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Policy Brief: Block Grants vs. Per-Capita Allotments and the Impact on Hospitals

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The President, Congressional Republicans, and many of the the nations' governors have all signaled a desire to reform the Medicaid program as part of the repeal and replacement of the Affordable Care Act (ACA). However, the details of these reforms remain mostly unknown – with the exception of many coalescing around the ideas of either block grants or per-capita allotments. With an estimated 11 million[1] people gaining health insurance coverage though the ACA's Medicaid expansion over the past three years, there is concern as to what will happen both to these newly covered individuals and to the providers who care for them.

There are many questions that must be answered in order to determine the impact of any proposed Medicaid reforms on individuals, states, and hospitals. While most of the current proposals do not address structural reforms to the Medicaid program in great detail, two different types of capped Medicaid funding have emerged as the most likely possibilities: block grants and per-capita allotments, or caps. Each of these is explained in more detail below.

Overview of funding options

Federal funding of Medicaid is currently determined by a formula that is based on a state's per capita income, meaning that the federal government contributes a larger share of program costs in poorer states. The Federal Medical Assistance Percentage (FMAP) determines the federal share of the cost of Medicaid services in each state. The lower a state's per capita income, the higher the state's FMAP, or federal Medicaid matching rate. FMAPs vary by state – from a floor of 50 percent to a high of 74 percent in 2016 in non-expansion states. The ACA provided expansion states 100 percent of federal funding for the cost of newly eligible adults under the Medicaid expansion from 2014-2016, with the federal share phasing down to 95 percent in 2017 and to 90 percent by 2020 and beyond[2].

Recent, leaked draft legislation from the House of Representatives and discussion papers from the National Governors Association Winter Meeting in Washington, D.C. outline the appetite and intent of the administration and Republicans in Congress to structurally reform Medicaid. By proposing to redefine the state-federal partnership, states are heavily engaged during this pre-conceptual phase and Congress is particularly receptive to Republican governors in expansion states. While there are working documents and drafts in a constantly shifting environment, they primarily propose to reform Medicaid by giving states an option between block grants and per-capita caps.

Each of these options contain many possible variations because answers to important policy questions – like how will the first year amounts be set, what growth rate will be used to index annual funding, and what products or services could be paid separately from federal funding caps – are still unknown. The impact on each state depends on program, population, and healthcare characteristics including current federal match rate; Medicaid expansion; eligibility criteria; population growth and demographics; scope of benefits; regional costs of health care; annual spending growth; role of managed care; and use of provider taxes.

Drawing from the most recent proposals, however, the issues that states and hospitals might face if they are implemented can begin to be examined. If they are implemented, they will likely be phased in, although over what length of time is also not known. Furthermore, it is possible that states may have an option to remain under the current structure with federal financial participation reduced to regular FMAP for the expansion population, rather than adopt either suggested model.

Additionally, some proposals intend to provide equitable access to federal resources for non-expansion states willing to enact reforms. Whether Congress plans to achieve that via extending new authorities to states for

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[1] Kaiser Commission on Medicaid and the Uninsured. "What Coverage and Financing is at Risk Under a Repeal of the ACA Medicaid Expansion?" December 2016. Available online at: http://files.kff.org/attachment/Issue-Brief-What-Coverage-and-Financing-is-at-Risk-Under-a-Repeal-of-the-ACA-Medicaid-Expansion
[2] Kaiser Commission on Medicaid and the Uninsured. "What Coverage and Financing is at Risk Under a Repeal of the ACA Medicaid Expansion?" December 2016. Available online at: http://files.kff.org/attachment/Issue-Brief-What-Coverage-and-Financing-is-at-Risk-Under-a-Repeal-of-the-ACA-Medicaid-Expansion

designing and administering their Medicaid programs, offering funds for safety-net providers during a transition, or a combination of policies remains unclear.

	Federal Funding	Enrollment Growth
Current Program	Open-ended matching funds (FMAP) based on actual state spending*	Federal funding grows as enrollment increases
Per-Capita Cap	Fixed amount for each beneficiary	Federal funding grows as enrollment increases
Block Grant	Fixed amount for a state	Funding does not adjust for increases in enrollment beyond population growth

*FMAP amounts currently vary between expansion and non-expansion states

Per-Capita Caps

Under this option, states would assume the increased risk associated with capped funding for benefits per Medicaid enrollee, but would continue to share risk with the federal government for population growth. This option would be based on federal match of expenditures by the state up to the amount(s) determined by the per-capita cap(s).

The recent proposal from the House of Representatives suggests that transitioning to a per-capita cap model would begin with the childless adult and parent populations for whom a state is receiving the enhanced Medicaid FMAP, and could be followed by additional populations at the state's discretion (e.g., children, elderly, disabled, etc.). The amount of the cap typically varies by enrollee group – a higher cap might be set for the elderly and a lower cap for children.

Block Grants

Under this option, similar to the per-capita cap model, states would convert financing for the adult Medicaid expansion population into a block grant – an annually set allotment of federal funds that may be adjusted for population growth. States may be able to choose to phase in other populations like the per-capita caps, except for the disabled and elderly eligibility groups which, under some current proposals, would receive mandatory benefits. Again, the specifics of a block grant option are still being discussed.

Impact on Providers: Key Considerations and Questions Remaining

While capped funding proposals vary in significant ways, they all have the ultimate goal of reducing federal Medicaid spending. The potential impact on states from reduced federal Medicaid funding is expected to be significant, although to what level would depend upon how a state chooses to implement their program. Possible consequences include, but are not limited to, reduced enrollment, reduced provider reimbursements, increased uncompensated care, and economic impacts at the state level. For instance, states that spend more per enrollee would fare worse under per-capita caps; whereas states that experience large increases in enrollment would struggle in a block grant scenario[3].

In designing the proposed reforms, how the baseline funding will be determined, what growth factors will be used to index funding, and what population and services will be included (or excluded) are critical yet unanswered questions.

Most agree that there is not a one-size-fits all solution for states. In fact, the commonly offered joke about Medicaid is that "when you understand one Medicaid program, you understand ONE Medicaid program." There are many policy details to be worked out and many political considerations at play. The Vizient office of public policy and government relations will continue to keep you apprised of ongoing developments regarding health care reform and the conversation around Medicaid.

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[3]Avalere. "Capped Funding in Medicaid Could Significantly Reduce Federal Spending." February 2017.