

---

# Medicaid Block Grants and Per Capita Caps: Projected Impact on Children

Prepared for the Children's Hospital Association | 7.17.19



**Avalere Health**  
An Inovalon Company

1350 Connecticut Ave, NW  
Washington, DC 20036

T | 202.207.1300  
[avalere.com](http://avalere.com)

# Table of Contents

## **Medicaid Block Grants and Per Capita Caps: Projected Impact on Children 1**

Executive Summary	1
Background	1
State Policy Proposals	2
Capped Funding and Impact on Federal Funding for Children	2
Impacts of Medicaid Funding Caps on Children	5
<b>Methodology</b>	<b>6</b>
<b>Appendix</b>	<b>7</b>

---

Funding for this research was provided by the Children’s Hospital Association. Avalere Health retained full editorial control.

---

# Medicaid Block Grants and Per Capita Caps: Projected Impact on Children

## Executive Summary

Given renewed focus on transitioning Medicaid to a block grant or per capita cap funding mechanism, Avalere analyzed the potential impact on federal funding to states as a result of moving to a capped funding methodology. Avalere's estimates for a potential loss in federal funding to states, *specifically for children*, range from a loss of \$89B to \$163B for FY2020-2029 nationally, depending on policy parameters. A reduction in federal Medicaid funding would require states to reduce spending in Medicaid or in other areas of their budget. In particular, states may reduce eligibility for coverage, limit access to covered benefits or services, increase beneficiary cost sharing or decrease payment for care, and/or seek other sources of funding.

## Background

Policymakers at the federal level have often considered proposals to cap Medicaid funding to reduce spending and deliver additional flexibility to states. Most recently, CMS Administrator Seema Verma has stated her support for a block grant system in Medicaid and indicated that CMS may be willing to approve waivers that seek to implement such policies.<sup>1</sup> Further, the President's fiscal year (FY) 2020 budget request included a proposal for Medicaid capped funding arrangements. That proposal, which is modeled after the Graham-Cassidy-Heller-Johnson legislation proposed in September 2017, would require states to implement either a per capita cap or block grant beginning in 2020.

Currently, the federal government provides funds to states based on federal medical assistance percentages (FMAP), whereby state per capita income levels determine the share of a state's Medicaid spending that will be funded by the federal government. Capped Medicaid funding policies would shift the federal government's funding mechanism from a formula-determined share of a state's total program spending to a set target based on core growth rate components and covered enrollee groups.

Capped Medicaid funding policies are designed to set a target for federal spending based on factors, such as inflation and population growth, that are distinct from state Medicaid policy decisions and actual program spending. Depending on the parameters of the capped funding policy, certain populations may experience reductions in federal funding.

---

<sup>1</sup> The Hill, "[Trump administration urging Alaska to be first to apply for Medicaid block grant](#)", April 4, 2019.

Nationally and in most states, children represent the largest group covered by Medicaid, which provides vital services including primary care, screening, and diagnostic services, as well as life-saving interventions for critical health needs.

## State Policy Proposals

In light of the administration’s focus on state Medicaid flexibility, several states have begun to pursue block grants or per capita caps for their Medicaid programs, including Tennessee and Utah.

State	Tennessee	Utah
<b>Proposal</b>	Passed <a href="#">HB 1280</a> on May 24	Released 1115 waiver <a href="#">request for public comment</a> on May 31
<b>Approach</b>	Directs state agency to submit a waiver request to CMS to convert nearly all Medicaid federal funding to a block grant	Proposes to request waiver authority to use a per capita cap funding mechanism for most adult Medicaid beneficiaries
<b>Growth Rates</b>	Indexes funding levels to inflation and population growth, but does not outline other parameters or related flexibilities	Utilizes CMS Office of Actuary’s projected Medical CPI as growth rate for cap
<b>Other Details</b>	Encourages the state to seek maximum flexibility with regard to existing federal mandates and regulations and with implementing cost controls	Does not include per capita caps for children, though adults with dependent children are included in the cap, which could result in spillover impacts on children

Lawmakers in several other states, most notably Alaska and Georgia, have also expressed interest in capped funding. While Administrator Verma is expected to issue new guidance for State Medicaid Directors on opportunities to shift Medicaid funding into capped funding models<sup>2</sup>, it is currently unclear if the upcoming waiver requests from Utah and Tennessee will be approved. If CMS approves these waiver requests and moves forward pending any legal challenges, its decision would signal a substantial change in the approach to Medicaid funding and could possibly lead other states to seek similar waivers.

