WHAT'S AT STAKE

Medicaid Financing

Over time, policy ideas gain and lose popularity, including several that threaten the effectiveness of major health care programs like Medicare, Medicaid, and the Affordable Care Act (ACA). In this series—What's at Stake—we explore some of these reform ideas and how they could affect coverage, care, and outcomes for older adults and people with disabilities.

Some policymakers support fundamentally restructuring Medicaid's financing.[1] These proposals often recommend transforming the program from a guaranteed benefit to a fixed payment system, coupled with new limitations on costs or care.

The Current System

Medicaid is financed and administered through a federal-state partnership. Under current law, the federal government matches state Medicaid spending based on a statutory formula, without a pre-set limit.[2] If state spending increases, for example due to increased enrollment or unexpectedly high program costs, then federal spending increases as well. The countercyclical nature of Medicaid, where economic downturns increase spending, makes the flexibility of the open-ended financing structure vital; it allows federal funds to flow to states based on actual costs and needs as economic and other circumstances change. For example, a pandemic like COVID-19 can increase Medicaid costs[3] by boosting enrollment, per capita spending, or both.

[1] Centers for Medicare & Medicaid Services, "State Medicaid Director Letter MD# 20-001: RE: Healthy Adult Opportunity" (January 30, 2020), https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf.
[2] Elizabeth Williams, et al., "Medicaid Financing: The Basics" (April 13, 2023), https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/.
[3] Elizabeth Hinton, et al., "Medicaid Spending and Enrollment Trends Amid the COVID-19 Pandemic – Updated for FY 2021 & Looking Ahead to FY 2022" (March 12, 2021), https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-spending-and-enrollment-trends-amid-the-covid-19-pandemic-updated-for-fy-2021-looking-ahead-to-fy-2022/.

The Proposals

While block grants and per capita caps function slightly differently, both are designed to produce federal savings over time regardless of need or state liabilities. Both would also ultimately leave states unable to afford coverage and important services. This would limit access to needed care and place millions of low-income people at risk of becoming un- or underinsured.

- **Block Grants**: Under a block grant, states would receive a fixed amount of federal funding each year to operate their Medicaid programs. States would be responsible for all costs that exceed the federal amount. Since block grants are designed to achieve federal savings, the grants would undercut current spending, either immediately or over time.[4] Depending on the new rules, the base grant might increase automatically to keep pace with inflation, but the share borne by the federal government would likely not adjust in times of need, making economic downturns a double hazard for state coffers.

  The dangers of block grants are not theoretical; Puerto Rico provides a case study. The territory receives its Medicaid funding as a block grant, so once the funds are exhausted, it must cover remaining costs itself. This lack of countercyclical assistance has been deadly: Before Hurricane Maria, the territory's funding limitations were not keeping pace with need. Maria spiked costs, plunging the territory into escalating debt, inability to cover health needs, and devastation for families.[5]

- **Per-Capita Caps**: A per-capita cap sets a limit on the amount of federal funding the state receives per Medicaid enrollee. These caps could be determined for all enrollees or separate caps could be calculated based on broad Medicaid coverage groups.[6] In either case, to generate federal savings, per-enrollee spending would be set lower than current spending or indexed to grow more slowly than is expected under current law. While this approach would tie federal funding to population changes, it would still not

[4] Robin Rudowitz, "5 Key Questions: Medicaid Block Grants & Per Capita Caps" (January 31, 2017), https://www.kff.org/medicaid/issue-brief/5-key-questions-medicaid-block-grants-per-capita-caps/.
[5] Edwin Park, "How States Would Fare Under Medicaid Block Grants or Per Capita Caps: Lessons from Puerto Rico" (January 6, 2021), https://www.commonwealthfund.org/publications/issue-briefs/2021/jan/how-states-fare-medicaid-block-grants-per-capita-caps-puerto-rico; Mc Nelly Torres, "Puerto Rico's Post-Maria Medicaid Crisis" (June 11, 2019), https://centerforhealthjournalism.org/our-work/reporting/puerto-ricos-post-maria-medicaid-crisis.
[6] Robin Rudowitz, "5 Key Questions: Medicaid Block Grants & Per Capita Caps" (January 31, 2017), https://www.kff.org/medicaid/issue-brief/5-key-questions-medicaid-block-grants-per-capita-caps/.

