

Health Advocate

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Delivery System Reform and Medicaid Caps

Prepared by: [Leonardo Cuello](#)

Key Resources

[NHeLP's Protect Medicaid Series](#)

[Fact Sheet: What is Per Capita Cap?](#)

[Fact Sheet: Per Capita Cap Vs. Block Grants in Medicaid](#)

**Coming in January
Health Advocate:
The Year Ahead**

Payment and delivery system reforms – designed to improve quality while reducing costs – have been the hottest topics in Medicaid for numerous years. Various models of delivery system reform are being discussed, and many are being tested under the auspices of the Center for Medicare and Medicaid Innovation, created under the Affordable Care Act (ACA). The basic idea is to find ways to provide care more efficiently and effectively by encouraging coordination among all aspects of an individual's care. Done well, delivery system reform might improve clinical care and create opportunities to address social factors that influence health, such as neighborhood conditions and the legacy of inequality in our country. While it is too early to draw conclusions about the success of the models being tested, the Medicaid financing schemes envisioned by the new administration and Congress pose a serious threat to these delivery system reform efforts.

Leaders in the incoming administration and new Congress have signaled their intent to make four radical changes to today's health system: dismantling of (1) the subsidized Marketplace and (2) the Medicaid expansion, (3) voucherizing Medicare, and (4) block granting or setting a per capita cap on federal Medicaid funding ("Medicaid cap"). This article focuses on Medicaid caps.

Beware of efforts to radically cut Medicaid in the guise of "flexibility"

Proponents of Medicaid caps say they will give the states "flexibility" to transform care and save dollars. But nothing could be further from the truth.

A review of proposals to cap Medicaid in recent years shows one clear objective: to massively reduce federal financing in Medicaid. The [caps are tied to growth indexes](#) that would increase much slower than actual health care spending. Over time, the caps completely choke the growth of Medicaid. One such proposal, suggested in 2012, would have [slashed](#) federal Medicaid contributions by almost 40%. Far from achieving helpful "flexibility," such caps result in a massive shift of cost and risk onto states, with the potential for creating huge state budget shortfalls even as the population ages and the numbers of children and adults with disabling and chronic conditions increases.

Look at that earlier number: 40%. State Medicaid budgets have already been cut so many times that most states do not have a dime to spare. Indeed, they *already* pay providers significantly less than private insurance or Medicare payers. States have no slack whatsoever to absorb a cut on the magnitude 40% -- or even 10%. Under the strain of Medicaid caps, states will be hard pressed to use flexibility to finance *any* improvements or build better systems. Rather, they will most certainly be forced to dismantle systems and capacity in an effort to balance the budget and avoid deficit spending.

Proponents of delivery system reform must understand the danger. Flexibility *will* be used to do the only thing states *can* do when they have massive shortfalls: reduce eligibility, reduce services, and further slash provider rates. There will be no money for pilot programs or innovation. New investment will be wild fantasy. In short: there will be a mass exodus of dollars from state Medicaid systems, and in that context, no improvement or reform is feasible. Medicaid caps are not a path to transformation. To the contrary, they are a roadblock.

Perhaps most stunning is that some hospitals, providers, issuers, and other industry stakeholders may be seduced by the flexibility refrain and go along with Medicaid caps. These stakeholders will end up bargaining against themselves. To be sure, flexibility may have value to them, but Medicaid caps are not a precondition to obtaining that flexibility. The new HHS and CMS leadership can already maximize existing Medicaid options and waiver programs to provide states with generous levels of administrative flexibility. States do not need to accept slashed budgets as part of the deal.

Capping Medicaid will not lead to any new flexibility that benefits delivery system reform stakeholders, it will only suck federal dollars out of the system and force states to make dangerous cuts in state Medicaid spending as well. Stakeholders will not gain flexibility, they will lose the ability to *do* anything with the flexibility they already have.

The principles of delivery system reform

Medicaid caps will not just bankrupt delivery system reform efforts. They will also violate the basic principles of delivery system reform. First, the delivery system reform movement has been built on the assumption of widespread quality health coverage under the ACA. However, the imposition of a Medicaid cap (along with repeal of the subsidized Marketplace and Medicaid expansion and conversion to Medicare vouchers) will decrease coverage by millions of lives. Those that do retain coverage will have access to services and providers that will be more limited than what is available today. Quality will be negatively affected.