## Capped Funding and Impact on Federal Funding for Children

In order to understand the potential budgetary impacts of recent proposals to cap Medicaid federal funding, and given the fact that children represent the largest covered group in Medicaid, Avalere conducted an analysis to determine the impact of these proposals on federal spending for children enrolled in Medicaid, both nationally and state-by-state.

<sup>2</sup> Politico, [“Trump wants to bypass Congress on Medicaid plan,”](#) January 11, 2019.

Avalere modeled both block grant and per capita cap policies. While under a waiver approach it is unlikely that all states would simultaneously implement identical capped funding policies, for the purposes of understanding how these policies would affect the Medicaid program, Avalere estimated the change in federal funding across all states during the budget window as if the policies started in 2020. For both the block grant and per capita cap policies, Avalere modeled two scenarios: one in which overall consumer inflation (CPI-U) is used, and the other in which consumer medical care inflation (CPI-M) is used. Of note, overall consumer inflation has been lower than consumer medical inflation, historically, due to faster price growth for medical goods and services; therefore, total capped funding would be lower if overall consumer inflation (CPI-U) is used instead of consumer medical care inflation (CPI-M).

## Block Grants

Block grant policies set the total federal contribution to Medicaid spending using factors other than the state's Medicaid program spending or enrollment. States may be able to reduce their Medicaid spending without losing federal funding, depending on the design of the policy, and states could experience unexpected program costs without receiving any additional federal funding. Accordingly, block grants can create incentives for states to reduce or limit access and leave states vulnerable to greater increases in spending during economic downturns, when Medicaid enrollment often spikes.

Avalere modeled a block grant policy that uses consumer inflation and population growth to determine federal funding, similar to Tennessee. Under a block grant option using overall inflation (CPI-U), states would see a national reduction in federal funding for children in excess of **\$163 billion** over the budget window.<sup>3</sup> By 2029, Avalere estimates that federal funding for children would be **24%** lower than it would have been under current Medicaid policy. States would see federal funding reductions for children ranging from 15% to 33%.

Under a block grant option using consumer medical care inflation (CPI-M), states would see a national reduction in federal funding for children of **\$110 billion** over the budget window. By 2029, Avalere estimates that federal funding for children would be **16%** lower than it would have been under current Medicaid policy. States would see federal funding reductions for children ranging from 6% to 26%.

---

<sup>3</sup> As some children are included in the "Disabled" category of Medicaid, this figure likely underestimates the total impact to children since it does not account for the reduction in federal funding to all Disabled beneficiaries.

**Table 1. Change in Federal Medicaid Spending for Children\* Under Block Grants, 2020—2029**

	Consumer Price Index-Urban (CPI-U)		Consumer Price Index-Medical (CPI-M)	
	Total Impact on Federal Medicaid Funding for Children (billions)	Total Percent Reduction in Federal Medicaid Funding for Children	Total Impact on Federal Medicaid Funding for Children (billions)	Total Percent Reduction in Federal Medicaid Funding for Children
<b>National</b>	<b>-\$163B</b>	<b>-24%</b>	<b>-\$110B</b>	<b>-16%</b>

*\*Does not include children eligible for Medicaid on the basis of disability or enrolled in the Children’s Health Insurance Program (CHIP)*

Recessions or the emergence of new high-cost medical treatments would increase the estimated reductions in federal funding. Avalere’s modeling does not account for future economic downturns and uses CMS forecasts for future Medicaid costs. Avalere’s modeling assumes states make no changes to current and future Medicaid enrollment.

## Per Capita Caps

Per capita cap policies define the total maximum federal contribution to Medicaid on a per enrollee basis, using factors other than the state’s Medicaid program spending. As with block grants, per capita caps can create incentives for states to reduce or limit access and leave states vulnerable to greater increases in spending if new medical treatments drive cost growth higher than funding cap growth. Unlike block grants, per capita cap policies would not leave states vulnerable to higher spending during economic downturns, when Medicaid enrollment often spikes, because per-enrollee funding automatically increases with enrollment.

Under a per capita option using overall consumer inflation (CPI-U), states would see a national reduction in federal funding for children of **\$143 billion** over the budget window.<sup>4</sup> By 2029, Avalere estimates that federal funding for children would be **22%** lower than it would have been under current Medicaid policy.

Under a per capita cap option using consumer medical care inflation (CPI-M), states would see a national reduction in federal funding for children of **\$89 billion** over the budget window. By

<sup>4</sup> As some children are included in the “Disabled” category of Medicaid, this figure likely underestimates the total impact to children since it does not account for the reduction in federal funding to all Disabled beneficiaries.

