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Blocking Grants, Blocking Health Care

We previously [wrote](#) about the Trump Administration’s use of Medicaid waivers to deny coverage to people who can’t satisfy work requirements. While D.C. District Judge Boasberg has struck down Medicaid work requirements for the time being, an [appeal is pending](#) and work requirements are still a big issue. But looming in the distance, the [Department of Health and Human Services](#) (HHS) is preparing to invite state Medicaid programs to apply for a waiver of another part of the program: capping federal Medicaid funding. The prospect of such a change is another huge threat. States like Tennessee have already begun the process of requesting these “block grant” waivers.

In this issue of Health Care in Motion, we’ll take a deep dive into the proposed capped funding mechanisms: block grants and per capita caps. You may hear “block grants,” “per capita caps” and “capped funding” used interchangeably, or hear all of them just collapsed under the term “block grants.” They’re actually the [same thing](#). Whatever you call them, these proposals pose the same danger: States on the hook for increased health care costs, together with dangerous “flexibility” to cut coverage and benefits

The Building Blocks of Block Grants

Medicaid is and always has been an entitlement program – meaning that everyone who qualifies is guaranteed coverage. The federal government sets the minimum standards for Medicaid. All states must provide coverage to certain [categories](#) of people who meet low-income thresholds: children and their parents, pregnant women, people with disabilities, and people aged 65 and older. They also must provide [mandatory minimum benefits](#). If they choose, states can go above and beyond to cover additional populations and provide optional benefits.

In return for meeting the federal government’s Medicaid requirements, states receive help with the bill for providing medical assistance. The federal government and the states split costs according to the [Federal Medical Assistance Percentage](#) (FMAP). The federal government pays at least 50%, up to about 75% for the poorest states. If enrollment or health care costs increase, both the federal government and the state chip in according to the FMAP. As the program is constructed, there is no ceiling on the dollars that the federal government is required to match.

Conservatives have long argued that Medicaid would be more efficient if the federal government simply gave states a lump sum of money to manage as they fit. In a block grant, the federal government would give each state a set amount of Medicaid funding in advance, instead of matching the actual costs of the program. It would be up to states to cover any costs beyond the federal block grant. One big problem: block grants don’t account for increases in enrollment. Block grants are especially dangerous in economic recessions, when more people need Medicaid but states have less tax revenue to pay for it. Traditionally, federal Medicaid funding would cover the extra costs and even help to [counteract](#) the recession. But under a block grant program, states could spiral into economic downturns.

Another conservative proposal tries to reduce this problem. Under a per capita cap, the federal government would still give

each state a lump sum of Medicaid funding, but that sum would be calculated based on the number of people in the program. The per capita adjustment helps somewhat, but it still doesn't account for changes in demographics. As the population ages, a larger portion of Medicaid enrollees will be seniors and people with disabilities or chronic illnesses, who incur [higher medical costs](#).

In both proposals, federal Medicaid funding would be capped at a pre-determined amount, and states would be left on the hook for unexpected increases in health care costs. Health care costs could increase for many reasons. A public health epidemic or natural disaster could strike, causing states to struggle like [block-grant funded Puerto Rico](#). States could have to pay for blockbuster medical breakthroughs, like for hepatitis C or cystic fibrosis. Or health care costs could increase from regular old inflation. Medical inflation rises [much faster](#) than general economic inflation and is [notoriously difficult to estimate](#). In any of these situations, federal funding would run out and states would be left to bear all the unexpected costs. All in all, block grants and per capita caps would [cost states billions](#) in federal funding losses.

The Conservative Push for Block Grants

Block grants are not a new threat. Converting Medicaid to a block grant structure has been [proposed by conservative presidents and Congress](#) since President Reagan in 1981. Most recently, block grants were at the [center](#) of Congressional Republicans' 2017 efforts to ["repeal and replace"](#) the Affordable Care Act. The Trump Administration plans to continue pushing block grant legislation in 2020, according to the newest [HHS budget](#).

