



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

Medicaid Per Capita Caps and Block Grants: Devastating for People with Disabilities

Establishing funding caps for the Medicaid program would be devastating to people with disabilities. Medicaid provides health care services and long-term services and supports that maintain the health, function, independence, and well-being of 10 million enrollees living with disabilities and, often, their families. For many people with disabilities, being able to access timely needed care is a life or death matter. Block grants or per capita caps will inevitably slash federal support for what is already a lean program and force states to cut services and eligibility that put the health and wellbeing of people with disabilities at significant risk.

Federal funding caps would shift huge costs onto states and consumers. The Consortium for Citizens with Disabilities strongly opposes any block granting, setting of per capita caps or significant cuts to the Medicaid program. Every recent proposal for a block grant or per capita cap would lead to drastic reductions in federal support for Medicaid over time, on the order of a 25 to 40% cut over 10 years relative to current law.¹ Already in dire financial circumstances, many states would not be able to bear additional expenses and would be forced to shift costs to consumers and/or cut services and eligibility for a growing and aging population.

Funding shortages would get worse over time. Block grants and per capita caps both cut federal funding, primarily by growing the cap slower than the average growth in health care costs. Over time, the gap between actual costs and available federal funding would steadily increase, putting states in an ever tighter bind to cover the difference. Because people with disabilities and older adults have the most extensive care needs and rely on a lot of optional Medicaid services, they often become the victim of cuts.

Efforts to provide additional "flexibility" to states must not open the door to abandoning essential enrollee protections. Currently, when states agree to accept federal Medicaid funding, they also agree to put in place protections that ensure access to coverage and care for enrollees. States agree to process all applications and promptly enroll everyone who is eligible. Generally, they may not create waiting lists, enrollment caps, or waiting periods for accessing services. Federal protections also limit out-of-pocket costs for services, ensure freedom to choose a provider, and prevent discrimination in health care delivery. Changes that seek to enable additional "flexibility" for states must not erode these vital federal enrollee protections.

Reduced federal funding will likely lead to cuts of Medicaid services that are optional for states to provide, but critical to people with disabilities – such as Home and Community-Based Services (HCBS). Cuts to these cost-effective and successful services may lengthen waiting lists for HCBS and force people out of their homes and communities and into more expensive institutions. Tight state budgets will stifle integration – states will not be able to expand and develop better community-integrated services and supports for people with disabilities.

Medicaid is already a lean program that is less expensive per beneficiary and growing slower than private employer coverage. Medicaid’s spending growth per beneficiary has typically grown slower than both Medicare and private insurance, and has also grown slower than the medical care inflation rate.² Medicaid administrative costs ran under 5% of total outlays in 2015, less than half the rate that is typically seen in the private sector.³ Long term supports and services are already highly managed in order to meet the basic needs of as many beneficiaries as possible. There is simply no extraneous fat to cut; a reduction in Medicaid funding will mean a reduction in valuable services.

Federal funding caps would threaten the Medicaid expansion, which is a lifeline for millions of people with disabilities and chronic conditions and many of their caregivers. These are often people who previously fell into one of many gaps in our coverage safety net, such as individuals with disabilities in a mandatory waiting period before their Medicare coverage begins. As one example, over one in five enrollees in Ohio’s Medicaid expansion reported treatment needs that indicated a disability, including many with mental or behavioral health conditions.⁴ Nearly 40% had a chronic condition before enrolling, and 25% received a new diagnosis *after* they enrolled.⁵ Other expansion states show similar proportions. Millions of family caregivers, who cannot work because they look after a child or older adult with a disability, also gained coverage through the Medicaid expansion. Recent repeal proposals would phase out the Medicaid expansion, opening those old holes in the social safety net that Medicaid expansion helped to fill.

Federal funding caps would stifle innovation. States already have plenty of options to innovate using Medicaid waivers and state options, particularly for people with disabilities and older adults. But many of the cutting edge innovations in health care require large up front investments in care management and preventive care that generate overall savings down the road. As per capita caps shift more and more costs to states, those initial investments would become steadily harder to come by. The likely result: long term investments in primary care and care coordination would lose out to short term demands to fill budget holes.

¹ Robin Rudowitz, KAISER FAMILY FOUND., *5 Key Questions: Medicaid and Per Capita Caps*, Fig. 4 (Jan. 31, 2017), <http://kff.org/medicaid/issue-brief/5-key-questions-medicaid-block-grants-per-capita-caps/>.

² MACPAC, *Trends in Medicaid Spending*, 8 (June 2016). This data is through 2014. Growth projections from 2014-2023 also predict Medicaid to grow slower (3.6%) than Medicare (4.2%) and private insurance (4-6%).

³ CMS OFF. OF THE ACTUARY, *2016 Actuarial Report on the Financial Outlook for Medicaid*, 6 (Jan. 2017). In 2015, net costs (administration, profits, etc.) of private insurance ran above 12%. See, CMS, *National Health Expenditures Accounts NHE Tables*, Table 04, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip>, (last visited Feb. 24, 2017).

⁴ Ohio Medicaid Assessment Survey, *The Changing Landscape of Healthcare Coverage Across Ohio*, 17 (August 19, 2015).

⁵ OHIO DEPT. OF MEDICAID, OHIO MEDICAID GROUP VIII ASSESSMENT: A REPORT TO THE OHIO GENERAL ASSEMBLY, 3, 28 (2016).