2029, Avalere estimates that federal funding for children would be **14%** lower than it would have been under current Medicaid policy.

**Table 2. Change in Federal Medicaid Spending for Children\* Under Per Capita Caps, 2020—2029**

	Consumer Price Index-Urban (CPI-U)		Consumer Price Index-Medical (CPI-M)	
	Total Impact on Federal Medicaid Funding for Children (billions)	Total Percent Reduction in Federal Medicaid Funding for Children	Total Impact on Federal Medicaid Funding for Children (billions)	Total Percent Reduction in Federal Medicaid Funding for Children
<b>National</b>	<b>-\$143B</b>	<b>-22%</b>	<b>-\$89B</b>	<b>-14%</b>

*\*Does not include children eligible for Medicaid on the basis of disability or enrolled in the Children’s Health Insurance Program (CHIP)*

States experience the same percentage reduction in federal funding for children under per capita cap policies because Avalere’s modeling assumes each state has the same future per enrollee cost growth for children. Avalere did not account for state difference in spending on higher-cost special-needs children, for whom states could end up paying a much larger share of costs under a per capita cap policy.

## Impacts of Medicaid Funding Caps on Children

Although the administration continues to support increased state flexibility in Medicaid, states have limited levers to control Medicaid program costs. Reductions in federal funding in addition to unexpected events (including epidemics or other public health crises) and new treatment innovations could increase Medicaid program spending beyond current projections. Further, the ongoing phasedown of the enhanced FMAP for Medicaid expansion already places new financial pressures on states as they to continue to cover the expansion population. These pressures may lead states to attempt to identify opportunities to offset reduced federal Medicaid funding, including:

- Changes in eligibility, including reducing income thresholds/eliminating coverage for optional enrollees, implementing work requirements, and/or enacting lockout periods
- Limiting service use, including reducing covered benefits, increasing utilization management, or implementing other policies to shift utilization patterns

- Changing payment, including increasing beneficiary cost sharing and/or reducing payments to providers or health plans
- Identifying other sources of funding, including raising taxes, adjusting provider taxes, and/or reducing spending elsewhere in the state budget

More than 1 in 3 children in the US are covered under Medicaid<sup>5</sup>, with almost half of children with special needs receiving care through the program.<sup>6</sup> While children represent a smaller share of Medicaid expenditures compared to other categories of beneficiaries, pressure on state budgets could lead to both direct and indirect implications for children, including children with special needs, depending on the policy and potential flexibility granted by the administration.

## Methodology

Avalere used its proprietary Medicaid forecasting and simulation model to estimate the national- and state-level effect of Medicaid block grant and per capita cap policies, focusing specifically on funding for children in the Medicaid program. Avalere's forecasting and simulation model uses a combination of CMS' Medicaid statistical information system (MSIS) and Medicaid budget and expenditure system (MBES) data to estimate recent and historical Medicaid spending and enrollment. To estimate future Medicaid spending and enrollment, it relies on the most recent CMS Medicaid actuarial report (2017) for future per enrollee spending growth and a combination of U.S. Census Bureau state population projections and each state's historical enrollment to estimate future state-specific enrollment by basis of eligibility group. Avalere uses Congressional Budget Office (CBO) assumptions for national federal Medicaid spending under current law and future overall inflation (CPI-U). Avalere forecasts medical inflation (CPI-M) by looking at Bureau of Labor Statistics (BLS) data showing the average difference in CPI-U and CPI-M from 2010-2019 and applying that difference to CBO forecasts of CPI-U. Direct changes in federal Medicaid spending exclude the effect of any resulting changes in Medicaid enrollment. The simulation assumes Medicaid funding policies start in 2020 (using 2019 as the base year for federal spending levels) and that states do not alter enrollment or benefits. Avalere's forecast period for this analysis aligns with the most recent CBO budget window, 2020-2029.

