DEEP DIVE

Why the GOP's proposals to cap Medicaid funding won't work

Puerto Rico's block grant shows "what it means to have a federal funding level set in an arbitrary way that is disconnected from actual need," Center on Budget and Policy Priorities' Edwin Park says.

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One of the key components in President Donald Trump's administration's effort to repeal and replace the Affordable Care Act (ACA), and among the most controversial, is capping federal Medicaid funding. Most of the major changes that would be made to the ACA in the long-awaited bill that Republicans put forth earlier this month – the American Health Care Act (AHCA) – are to the Medicaid program, including the proposal for converting it into a block grant or per capita cap financing model.

This would occur by 2020, which is when the Medicaid expansions that came with the ACA are expected to have been fully eliminated. However, limiting the amount of funding made to state's Medicaid programs to generate federal savings could cost billions of dollars and strip millions of Americans from their health insurance coverage.

It has not worked well for U.S. territories, which currently receive a limited amount of Medicaid funding. In Puerto Rico, for example, the pre-determined amount of funding it receives doesn't come

close to covering the costs of the medical services provided through the Commonwealth's program to its beneficiaries. This has caused its healthcare system to be in a financial crisis, which could soon also become a humanitarian crisis.

Healthcare executives in Puerto Rico and policy analysts believe that capping Medicaid funding could be highly detrimental to the mainland just as it has been for the Commonwealth's healthcare system. From freezing hiring and reducing work hours to pay cuts for healthcare employees and the island's mass exodus of physicians, Center on Budget and Policy Priorities (CBPP) Vice President for Health Policy Edwin Park tells Healthcare Dive what has happened with the system in Puerto Rico after its Medicaid funding was capped "offers a history lesson on how caps work pre-Affordable Care Act."

The AHCA faces obstacles for passage in the House, which will vote on the bill on Thursday, and particularly in the Senate. It has received some support, including from the White House and Anthem. The manager's amendment introduced on Monday gives states the option of choosing between per capita caps or block grants.

However, it has been widely criticized because of analyses that suggest implementing the bill will lead to a spike in the number of uninsured Americans and cost billions of dollars not just to the federal and state governments but also to hospitals and health systems nationwide.

What the arguments are for and against a block grant

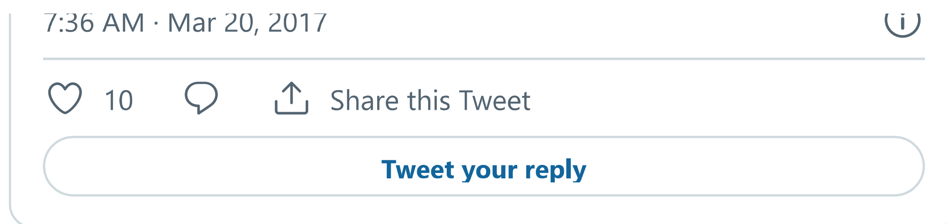
Current law allows states to design their Medicaid program to the unique needs of their patient populations with annual federal matching payments that have no funding limit. This means the

federal government right now pays a fixed percentage of states' Medicaid costs and as costs go down or up the federal government shares in that fluctuation.

Under a per capita cap or block grant, the federal government "doesn't give states any additional federal funding above the cap and states are responsible for 100% of costs above that level and states are effectively locked into the spending they are making now," Park says.

The AHCA previously just proposed a per capita cap, in which the amount of funding a state would receive would depend on the average cost of an enrollee. Yet the CBO suggested in a letter sent to the House Budget Committee last week a block grant "could be more attractive to some states" because it "would be coupled with new flexibility, by which the federal government could cede more control to states for a range of program features."

The Kaiser Family Foundation (KFF) highlighted a few other key differences:



The goal with a per capita cap is to produce federal savings to pay for other priorities. In this case, it's to pay for the tax cuts that are in the House bill, according to Park. “There are many other arguments about making Medicaid more efficient and providing states greater flexibility,” he says.

