

Medicaid Reform Proposals August, 2015

Two documents publicly released in August 2015 propose major changes to the Medicaid entitlement program.

The first, entitled [Medicaid: After 50 Years, It's Time for Reform](#), authored by Tara O'Neil with the American Action Forum (AAF), argues that the current program is unsustainable. The paper lays out three potential reform options – block grants, capped allotments, and per capita caps – and positive and negative aspects of each. The paper also references managed care as a preferred delivery system approach likely to make any reforms more successful, albeit with strengthened reporting and monitoring requirements.

In brief, here are some of the insights offered on the three options:

Block Grants

- Mostly likely approach to ensure slower growth in program costs for the federal government.
- May not adequately accommodate the counter-cyclical nature of the program (i.e., increased need for funding during natural disasters or economic dislocation).
- While potentially providing maximum flexibility for states, this approach relinquishes much of the federal government's oversight role.
- Concurrent use of managed care plans (and maintaining and strengthening managed care regulatory requirements) could be a way to ensure sufficient accountability.

Capped Allotments (based on CHIP funding model)

- Better way to maintain federal program requirements while allowing more state flexibility.
- Like block grants, ends individual entitlement to funding based on eligibility, but more easily allows for adjustment of funding levels based on prior year spending.

Per Capita Caps

- Would limit expenditures per enrolled beneficiary rather than establishing a fixed amount for each state.
- Helps to address counter-cyclical funding needs and maintains limited entitlement to funding.
- Allows for variation in per enrollee caps to reflect age, medical condition, and regional differences in cost of care.
- Easiest approach to implement without major changes in federal oversight.

The AAF paper also cites some additional considerations, including whether any groups might be excluded from these approaches (and the fiscal impact of their exclusion), the potential use of risk corridors for funding provided for disabled beneficiaries, incentivizing better health among

the Medicaid population, and the appropriate level of state funding (the paper recommends maintaining a state match requirement similar to the existing program).

The second paper outlines a plan for replacing Obamacare, [The Day One Patient Freedom Plan](#), which was released by the presidential campaign of Wisconsin Governor Scott Walker (R). His proposal would split Medicaid into three separate programs. Below are the plan's highlights:

- The first program would be called Medical Assistance to Needy Families (MANF) and would be a capped allotment patterned after the CHIP program. Coverage would be provided to low-income children, their parents, and nondisabled adults. States would set eligibility and rules for service delivery and cost sharing. States would be guaranteed a level of funding from the federal government and provide a specified state contribution. Savings from program efficiencies would be retained by states. There is no mandatory coverage group specified in the proposal and no detail on how state allotments would be established.
- A second program would provide acute services to people with disabilities, foster kids, and low-income seniors and continue to provide open-ended funding matched by states. There would be no change to eligibility or the current structure of mandatory and optional benefits. Children with disabilities and those in foster care would continue to receive all medically necessary services they currently get under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.
- A third program would provide long-term services and supports (LTSS) for low-income seniors and people with disabilities. This program would also operate as a capped allotment and each state's share would be based on LTSS spending in a base year indexed over time. Eligibility would be established separately from the acute care program, although an individual could qualify for both. A three-part eligibility test would include financial and functional criteria, as well as a needs assessment. States would also keep any savings achieved through program efficiencies, similar to the proposed MANF program.