With Medicaid Per Capita Caps, Arkansas Loses

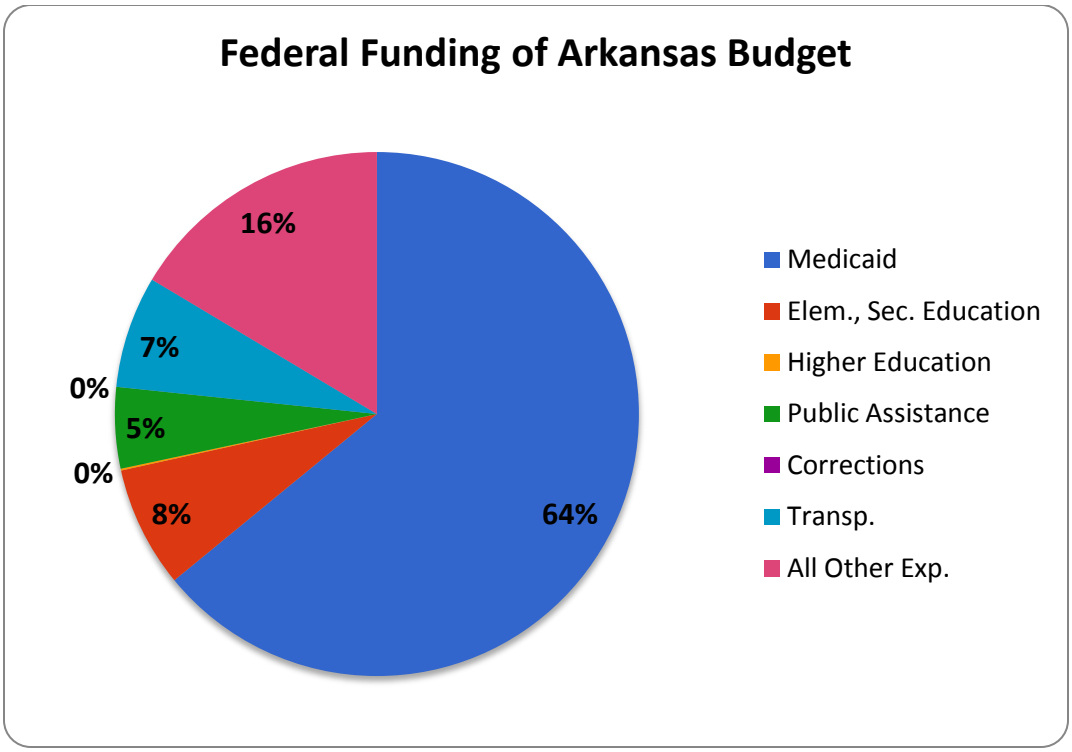
For the last 50 years, Medicaid has provided vital services to people with disabilities, the elderly, children, families, and pregnant women. Medicaid achieves this goal through an open-ended state-federal funding partnership that guarantees coverage for all who qualify. The American Health Care Act (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 Medicaid funding caps.

Medicaid caps limit the total amount of federal Medicaid funds states can receive. While some states will experience deeper cuts than 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 Arkansas' future need or predicted growth, and will disproportionately harm lower-income states and states that expanded Medicaid, like Arkansas. Furthermore, the caps would make it harder for Arkansas to respond to crises: federal Medicaid funding would no longer increase automatically to share the cost of care after natural disasters, new epidemics, or costly new medical treatments or public health emergencies, like the opioid epidemic or Zika. The cap also wouldn't have 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 funding cap cannot appropriately account for the specific spending pressures, needs, and values of Arkansas.

