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Fact Sheet

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Dangers of Block Grants and Per Capita Caps in Medicaid Financing

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 that guarantees a minimum package of health benefits to all who qualify. In recent years, Congress has repeatedly rejected proposals to change Medicaid's financing to a block grant structure, which would cap federal spending and shift the risk of increased costs to states. Nonetheless, in January 2020 the Centers for Medicare and Medicaid (CMS) released guidance to states encouraging them to apply for per capita caps, and eventually block grants, using waiver authority. 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.

The consequences of such a drastic change to Medicaid would be far reaching and cause significant damage to a program that's vital to the people it serves. 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. 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.[2] Such significant changes to Medicaid would place severe fiscal pressures on states and threaten patient access to care. Any discussion about strengthening the program should build on the current successful foundation rather than threatening states' financial stability—and patients' health and well-being—with drastic changes to the program's financing and structure.

Five consequences of changing Medicaid's financing structure:

1. Funding will not keep up with need, burdening state budgets.
2. Medicaid will no longer respond automatically to economic downturns or health crises.
3. States will be under pressure to cut benefits and reimbursements.
4. States may cut eligibility, pitting populations in need against each other.
5. The safety net will be inconsistent across states, increasing racial disparities.

The January 2020 CMS guidance outlined 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, both of which fundamentally alter a state's Medicaid funding and pose risks to enrollees, providers, and state budgets.

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 state, 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.

Lessons from TANF and CCDBG

Lessons from two current block grants—the Temporary Assistance for Needy Families (TANF) block grant and the Child Care and Development Block Grant (CCDBG)—demonstrate the key weaknesses of block grants: funding fails to keep up with the costs of services and population growth over time, and funding is unresponsive in times of recession, when more people need help just as state revenue is declining. This pressures states to cut benefits and reimbursements, or to cut eligibility, pitting populations needing support against each other. The result is increased disparities in the services available to residents of different states.

TANF

The transition from Aid to Families with Dependent Children (AFDC) to TANF in 1996—and the experience in the two decades since—provides key evidence and cautions about how a block grant structure might change Medicaid. TANF has been flat funded since it was block granted 24 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 eroded 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 child as they did when TANF was created.[3] States have responded by both cutting benefits—36 states have allowed their TANF benefits to decline by 20 percent or more in real terms—and by serving fewer families—less than one in five children who are living in poverty receives any cash assistance.[4] During the Great Recession that started in 2008, TANF caseloads only grew slightly, and the program played a marginal role in lifting families out of deep poverty. States' flexibility to use TANF funds for a range of purposes has only increased the competing demands on a limited pool of funding.

CCDBG

A key benefit lost in the creation of TANF was a guarantee for access to child care assistance. Because Congress expected women earning low wages to go to work, policymakers initially provided a large increase in funding for CCDBG. However, CCDBG did not receive another funding boost until 2018, and that increase did not fill the gap from over two decades of underfunding. States have been left to balance the needs of serving both families receiving TANF and working families with low incomes by using limited TANF and CCDBG dollars. States have turned to policies such as low eligibility limits, waiting lists, increased co-payments, and lowered provider payment rates to control costs. 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.[5] 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.[6] Today, only 15 percent[7] of eligible children are able to get help, and Latinx and Asian American

families are particularly underserved.[8] As child care investments have not kept pace with rising costs, subsidy values have declined by about 20 percent.[9]

Proponents argue that structural changes to Medicaid are needed to give states more flexibility. This is a flawed argument, particularly because states currently have flexibility in their Medicaid programs. As Governor John Bel Edwards of Louisiana explained, "Under such a 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."

For more information, read CLASP's full report https://www.clasp.org/publications/medicaid-financing-dangers-block-grants-and-capita-caps-summary-and-full-report.

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, Employer-Sponsored Coverage Rates for the Nonelderly by Race/Ethnicity, 2018.
[3] U.S. HHS OFA, "TANF Financial Data," 1997-2015, U.S. Census Bureau CPS March Supplement, "Related Children Under Age 18," 1997-2015.
[4] U.S. Census Bureau, "Income and Poverty in the United States: 2015," September 2016, U.S. DHHS OFA, "TANF Caseload Data 2015", 2016, CLASP, "TANF 101: Block Grant," November 2016.
[5] National Women's Law Center, "Red Light, Green Light: State Child Care Assistance Policies 2016," 2016.
[6] 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.**
[7] 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**.
[8] 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**
[9] 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.**