---

5 Medicaid and CHIP Payment and Access Commission, "MACStats: Medicaid and CHIP Data Book," December 2018.

6 Kaiser Family Foundation, "Medicaid's Role for Children With Special Health Care Needs," June 12, 2019.

## Appendix

**Table 3. Change in Federal Medicaid Spending for Children\* Under Block Grants, 2020—2029**

State	Consumer Price Index-Urban (CPI-U)		Consumer Price Index-Medical (CPI-M)	
	Total Impact on Federal Medicaid Funding (millions)	Total Percent Impact on Federal Medicaid Funding	Total Impact on Federal Medicaid Funding (millions)	Total Percent Impact on Federal Medicaid Funding
Alaska	-\$860	-28%	-\$630	-21%
Alabama	-\$2,230	-21%	-\$1,370	-13%
Arizona	-\$5,650	-26%	-\$3,970	-18%
Arkansas	-\$2,220	-19%	-\$1,240	-10%
California	-\$26,510	-33%	-\$20,830	-26%
Colorado	-\$1,880	-23%	-\$1,250	-15%
Connecticut	-\$2,170	-25%	-\$1,510	-18%
District of Columbia	-\$810	-28%	-\$590	-21%
Delaware	-\$460	-20%	-\$280	-12%
Florida	-\$7,440	-25%	-\$5,110	-17%
Georgia	-\$5,050	-23%	-\$3,320	-15%
Hawaii	-\$600	-31%	-\$460	-23%
Iowa	-\$830	-18%	-\$450	-9%
Idaho	-\$740	-21%	-\$460	-13%
Illinois	-\$6,450	-23%	-\$4,270	-15%
Indiana	-\$2,260	-19%	-\$1,290	-11%
Kansas	-\$1,030	-22%	-\$660	-14%
Kentucky	-\$2,120	-17%	-\$1,110	-9%
Louisiana	-\$2,170	-22%	-\$1,390	-14%
Massachusetts	-\$2,430	-24%	-\$1,630	-16%
Maine	-\$730	-20%	-\$440	-12%
Maryland	-\$2,740	-25%	-\$1,870	-17%
Michigan	-\$4,300	-20%	-\$2,510	-11%
Minnesota	-\$2,320	-21%	-\$1,420	-12%
Missouri	-\$3,630	-21%	-\$2,210	-12%

State	Consumer Price Index-Urban (CPI-U)		Consumer Price Index-Medical (CPI-M)	
	Total Impact on Federal Medicaid Funding (millions)	Total Percent Impact on Federal Medicaid Funding	Total Impact on Federal Medicaid Funding (millions)	Total Percent Impact on Federal Medicaid Funding
Mississippi	-\$1,680	-19%	-\$930	-10%
Montana	-\$460	-20%	-\$280	-12%
North Carolina	-\$5,180	-21%	-\$3,200	-13%
North Dakota	-\$190	-21%	-\$120	-12%
Nebraska	-\$520	-21%	-\$320	-12%
New Hampshire	-\$420	-21%	-\$270	-13%
New Jersey	-\$2,840	-25%	-\$1,950	-17%
New Mexico	-\$3,980	-28%	-\$2,910	-20%
Nevada	-\$1,080	-23%	-\$700	-15%
New York	-\$8,860	-24%	-\$5,960	-16%
Ohio	-\$4,790	-19%	-\$2,740	-11%
Oklahoma	-\$2,790	-23%	-\$1,810	-15%
Oregon	-\$1,850	-24%	-\$1,230	-16%
Pennsylvania	-\$5,530	-20%	-\$3,280	-12%
Rhode Island	-\$20	-25%	-\$20	-18%
South Carolina	-\$2,470	-22%	-\$1,550	-13%
South Dakota	-\$240	-19%	-\$130	-10%
Tennessee	-\$3,960	-20%	-\$2,390	-12%
Texas	-\$19,020	-27%	-\$13,790	-20%
Utah	-\$1,270	-22%	-\$810	-14%
Virginia	-\$2,620	-23%	-\$1,740	-15%
Vermont	-\$330	-19%	-\$190	-10%
Washington	-\$2,810	-25%	-\$1,960	-18%
Wisconsin	-\$1,360	-20%	-\$790	-11%
West Virginia	-\$670	-15%	-\$290	-6%
Wyoming	-\$180	-23%	-\$120	-15%

*\*Does not include children eligible for Medicaid on the basis of disability or enrolled in the Children's Health Insurance Program (CHIP)*