How Medicaid Caps Will Harm Arkansas

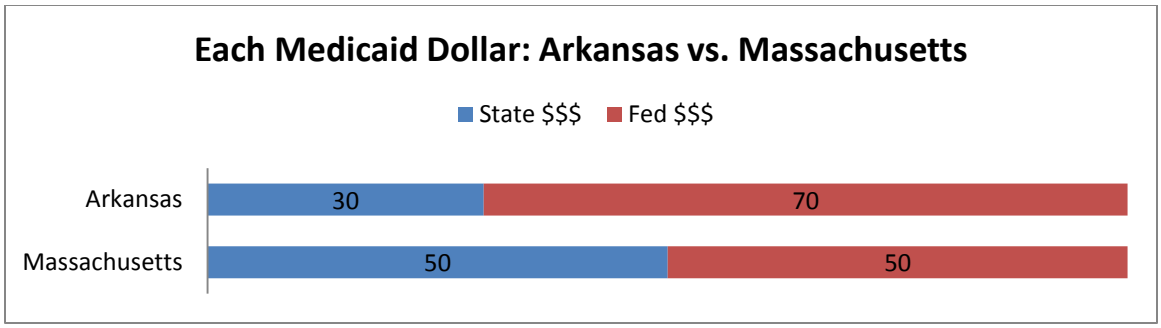
1. **Cuts to Medicaid will jeopardize Arkansas' ability to provide health care to children, seniors, and people with disabilities.** The proposed caps, combined with the effective elimination of the Medicaid expansion, under AHCA would effectively cut $3 billion of federal funding for Arkansas over a ten-year period, shifting these costs to the state. Arkansas would have to raise taxes, cut other parts of its budget, like education, or – more likely -- severely cut Medicaid services, eligibility, and provider payments to make up for this shortfall. The magnitude of this cut would be unprecedented. States have struggled to absorb reductions as small as 2% in Medicaid funding, but the AHCA's proposed cap could lead to cuts in Medicaid spending as high as 5.9%.[i]

2. **Caps on Medicaid funding would blow a hole in Arkansas' budget.** Arkansas' budget relies heavily on federal funding, comprising 64.1% of total federal funds to the state.[ii] Federal funding of Medicaid frees up state funding for schools, workforce development, transportation, and public safety.



3. **Medicaid caps would strip Arkansas' flexibility to address health care needs that change over time.** Arkansas spends $16,603 per disabled Medicaid enrollee, the 14th lowest rate in the country.[iii] Medicaid caps would turn Arkansas'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 and policy choices.

4. **Arkansas will be unfairly penalized by any cut to Medicaid because Arkansas has a higher than average federal Medicaid matching rate.** A state's federal Medicaid matching rate—that is, the percentage of each dollar spent on Medicaid that the federal government contributes—is based on the state's average per capita income. Poorer states get more federal contribution for every state dollar spent on Medicaid, because those states need more federal assistance than their relatively wealthier counterparts.



Under a per capita cap, once Arkansas inevitably hits the cap, Arkansas would have to spend 39% more than a wealthier state, such as Massachusetts, to make up for the lost federal dollars, compared to what happens under current law. Put simply, a state like Arkansas that only pays 30 cents for every Medicaid dollar has much more to lose when federal funding is capped.[iv]

5. **States that expanded Medicaid will be unfairly penalized by any cut to Medicaid.** Caps create even greater disparities for states that expanded Medicaid. Under the current funding structure, Arkansas will never spend more than 10 cents on the dollar for individuals covered through the Medicaid expansion. Under the caps proposed under AHCA, once Arkansas inevitably hits the cap, to continue to cover this population, Arkansas would be obligated to spend 100 cents on the dollar, instead of 10 cents on the dollar for this population – a gargantuan cost-shift.

6. **A federal standard growth factor fails to meet the varying and changing needs of states.** The proposed federal caps do not account for state-specific spending growth rates. If a cap proposed like the one proposed in AHCA had been in effect from 2001-2011, Arkansas would have lost 17 percent of federal Medicaid funds.[v] Caps will create this unfair result any time a state experiences higher growth than the federal standard. Consider, for example, that Arkansas experienced a faster than the national average growth rate among all Medicaid enrollee groups.[vi] A cap does not recognize varying state growth rates that may be impacted by a growing elderly population (or an increase in average age within that 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.

7. **Priority health initiatives in Arkansas 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 funding helps people who need long term care, like seniors and people with disabilities, stay in their homes and communities and out of nursing facilities. 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.
- Medicaid funding allows 507,400 women and girls in Arkansas to obtain the health care they need throughout their lives.[vii] 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 nearly half of pregnant women and paying for half of the nation's long-term services and supports costs.
- 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 residents 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.

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[i] 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, https://www.hhs.gov/sites/default/files/fy2018-budget-in-brief.pdf.

[ii] 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/.

[iii] Medicaid and CHIP Payment and Access Commission (MACPAC), *MACStats*, December 2016, Exhibit 22, https://www.macpac.gov/macstats/. Estimates reflect Medicaid per beneficiary spending in 2013 and are the most recent available.

[iv] Kaiser Family Foundation, *Kaiser State Health Facts,* FMAP. Medicaid matching rate figures included are for federal fiscal year 2017.

[v] 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/.

[vi] 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/.

[vii] 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.