The difference now is that the Trump Administration is also proceeding to institute block grants through agency action. [Centers for Medicare & Medicaid Services](#) (CMS) Administrator [Seema Verma](#) has previously [urged states](#) to [seek](#) block grants through Section 1115 waivers. Some states are taking her up on the offer. Alaska has [hired consultants](#) to study the prospects of block grants. Utah submitted a [waiver request](#) seeking a partial per capita cap on certain expansion populations. Tennessee, which is furthest along, has submitted a [proposal](#) to CMS that would convert its Medicaid funding to a modified block grant. Any "savings" from under-spending the block grant would be split equally between Tennessee and the federal government.

So why are conservatives such a fan of capped funding, and why would states want to try it? The justifications play into conservatives' traditional arguments for small government. Block grant proponents argue that states are best at finding ways to cut costs, and give little thought to the impact this would have on beneficiaries. Some argue that Medicaid's funding creates ["pernicious incentives,"](#) encouraging states to spend their own money frivolously in order to ["draw down"](#) matching funds from the federal government. Such arguments rest on the belief that capped funding would save the federal government money. With a legislative block grant, Congress [could cut](#) Medicaid funding over time. And through waiver negotiations, CMS could persuade states to accept less money in block grant form than they would through usual funding.

But why would states willingly accept less money? Presumably, capped funding would come with additional state "flexibility" to cut coverage and benefits. In exchange for accepting a cap on federal funding, states would be allowed near total control over the content of the program, which would allow freedom to cut corners on meeting the federal standards. States that accept block grant funding would be subjected to less federal oversight and wouldn't be held to the minimum federal standards for Medicaid eligibility and benefits. If states ran out of federal funding, they could cut coverage to avoid extra costs. Even without unexpected health care costs, a capped funding structure creates an incentive for states to spend as little as possible on Medicaid. So as states approach their federal funding cap (or just want to save money), how would they respond?

Coverage loss for beneficiaries who are most expensive to cover.

States are likely to cut their most expensive beneficiaries-- including individuals living with disabilities or chronic conditions who need coverage most. While Tennessee says cutting enrollment isn't the goal, the state can't guarantee that it won't make cuts in the future. Even if states don't cut eligibility directly, they could make it much harder for individuals to become or stay enrolled. Requirements for enrollees to complete more paperwork or renew coverage more frequently [cause drops in enrollment](#), even when eligibility rules remain the same. Tennessee has already

[disenrolled 12% of children](#) by introducing a new renewal process. There's no reason to believe it wouldn't go further with a block grant.

These coverage gaps have serious health impacts for patients. Health coverage [increases access](#) to regular care and management, which is critical for patients with chronic illnesses. Treatment disruptions can put patients at risk for more expensive care down the line if their condition worsens due to a lapse in treatment. Ensuring access to care, therefore, decreases downstream health care costs.

Cut benefits.

It's no surprise that states would attempt to contain costs by [curtailing benefits](#). Despite assurances otherwise, Tennessee would likely need to cut benefits to achieve any savings — and manipulating the benefits package is one of the “flexibilities” included in its waiver application. Tennessee already pointed out one benefit they want to restrict: prescription drug coverage. In its proposal, Tennessee proposes a closed formulary model, where the state would only cover one drug per condition, as opposed to the baseline of covering all medically necessary drugs for enrollees. Drug restrictions are dangerous for people living with chronic diseases, who need the flexibility to tailor their medicines individually. And cutting other benefits has obviously harmful implications as well. When the nonpartisan [Congressional Budget Office](#) (CBO) analyzed the economic impact of Medicaid funding caps, it [predicted](#) that benefits restrictions would cause beneficiaries to pay out of pocket or forgo services entirely. Instead of cutting benefits outright, states could also impose increased premiums, deductibles, or co-pays. All of these changes would discourage enrollment and reduce access to care.

