth Lower-Basch, "TANF 101: Block Grant", Center for Law and Social Policy, December 2019, <https://www.clasp.org/publications/report/brief/tanf-101-block-grant>.

²⁹ Office of Family Assistance, "TANF Caseload Data 2015", Administration for Children and Families, U.S. Department of Health and Human Services, <https://www.acf.hhs.gov/ofa/resource/tanf-caseload-data-2019>.

³⁰ Welfare Rules Database, "Table II.A.4 Maximum Monthly Benefit for a Family with No Income," Urban Institute, July 2015, <http://wrdb.urban.org/wrd/Query/query.cfm>.

³¹ Ife Floyd, "Policy Brief: Cash Assistance Should Reach Millions More Families," Center on Budget and Policy Priorities, March 2020, <https://www.cbpp.org/research/family-income-support/policy-brief-cash-assistance-should-reach-millions-more-families>.

³² U.S. Department of Health and Human Services, Administration for Children and Families, FY 2017 Final Data Table 1 "Average Monthly Adjusted Number of Families and Children Served", <https://www.acf.hhs.gov/occ/resource/fy-2017-final-data-table-1> and U.S. Department of Health and Human Services, Administration for Children and Families, FY 2006 Final Data Table 1 "Average Monthly Adjusted Number of Families and Children Served", <https://www.acf.hhs.gov/occ/resource/ccdf-data-06acf800-final>.

³³ Rebecca Ullrich, Stephanie Schmit, Ruth Cosse, *Inequitable Access to Child Care Subsidies*, CLASP, 2019, https://www.clasp.org/sites/default/files/publications/2019/04/2019_inequitableaccess.pdf.

³⁴ Robert Pear, "Trump's Health Plan Would Convert Medicaid to Block Grants, Aide Says," New York Times, January 22, 2017, <https://www.nytimes.com/2017/01/22/us/politics/donald-trump-health-plan-medicaid.html>.

³⁵ Office of Family Assistance, TANF Financial Data for years 1997 through 2018.

³⁶ Jane Perkins, "Section 1115 Demonstration Authority: Medicaid Act Provisions That Prohibit a Waiver," National Health Law Program, 2017, https://9kqpw4dcaw91s37koz5jx17-wpengine.netdna-ssl.com/wpcontent/uploads/2017/07/Section1115_1396a-limits-1.pdf.