**Table 4. Change in Federal Medicaid Spending for Children\* Under Per Capita Caps, 2020—2029<sup>7</sup>**

State	Consumer Price Index-Urban (CPI-U)		Consumer Price Index-Medical (CPI-M)	
	Total Impact on Federal Medicaid Funding (millions)	Total Percent Impact on Federal Medicaid Funding	Total Impact on Federal Medicaid Funding (millions)	Total Percent Impact on Federal Medicaid Funding
Alaska	-\$640	-22%	-\$400	-14%
Alabama	-\$2,260	-22%	-\$1,400	-14%
Arizona	-\$4,620	-22%	-\$2,870	-14%
Arkansas	-\$2,530	-22%	-\$1,570	-14%
California	-\$16,860	-22%	-\$10,480	-14%
Colorado	-\$1,690	-22%	-\$1,050	-14%
Connecticut	-\$1,800	-22%	-\$1,120	-14%
District of Columbia	-\$610	-22%	-\$380	-14%
Delaware	-\$470	-22%	-\$290	-14%
Florida	-\$6,340	-22%	-\$3,940	-14%
Georgia	-\$4,630	-22%	-\$2,880	-14%
Hawaii	-\$410	-22%	-\$250	-14%
Iowa	-\$970	-22%	-\$610	-14%
Idaho	-\$740	-22%	-\$460	-14%
Illinois	-\$5,860	-22%	-\$3,640	-14%
Indiana	-\$2,500	-22%	-\$1,550	-14%
Kansas	-\$980	-22%	-\$610	-14%
Kentucky	-\$2,570	-22%	-\$1,590	-14%
Louisiana	-\$2,070	-22%	-\$1,280	-14%
Massachusetts	-\$2,150	-22%	-\$1,330	-14%
Maine	-\$750	-22%	-\$470	-14%
Maryland	-\$2,360	-22%	-\$1,470	-14%
Michigan	-\$4,640	-22%	-\$2,880	-14%
Minnesota	-\$2,360	-22%	-\$1,460	-14%
Missouri	-\$3,730	-22%	-\$2,320	-14%

<sup>7</sup> Note: States experience the same percentage reduction in federal funding for children under per capita cap policies because Avalere’s modeling assumes each state has the same future per enrollee cost growth for children.

State	Consumer Price Index-Urban (CPI-U)		Consumer Price Index-Medical (CPI-M)	
	Total Impact on Federal Medicaid Funding (millions)	Total Percent Impact on Federal Medicaid Funding	Total Impact on Federal Medicaid Funding (millions)	Total Percent Impact on Federal Medicaid Funding
Mississippi	-\$1,910	-22%	-\$1,180	-14%
Montana	-\$490	-22%	-\$310	-14%
North Carolina	-\$5,200	-22%	-\$3,230	-14%
North Dakota	-\$200	-22%	-\$120	-14%
Nebraska	-\$540	-22%	-\$330	-14%
New Hampshire	-\$420	-22%	-\$260	-14%
New Jersey	-\$2,410	-22%	-\$1,500	-14%
New Mexico	-\$3,010	-22%	-\$1,870	-14%
Nevada	-\$1,000	-22%	-\$620	-14%
New York	-\$7,820	-22%	-\$4,860	-14%
Ohio	-\$5,270	-22%	-\$3,270	-14%
Oklahoma	-\$2,600	-22%	-\$1,620	-14%
Oregon	-\$1,660	-22%	-\$1,030	-14%
Pennsylvania	-\$5,850	-22%	-\$3,630	-14%
Rhode Island	-\$20	-22%	-\$10	-14%
South Carolina	-\$2,430	-22%	-\$1,510	-14%
South Dakota	-\$270	-22%	-\$170	-14%
Tennessee	-\$4,100	-22%	-\$2,550	-14%
Texas	-\$14,620	-22%	-\$9,090	-14%
Utah	-\$1,210	-22%	-\$750	-14%
Virginia	-\$2,370	-22%	-\$1,470	-14%
Vermont	-\$370	-22%	-\$230	-14%
Washington	-\$2,330	-22%	-\$1,450	-14%
Wisconsin	-\$1,460	-22%	-\$910	-14%
West Virginia	-\$950	-22%	-\$590	-14%
Wyoming	-\$170	-22%	-\$100	-14%

*\*Does not include children eligible for Medicaid on the basis of disability or enrolled in the Children's Health Insurance Program (CHIP)*

## About Us

Avalere is a vibrant community of innovative thinkers dedicated to solving the challenges of the healthcare system. We deliver a comprehensive perspective, compelling substance, and creative solutions to help you make better business decisions. As an Inovalon company, we prize insights and strategies driven by robust data to achieve meaningful results. For more information, please contact [info@avalere.com](mailto:info@avalere.com). You can also visit us at [avalere.com](http://avalere.com).

## Contact Us

**Avalere Health**  
An Inovalon Company  
1350 Connecticut Ave, NW  
Washington, DC 20036  
202.207.1300 | Fax 202.467.4455  
[avalere.com](http://avalere.com)