The per capita cap is a crucial component of the AHCA to make the GOP’s numbers work. While it is often sold as a means to provide states more flexibility, the only flexibility they would have would be to cut coverage in ways they can’t today, Park noted. The reduced funding would likely shift costs and risk to Medicaid and Medicare beneficiaries, states and providers.

“Our view is that Medicaid has already been efficient and costs less per person than private insurance,” Park says. “It grows much more slowly than private insurance and states already are being innovative in how they deliver healthcare, reducing costs and improving quality.”

If federal Medicaid funding is capped, states could have less financial flexibility to invest in the kind of innovative delivery systems they are experimenting with now. With the current system, states have the ability to invest in models that pay off down the road.

> **“The savings that states are going to achieve under per capita cap are the kind of cuts that we fully expect –**

> **cuts to eligibility benefits and provider payments."**
>
> Edwin Park
> *Vice President for Health Policy, Center on Budget and Policy Priorities*

CBPP estimates the radical restructuring of the federal financing system for the Medicaid program through per-capita caps would shift $370 billion in costs to states if they want to maintain their programs as they currently are. "Millions of low-income seniors, people with disabilities, kids, adults, the 11 million who gained coverage under the Medicaid expansion would be at risk of being uninsured, of losing access to needed care," Park says.

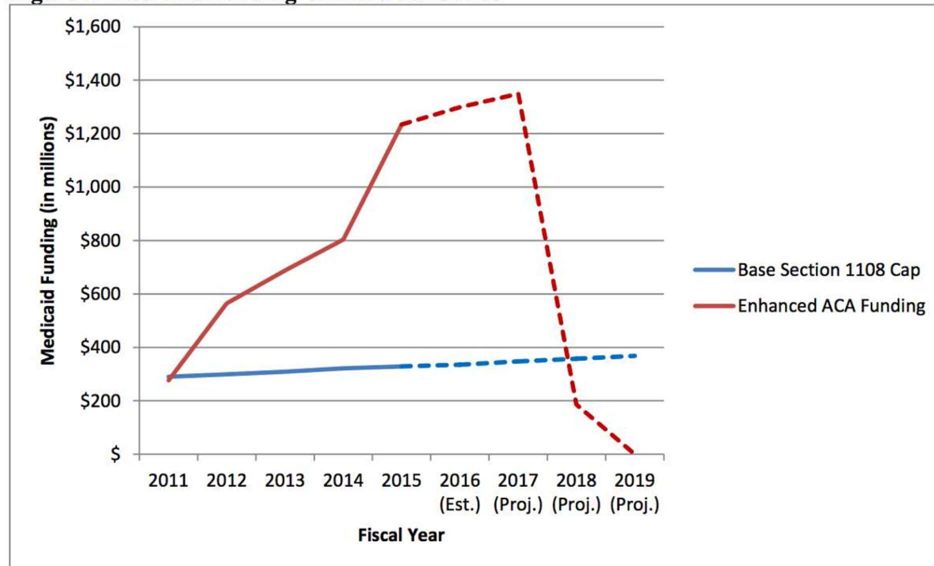
There are more than 70 million individuals (1 in 5 Americans) currently enrolled in the Medicaid program and 11 million are dually eligible, according to KFF.

In Puerto Rico, Medicaid patients have already been having serious problems with access and health outcomes.

There is a cap on the total amount of funding that the federal government gives to each U.S. territory, though their Federal Medical Assistance Percentages (FMPA) grew from 50% to 55% with the ACA. The law also provided Puerto Rico's Medicaid program with $6.4 billion additional funds available from FY 2011 to FY 2019.

But these funds are projected to be exhausted by late 2017 or early 2018, the Assistant Secretary for Planning and Evaluation (ASPE), the principal advisor to the HHS, reported earlier this year. "As many as 900,000 American citizens covered by Medicaid in Puerto Rico could lose coverage as a result of the depletion of these funds," ASPE wrote.

