With Medicaid Per Capita Caps, California Loses:

Top Five Reasons Why Medicaid Caps Do Not Work For California

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For over 50 years, Medicaid has provided vital services to children, families, pregnant women, people with disabilities, and the elderly. Medicaid achieves this goal through an open-ended state-federal funding partnership that guarantees coverage for all who qualify. The American Health Care Act (AHCA) proposes to break this partnership. It would cut hundreds of billions of dollars of federal funding to the states through drastic changes including dismantling Medicaid's current state-federal financing structure by implementing per capita caps.

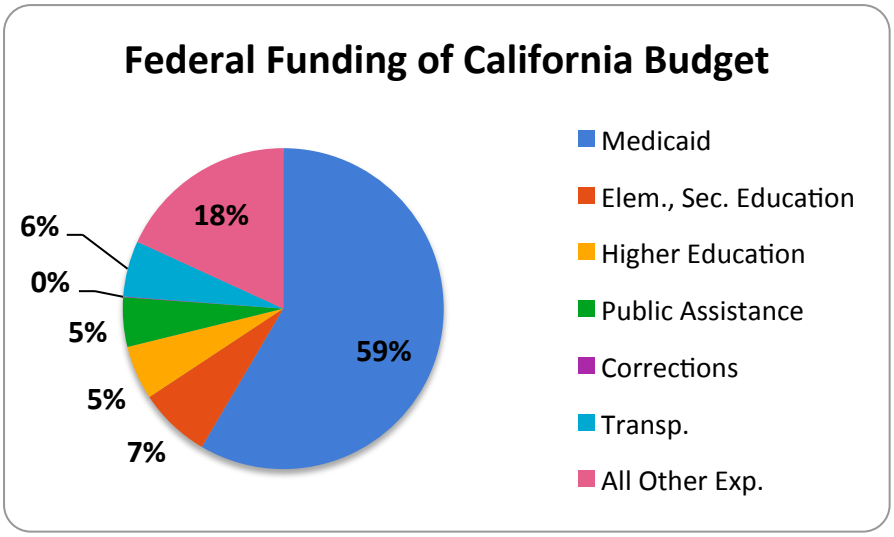
Medicaid caps limit the total amount of federal Medicaid funds states can receive. While California will experience deeper cuts than most others, every state is at risk for major losses, and no state will see an increase in federal funds. Caps will lock in historic spending trends without regard to California's future needs, economic fluctuations, or predicted growth in health care spending, and will disproportionately harm states like California that expanded Medicaid. Furthermore, the caps would make it harder for California to respond to crises: federal Medicaid funding would no longer be responsive to increases in the cost of care after natural disasters, when costly new medical treatments become available, or during public health emergencies, like the opioid epidemic or Zika. Further, a capped financing structure would not allow states the flexibility to meet demographic changes, such as the rise in seniors' Medicaid costs as they age, leaving states with even larger cuts over the long run. ***A federal Medicaid funding cap cannot appropriately account for the specific spending pressures, needs, and demographics of California***.

Top Five Reasons Why Medicaid Caps Do Not Work For California

1. **Cuts to Medicaid will jeopardize California's ability to provide health care to children, families, seniors, and people with disabilities.** The proposed caps, combined with the effective elimination of the Medicaid expansion, under AHCA would effectively cut $45 billion of federal funding for California over a ten-year period, shifting these costs to the state; only New York would lose more in Medicaid funding. **The AHCA cap would *cut California's Medicaid funding for kids by a whopping 25%,*[1] *and make even deeper cuts for children with special health care needs who rely on Medicaid.*** California, like other states, would have to raise taxes, cut other parts of its budget, like education, or severely cut Medicaid services, eligibility, or provider payments to make up for this shortfall. The magnitude of this cut would be unprecedented. ***In the past, states have struggled to absorb reductions as small as 2% in Medicaid funding, but the AHCA's proposed cap could lead to cuts in California's Medicaid by as much as 11.1%.***[2] However, this cut is likely to be only the

first of others to follow that could be made simply by adjusting the growth rate down, as President Trump's budget proposed, any time additional savings are needed. This would not be possible under the current Medicaid financing structure.

2. **Caps on Medicaid funding would blow a hole in California's budget and shift costs.** California's budget relies heavily on federal Medicaid funding, which makes up 58.5% of total federal funds to the state.[3] With capped federal funding, Medicaid costs such as the costs of school-based health services and special education services currently covered by Medicaid, would shift to school districts and other educational agencies.[4] In addition, California and other states that expanded Medicaid would be unfairly penalized as the state would have to spend 100 cents on the dollar instead of 10 cents on the dollar to continue coverage for this population – a gargantuan cost-shift. States that hit their cap would be financially penalized the following year, so they have a big incentive to make very deep cuts. Under a per capita cap, the already huge Medicaid spending disparities between states – with California spending lower than average - would be permanently locked-in and worsened over time.



3. **Medicaid caps would strip California's flexibility to address health care needs that change over time.** California spends $2,500 per child Medicaid enrollee, below the national average of $2,602.[5] Medicaid caps would turn California's historically low spending into a *permanent* federal funding ceiling, stripping the state's flexibility to get increased federal support to address changing health markets, residents' needs, emerging treatments and technology, public health emergencies (e.g., California's recent whooping cough outbreak and child deaths[6]), and policy choices.