Reduce payments to providers and managed care plans.

States could contain costs by reducing provider reimbursement, making providers less willing to accept Medicaid patients. The CBO's analysis also predicted that cuts to managed care plans would cause them to “shrink their provider networks, curtail quality assurance, or drop out of the program altogether.” Unsurprisingly, Tennessee has asked for flexibility with its hospital payment structure and managed care contracts. As a result, Tennessee Medicaid patients could struggle to find willing providers and would have to travel long distances for their care.

Section 1115 Waiver Funding Caps Are Illegal

Medicaid funding caps are not just bad policy. They're also illegal to create through Section 1115 waivers.

[Section 1115](#) of the Social Security Act gives the HHS Secretary discretion to waive certain federal Medicaid requirements to allow states to conduct “experimental, pilot, or demonstration project[s] that are likely to promote the objectives of Medicaid. States have [historically](#) used Section 1115 waivers to expand coverage to ineligible populations, implement delivery system reforms, and provide expedited services. In the past two years, HHS approved a number of Section 1115 waivers allowing states to institute work requirements. Court challenges have been successful and are ongoing. Now, the Trump Administration seeks to use Section 1115 waivers to allow block grant demonstration projects. Expect similar results — here's why.

Block grant proponents seek to waive Medicaid's funding mechanisms, set out in [Section 1903](#) of the Social Security Act — the federal law that governs Medicaid. Section 1903 says that the federal government must pay the FMAP of the actual amount each state spends on healthcare costs. Capped funding proposals would clearly violate this [section](#), because they replace reimbursement of states' actual Medicaid costs with an estimate or a lump sum. The Trump Administration seems to think block grants could be created just by waiving Section 1903. But Section 1903 is not a waivable provision. Section 1115 waivers allow the Secretary to waive *certain* requirements of Medicaid: those found in sections 2, 402, 454, 1002, 1402, 1602, and 1902. Section 1903 does not appear in that list.

CMS itself has [unambiguously stated](#) that “Section 1115(a)(i) waiver authority extends only to provisions of section 1902 of the Act.” In 2018, CMS denied North Carolina's request to change its funding by waiving [Section 1905\(b\)](#), which defines the FMAP.

Others have [noted](#) that HHS is well aware of the fact that it lacks the legal authority to change the Medicaid funding structure.

Furthermore, capped funding would not meet the requirements of a Section 1115 demonstration project. Section 1115(a) allows waivers for projects that are “likely to assist in promoting the objectives” of Medicaid. But the D.C. District has [repeatedly affirmed](#) that the core objective of Medicaid is **health care coverage**. It is obvious that capped funding does not promote Medicaid coverage; rather, it necessarily endangers it. As states run out of federal funding, block grants allow them to use new “flexibilities” to cut enrollment and benefits.

Since Medicaid’s funding structure is not a waivable provision, and because capped funding is not “likely to assist in promoting the objectives” of Medicaid, HHS could not legally approve a Section 1115 waiver for a block grant or per capita cap.

How Advocates Can Help

A key opportunity for advocates is to submit public comments on forthcoming Section 1115 waiver proposals. According to federal regulation, both states and CMS [must collect and consider public comments](#) before submitting or approving Section 1115 waivers. Notably, CMS must show that it adequately considered public comments, or it risks having the waiver approval vacated by the courts. Public comments have been key to [Judge Boasberg’s rejection](#) of CMS’s work requirement waiver approvals.

Submitting public comments for the record is crucial. At the state level, you can submit public comments when states release a draft of their Section 1115 waiver, like Tennessee did in September. At the federal level, you can submit comments to CMS when states submit their waiver applications for approval. CMS is currently [accepting comments](#) on Tennessee’s waiver application until December 27. While this waiver would only apply to Tennessee, as we saw with work requirements, the ideas is likely to spread quickly if approved by CMS, so [comments matter!](#)

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