Data displayed in this graphic compares the funding Puerto Rico receives under its block grant program with its ACA funding and illustrates the projected drop:



Medicaid and Medicare Advantage Products Association of Puerto Rico

Puerto Rico had higher rates of infant mortality and fair or poor health compared to the mainland as of 2015, according to ASPE. In contrast, the Medicaid expansion program the state of Kentucky adopted through the ACA has resulted in declines in infant mortality rates and improvements in its health and financial security, KFF reports.

How the cap is hurting Puerto Rico's healthcare system

Medicaid funds in Puerto Rico have been capped for decades. They have been deemed as inadequate by policy analysts and medical professionals alike. And the lack of federal funding has contributed to the island's economic and fiscal crisis.

A recent survey conducted by the Urban Institute found the annual federal cap on reimbursements “creates a structure that results in

recurrent fiscal crises" for the island's program and "a need for repeated infusions of additional funds to temporarily sustain" it.

The Puerto Rican healthcare system has still been attempting to make care services accessible for its residents with low incomes and/or disabilities. But the mass exodus of physicians has made this increasingly difficult over the past several years. Research shows about one doctor a day is migrating to the mainland in search of better wages.

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The number of physicians on the island has dropped from 14,000 in 2006 to 9,000 in 2016, Victor Ramos, president of the Puerto Rico College of Physicians and Surgeons tells Healthcare Dive. The medical specialties with the largest shortages are pediatrics and surgery. There is only one cardiovascular and one thoracic pediatric surgeon left on the entire island, Ramos says.

Puerto Rican patients sometimes have to wait for up to a year for a doctor's appointment and the overall average wait time is six months, Ramos adds.

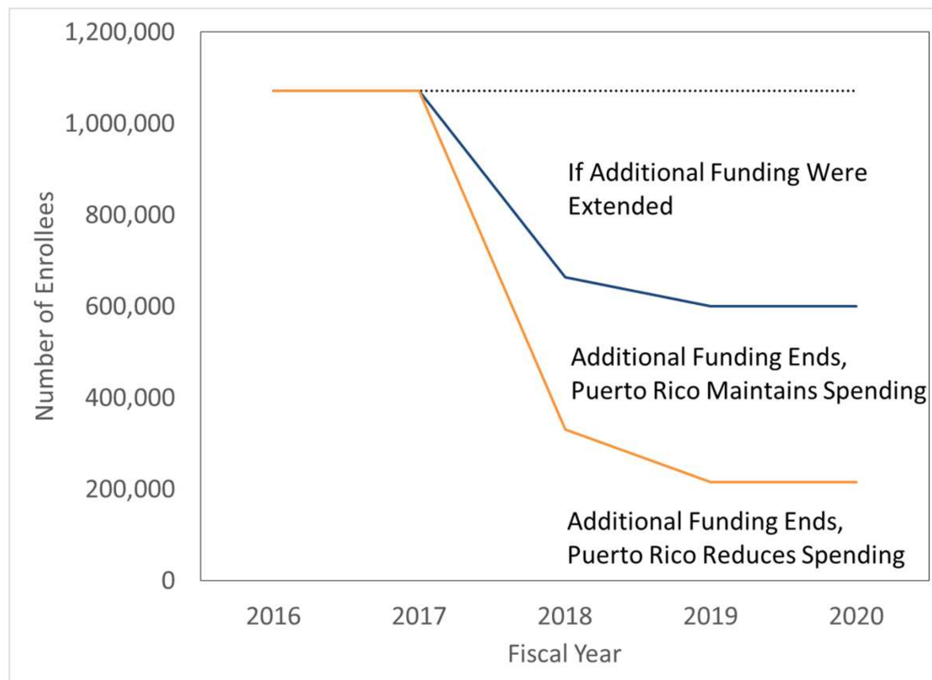
Payers on the island have been under pressure to limit payments to providers because of the low Medicaid funding, according to Dr. Raul F. Montalvo Orsini, president of Puerto Rico-based medical services company MSO tells Healthcare Dive. But this has led physicians to be more reluctant to contract to serve Medicaid patients, Orsini says. This has in turn contributed to patients' longer wait times, particularly for services from specialty providers.