4. **A federal standard growth factor fails to meet the varying and changing needs of California.** The proposed federal caps do not account for state-specific spending growth rates. If a cap like the one proposed in AHCA had been in effect from 2001-2011, California would have lost 11 percent of federal Medicaid funds.[7] Caps will create this unfair result any time a state experiences higher growth than the federal standard. Consider, for example, that California experienced a faster than the national average

spending growth rate among all Medicaid enrollee groups.[8] A cap does not recognize varying state spending growth rates that may be impacted by a growing elderly population, greater need for substance abuse treatment, higher medical costs with the invention of new technology or prescription medication, or other drivers of cost.

5. **Priority health initiatives in California are at risk if Medicaid funding is capped.**
   - Medicaid funding helps support critical early childhood and education services, including home visiting programs, development services that help ensure school readiness, special education services in public schools, school-based health care services, and even school nurses.
   - Medicaid is a critical source of health coverage for children in the child welfare system who have experiences of abuse, neglect, loss, and trauma and have higher needs than their peers. Medicaid is also a lifeline for over 18,000 former foster youth in California who rely on Medicaid's health services as they transition into adulthood.[9]
   - Medicaid funding allows nearly 6.6 million women and girls in California to obtain the health care they need throughout their lives.[10] Women have unique health care needs – they are the primary users of maternity care, family planning, and long-term care services – and nearly half of all women have an ongoing condition requiring regular monitoring, care, or medication. Medicaid is a vital source of long-term care, family planning and maternity care, providing care for more than half of all California's pregnancies and births.[11]
   - Medicaid is the primary source of funding for treatment services for people with mental illness and substance abuse disorders. It provides a consistent source of revenue for behavioral health providers without which the current shortage of behavioral health providers would worsen. Medicaid provides access to essential outpatient opioid abuse treatments, such as medication assisted treatment and overdose reversal drugs.
   - Medicaid funding is essential to delivering care in rural areas. Rural children and adults are more likely to be enrolled in Medicaid than urban residents for a variety of reasons: lower access to job-based coverage, greater prevalence of self-employed jobs, lower incomes, and a greater share of the population with a disability. Medicaid is also a critical source of income for rural hospitals.
   - Medicaid funding helps people who need long term care, like people with disabilities including children, and seniors, stay in their homes and communities and out of nursing facilities and institutions. Because these home and community-based programs are optional – and are generally the biggest optional programs in states' Medicaid programs – capping federal Medicaid funding will force states to end these programs, cut services, raise eligibility levels, or impose waiting lists.

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The California Children's Health Coverage Coalition is comprised of California Coverage & Health Initiatives, Children Now, Children's Defense Fund-California, PICO California, The Children's Partnership, and United Ways of California. Follow the Coalition on Twitter or tumblr @KidsHealthCA.

Footnotes

[1] Avalere Health, "The Impact of Medicaid Capped Funding on Children," (May 18, 2017), http://avalere.com/expertise/managed-care/insights/per-capita-caps-could-reduce-funding-for-children-covered-by-medicaid

[2] John Holahan, et.al., "The Impact of Per Capita Caps on Federal and State Medicaid Spending," Urban Institute and Robert Wood Johnson Foundation, March 2017, http://www.urban.org/sites/default/files/publication/89061/2001186-the_imapct-of-per-capita-caps-on-federal-spending-and-state-medicaid-spending_2.pdf.

[3] Manatt analysis of National Association of State Budget Officers (NASBO), "State Expenditure Report: Examining Fiscal 2014-2016 State Spending," (February 2017), http://www.statenetwork.org/resource/data-points-to-consider-when-assessing-proposals-to-cap-federal-medicaid-funding-a-toolkit-for-states/.

[4] Wayne Turner, **"**School Districts Hit Hard Under Proposed Medicaid Cuts," National Health Law Program (May 24, 2017), http://www.healthlaw.org/blog/575-school-districts-hit-hard-under-proposed-medicaid-cuts.

[5] KFF estimates based on analysis of data from the FFY 2014 Medicaid Statistical Information System (MSIS) and Urban Institute estimates from CMS-64 reports. Because FFY 2014 data was missing some or all quarters for some states, the adjusted the data using secondary data to represent a full fiscal year of enrollment. See "Data Note: Variation in Per Enrollee Medicaid Spending" (June 9, 2017) at /http://www.kff.org/medicaid/fact-sheet/data-note-variation-in-per-enrollee-medicaid-spending/.

[6] See Department of Health Care Services, "Plan to Prevent Infant Pertussis for Prenatal Care Providers," (January 20, 2017), http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_25577.asp.

[7] Rachel Garfield, Robin Rudowitz, and Katherine Young, "What if Per Enrollee Medicaid Spending Growth Had Been Limited to CPI-M from 2001-2011?," Kaiser Family Foundation, March 2017, http://kff.org/medicaid/issue-brief/data-note-what-if-per-enrollee-medicaid-spending-growth-had-been-limited-to-cpi-m-from-2001-2011/.

[8] Katherine Young, et.al., "Medicaid Per Enrollee Spending: Variation Across States," Kaiser Family Foundation, (January 2015), http://kff.org/medicaid/issue-brief/medicaid-per-enrollee-spending-variation-across-states/.

[9] See Children Now, "Medi-Cal Coverage until Age 26: A Lifeline for Former Foster Youth," (February 2017), https://www.childrennow.org/files/8214/8719/7196/CN-FFY-ACA-infographic.pdf.

[10] Hannah Katch, and Jessica Schubel, "Medicaid Works for Women – But Proposed Cuts Would Have Harsh, Disproportionate Impact," Center on Budget and Policy Priorities, (May 2017), http://www.cbpp.org/research/health/medicaid-works-for-women-but-proposed-cuts-would-have-harsh-disproportionate-impact.

[11] See Department of Health Care Services, "Medi-Cal Birth Reports," http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-CalBirthReports.aspx