COMMUNITY CATALYST

No Good Deal:
5 Reasons Why All States Lose Under the AHCA's Medicaid Changes

The American Health Care Act (AHCA) would reduce Medicaid funding by $834 billion dollars, leaving no state unaffected by its massive cuts. By capping federal Medicaid funding and phasing out the Medicaid expansion, AHCA is designed to reduce federal spending by shifting costs to states and beneficiaries. The current Medicaid financing structure is set up so that federal spending can be adjusted to meet each state's unique needs and circumstances. In contrast, AHCA's capped funding would apply a "one-size fits all" formula to Medicaid financing that is federally dictated and would not provide any state the flexibility necessary to respond to its unique needs.

Under the AHCA, ***no state will get a good deal.*** Here are five reasons why:

1. States would lock in current spending with no flexibility to adjust to state needs
There are currently significant variations across states in Medicaid spending that are the result of a number of factors including federal matching rates, geographic variation in health care costs, demographics, and state policy decisions. As these factors change over time, the current system allows federal spending to adjust accordingly.

However under the AHCA, the amount of federal Medicaid funding a state receives would be based on state spending in 2016, with no mechanism for adjustment beyond an annual growth rate, effectively locking states into previous policy decisions. For example, under the AHCA, if a state needed to increase provider rates in order to retain or attract more Medicaid providers and improve health care access, the state would take on the full cost of increasing provider rates.

- *Some states would get a worse deal than others:* states with lower Medicaid spending in 2016 would receive smaller block grant or per capita cap amounts. While all states would receive less money than necessary to maintain their Medicaid program in its current form, states with below average Medicaid spending would not only start off with a smaller base amount but would also have fewer policy options available to accommodate cuts. A recent Brookings report found that had a per capita cap been instituted in 2004, by 2011, over 85 percent of cuts in federal funding would have occurred in states with below average Medicaid spending.

2. No state will get more money than under the current system, only less
Under the AHCA's per capita cap, states would be penalized if their spending is above the capped amount in a given year, but they would not receive enhanced federal funding if they improve efficiency and spend below the given capped amount. This means that the best a state can hope for would be to

receive the same amount of federal funding as under current law. It would not be possible for a state to receive more money under a per capita cap than they are currently receiving. No state would get a better deal under per capita caps than under current law.

- *Some states would get a worse deal than others:* While no state will receive more funding than under current law, many states would receive significantly less funding and would have to increase state spending in order to make up the difference. A recent Brookings report found that there was significant variation in the amount of money states would need to spend in order to maintain pre-capped funding levels. For example, one state would have to increase spending by 77% compared to other states who would only have to increase funding by 25%.

3. States won't have the funds needed to maintain their current Medicaid programs over the long-term

The Medicaid caps included in the AHCA are designed to explicitly reduce federal spending and would not keep pace with changing health care costs over time. A recent Brookings analysis based on prior spending data found that if Medicaid spending had grown by only a percentage point faster than it actually did, the reduction in federal funding as the result of a per capita cap would have been nearly double.

The Trump administration has also proposed $627 billion in Medicaid cuts on top of those in the AHCA, resulting in over a trillion dollars in decreased federal funding. This underscores the fact that capped funding creates a dial, the annual growth rate, that policymakers could easily dial down to generate whatever savings the federal government needs to pay for other priorities.

- *Some states would get a worse deal than others:* States that experience higher than average increases in health care spending would be especially hard hit by the inflexible nature of per capita caps. This would be particularly true for states faced with aging populations. For example, in Florida, elderly and disabled populations make up nearly 30 percent of the Medicaid population and account for 64 percent of Medicaid costs. These costs will grow over time as the senior population is expected to double between 2010 and 2040 while the oldest and costliest age groups (over 75) will more than double.

4. A per capita cap doesn't inherently offer new flexibility to states and would actually inhibit Medicaid innovation

AHCA would force states to give up billions of dollars in federal funding while getting little to nothing in return. There is already significant flexibility in the Medicaid program and the Trump administration has indicated they are willing to provide states with considerable administrative flexibility to make additional changes. Per capita caps don't provide ***any additional flexibility*** to states.

Because Medicaid caps would mean drastic cuts in federal funding, implementing innovative program changes would become significantly harder. The scale of funding cuts would force states to focus on short term savings, by cutting eligibility, benefits, and provider payments rather than improving care for enrollees and lowering long-term costs through innovations and investments in population health. A decrease in available funds would also mean that states won't be able to provide the upfront investments and incentives needed to help providers transform their practices to provide more integrated services and better care coordination. Additionally, per capita caps and block grants would lead to eligibility cuts and reduce the number of people who are able to access the Medicaid program. This means any Medicaid innovations states are able to accomplish would reach fewer people.

- *Some states would get a worse deal than others:* While some states participate in a number of delivery reform initiatives, such as health homes, patient centered medical homes, and the delivery system reform incentive payment program, other states don't currently participate in any of these programs. Under capped Medicaid funding, these states won't be able to come up with the dollars needed upfront to invest in innovations. Conversely, states that have made significant investments to improve the efficiency and effectiveness of their Medicaid program would have fewer mechanisms available to them for trimming costs and finding savings without making major cuts in eligibility, benefits, or provider rates.

5. States won't have the flexibility to respond to emergencies or health care challenges

Because per capita caps provide states with a fixed amount of funding and aren't responsive to increased medical needs and costs, all states would have difficulty responding to unforeseen circumstances such as natural disasters, disease outbreaks, and emerging health challenges.

- *Some states would get a worse deal than others:* This system will particularly disadvantage states that are:
    - *Prone to natural disasters such as hurricanes:* A study of Medicaid spending after Hurricane Floyd hit North Carolina in 1999 found a $13.3 million increase in state and federal Medicaid spending as a result of the hurricane.
    - *Likely to experience disease outbreaks such as West Nile Virus or Zika:* For example, Puerto Rico currently operates under a capped Medicaid system and the financial constraints have made it difficult for them to respond effectively to the Zika outbreak.
    - *Susceptible to emerging health challenges, such as the growing opioid epidemic in rural areas:* Virginia estimates that in 2013, its Medicaid program spent $26 million on addressing opioid use disorders and misuse.