Second, one of the core tenets of the delivery system reform movement has been the need to address health equity and the social determinants of health. Capping Medicaid and repealing the Medicaid expansion undermines that goal because those acts will directly harm [minority populations](#). It will be impossible to reduce health care disparities when coverage across diverse populations itself becomes much more disparate. The notion that states will be able to design new systems to “get outside the hospital walls” and address social determinants while they are halving their Medicaid agency staff is absurd.

Finally, at its core, the delivery system reform movement is about making strategic investments in long-term outcomes. Such a vision will fail miserably in a world of capped Medicaid programs. States will not have the money to make any investments, and they certainly will not have the luxury of thinking about long-term outcomes or spending trends. When states face huge budget crises, the reverse becomes true: they willingly forfeit greater future savings to pay off current deficits. Instead of lengthening, the state “return on investment” time horizon will shorten.

Those who do not learn from history...

There is one astounding irony in the coming proposals to cap Medicaid that should be painfully obvious to delivery system reform gurus. In 1997, out of concern with growing Medicare spending, Congress passed the infamous Sustainable Growth Rate (SGR), which artificially tied Medicare payment rates to Gross Domestic Product (GDP). Since GDP rises slower than health care costs, applying GDP would have resulted in yearly losses for providers. In 2002 alone, it would have led to a near 5% *reduction* in payment rates. More importantly, the year-after-year cumulative underpayments would have been so devastating for providers that

Congress was forced to implement annual “doc fixes” to remedy the underfunding, and by 2015, the corrected payments were totaling more than 20% of the SGR rate. In 2015, after a decade of trying, Congress finally replaced the SGR system with a new payment mechanism (via the Medicare and CHIP Reauthorization Act of 2015, also known as MACRA).

Yet, just one year later, some members of Congress are *again* proposing to tie health care funding rates – this time in Medicaid – to GDP (or a similar index). The failure of the SGR in Medicare methodology should serve as a lesson for the delivery system reform movement. Throttling health care financing by reference to a growth index that consistently underestimates actual health care spending is a recipe for disaster. Just as SGR would have done if actually implemented, capping of Medicaid would gravely underfund the health care system.

The future of delivery system reform advocacy

Many consumer advocates joined delivery system reform conversation with great trepidation. The lack of objective data supporting new models of care, clear-cut risks for consumers in a model aimed at saving money, and previous bad experiences with managed care rollouts all contributed to the discomfort. At the same time, advocates recognize that care *can* be better managed when the correct tools and incentives are created and consumer interests are represented in the design process. Recognizing that potential, consumers and their representatives actively participate in myriad re-design processes, underway at both the state and federal levels.

That consumer participation is likely to change if Medicaid caps are seriously proposed. Rather than focusing on innovation, consumer advocates will be forced to focus resources on saving the program that has a 50-year track record of supporting the health of millions of individuals. Worse, the delivery system reform movement may be exploited – gargantuan cuts to Medicaid may be “justified” by the small savings theorized in delivery system reform.

The delivery system reform movement must not allow itself to become associated with Medicaid caps and instead should *publicly reject* them. Medicaid caps would obliterate state Medicaid funding and turn all delivery system reform efforts into exercises in futility. [Millions of people will lose coverage](#), lose services, and lose access to providers. If proponents of delivery system reform truly care about getting to better care for patients then neutrality is not possible: all delivery system reform stakeholders must oppose Medicaid caps or the quality, cost, and care innovations that these reforms have been seeking will be lost.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. NHeLP advocates, educates and litigates at the federal and state level.

Author

This month's *Health Advocate* was prepared by:

Leonardo Cuello
Director of Health Policy



Offices

Washington, DC
1444 I Street NW, Suite 1105
Washington, DC 20005
(202) 289-7661
nhelpdc@healthlaw.org

Los Angeles
3701 Wilshire Blvd, Suite 750
Los Angeles, CA 90010
(310) 204-6010
nhelp@healthlaw.org

North Carolina
200 N. Greensboro Street, Suite D-13
Carrboro, NC 27510
(919) 968-6308
nhelpnc@healthlaw.org

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