address changes in health costs, like those associated with a pandemic, natural disaster, or expensive new therapy.[7]

Specific Risks for Older Adults and People with Disabilities: Though structurally different, block grants and per-capita caps are both designed to curtail federal spending and increase states' ability to limit who is covered, provide less coverage, or both.

- **Increased "Flexibility"**: Most proposals to institute these financing changes would promise states more flexibility to administer their Medicaid programs, such as by removing or loosening federal requirements on what benefits and eligibility categories states must maintain.[8] If federal requirements are removed, states would be free to cut services, impose cost-sharing, roll back eligibility categories, or restrict enrollment through waiting lists or caps.

- **Highest Cost Beneficiaries**: As capped Medicaid funding shortfalls grow larger over time, states would have little choice but to cut the most expensive parts of the program to curtail costs. Older adults and people with disabilities would likely bear the brunt of major cuts, as their health care costs comprise almost half of all Medicaid spending while being only 21% of the Medicaid population.[9]

- **Nursing Facility Residents**: Medicaid was the primary payer for 62% of nursing facility residents in 2023.[10] Coverage of nursing facility care is required by the Medicaid statute, but this requirement could potentially be eliminated or waived by a new financing statute. Depending on the statute, states could also gain the ability to put waiting lists or caps into place, which could leave millions of residents at risk of losing both care and facility housing.

- **Home- and Community-Based Services**: HCBS services are generally for Medicaid beneficiaries who would otherwise be institutionalized in a nursing facility.[11] HCBS can be less expensive than nursing facility care—some of the savings are a result of

[7] Even under current financing, Medicaid programs can struggle to pay for expensive therapies. See, e.g., National Vial Hepatitis Roundtable (NVHR) & Center for Health Law and Policy Innovation of Harvard Law School (CHLPI), "Hepatitis C, the State of Medicaid Access" (last visited January 22, 2024), https://stateofhepc.org/.
[8] Samantha Artiga, et al., "Current Flexibility in Medicaid: An Overview of Federal Standards and State Options" (January 31, 2017), https://www.kff.org/report-section/current-flexibility-in-medicaid-issue-brief/.
[9] Robing Rudowitz, et al., "10 Things to Know About Medicaid" (June 30, 2023), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/.
[10] Priya Chidambaram & Alice Burns, "A Look at Nursing Facility Characteristics Between 2015 and 2023" (January 5, 2024), https://www.kff.org/medicaid/issue-brief/a-look-at-nursing-facility-characteristics/.
[11] Medicaid.gov, "Long Term Services & Supports" (last visited January 22, 2024), https://www.medicaid.gov/medicaid/long-term-services-supports/index.html.

underpayment of direct care workers, or a reliance on family caregivers[12]—but is still costly. Importantly, most HCBS programs and services are optional for states.[13] This means that at least some states would likely seek to cut HCBS or institute draconian waiting lists or caps if they began to experience massive shortfalls in funding. This in turn would lead to more beneficiaries being forced to leave their homes and communities for nursing facilities and, paradoxically, more drain on state budgets.

[12] MaryBeth Musumeci, et al., "Voices of Paid and Family Caregivers for Medicaid Enrollees Receiving HCBS" (October 8, 2021), https://www.kff.org/medicaid/issue-brief/voices-of-paid-and-family-caregivers-for-medicaid-enrollees-receiving-hcbs/.
[13] MaryBeth Musumeci, et al., "Key State Policy Choices About Medicaid Home and Community-Based Services" (February 4, 2020), https://www.kff.org/medicaid/issue-brief/key-state-policy-choices-about-medicaid-home-and-community-based-services/.