The federal government was supposed to pay half of Puerto Rico's Medicaid costs pre-ACA under its block grant program, according to Park. But the block grant amount actually pays only about 15% to 20% of those costs, Park adds.

The severe stress Puerto Rico's healthcare system is under is going to be substantially worsened if the federal funding isn't continued.

Without that money hundreds of thousands more patients would be uninsured and subsidies will rise dramatically, Julio Colon, CEO of medical services at Hospital San Lucas in Puerto Rico, tells Healthcare Dive. “If there is no way for us to replace that funding, we will not be able to treat our low-income, indigent patients,” he says. Colon argues these patients typically have more complex and costly health conditions to provide treatment for than those with other types of insurance coverage.

The graphic below shows Medicaid enrollment projections based on different scenarios of what could happen with the island's funding and spending:



Medicaid and Medicare Advantage Products Association of Puerto Rico

Park argues that is "going to be catastrophic." However, it would "show what it means to have a federal funding level set in an arbitrary way that is disconnected from actual need," he says.

The population of Puerto Rico is about 3.5 million and, because of a high poverty rate and a lower income threshold for beneficiaries than in the mainland, more than 1.7 million residents have Medicaid coverage, according to Colon.

> **"It's a complicated situation for Puerto Rico to be dealing with a financial crisis with the lack of Medicaid funding being an additional problem."**
>
> Julio Colon
> *CEO of Medical Services, Hospital San Lucas*

The cost for a Medicaid beneficiary in Puerto Rico is about three times less than in any state, research shows. Therefore, it "would be a good business decision by the federal government to provide the island with continued funding" as more and more residents continue to head toward the states, Orsini says.

Why the issues in Puerto Rico would likely emerge in the U.S. mainland

Currently, states can receive additional federal funding for efforts to increase spending or raise provider rates as part of an effort for more coordinated care or new care delivery systems. Under a block grant program, however, states don't get any additional money even if costs are rising. They are responsible for all of the costs.

"If need increases, healthcare costs rise faster than expected," Park says. This could happen, for example, if there's a new epidemic, the opioid crisis gets worse, or there is a new treatment introduced in the market that comes as a big shock to the system, he adds.

Moreover, there will be a substantial increase in the number of American seniors soon because of the country's aging population. Data from the U.S. Census Bureau released this week show the number of grandparents in the country has already spiked by 24% since 2001.

> **"What people don't often understand is that it cost a lot more to have an 85-year-old on Medicaid than it is a 65 and that's because as you get older you need much more help and long-term care."**

> Edwin Park
> *Vice President of Health Policy, Center on Budget and Policy Priorities*

A federal per capita cap would not reflect the age distribution of seniors that is going to be a lot different and a lot more costly. States would be responsible for all of it and, as a result, they are likely to scale back coverage.

Park argues that the cost shift to states and ending the Medicaid expansions under a per capita cap will really only give states two choices: raise taxes and cut the rest of their budget, or cut the Medicaid program. Then, states will have three levers to choose from within Medicaid: cut eligibility, cut benefits and cut provider payments and rates to health plans, he adds.

So while states wouldn't necessarily see an out migration like Puerto Rico has, the funding cuts would likely lead to physicians and hospitals facing big reductions to their payment rates. They are likely to then begin to question whether they should stop seeing Medicaid patients. Park believes these are "all natural consequences of a per capita cap bill over the long run."

A per capita cap locks states in at current funding levels and the cap amounts will grow at a slower rate than under current law, according to Park. As a result, states "are going to have to reverse a lot of the progress they have made in making their Medicaid program more effective to deliver care at a lower cost while improving quality of care for low income beneficiaries," Park says. "That innovation is going to be stagnant and likely reversed."

The interviews with MSO's Dr. Raul F. Montalvo Orsini and Hospital San Lucas' Julio Colon were conducted in Spanish and

translated to English.