American Society of Clinical Oncology Position Statement
Block Grants in Medicaid & Their Impact on Cancer Care

Approved by the ASCO Board of Directors January 16, 2020

OVERVIEW

Medicaid provides insurance coverage for over 72 million Americans, creating a vital path to early cancer detection, optimal treatment availability, and favorable cancer outcomes for beneficiaries. In the 2014 American Society of Clinical Oncology Policy Statement on Medicaid Reform, ASCO called for major changes to the Medicaid program to ensure access to high-quality cancer care for all low-income individuals. ASCO believes that Medicaid beneficiaries should: 1) have access to cancer care delivered by a cancer specialist, 2) receive the same timely and high-quality cancer care as patients with private insurance, and 3) have access to cancer screening and diagnostic follow up without copays. In 2017, ASCO also released Principles for Patient-Centered Health Care Reform, which stated that every American should have access to affordable and sufficient health care coverage, regardless of their income or health status. As health care reform evolves, any efforts at the national, state, or local levels should ensure that individuals can continue to access the health care system without interruption.

Many recent Medicaid reform proposals could impede access to care for people with cancer. Such proposals have emerged at both the state and federal levels. For example, ASCO has been concerned by ongoing efforts to incorporate requirements for work or community service into Medicaid eligibility criteria, because such requirements are inappropriate for individuals with cancer and create burdensome obligations for oncologists and patients.[1] Recent proposals to establish annual limits on federal funding to states for Medicaid (i.e. block grants) could result in inadequate benefit design, decreased provider reimbursement, and reduced access to care. A transition to block grants also could transform the Medicaid program from its status as a safety net designed to meet basic health needs of low-income Americans, into a program with funding limits that drive rationing of care for the most vulnerable. If the reforms championed by ASCO are to be achieved in the Medicaid program, they must be supported through robust and reliable public funding. This statement summarizes ASCO's concerns about the potential negative impact of Medicaid block grants on patients with cancer and their health care providers and provides recommendations to state and federal policymakers.

BACKGROUND

Medicaid is a program jointly administered and funded by states and the federal government. Medicaid provides health insurance coverage to eligible low-income adults, children, pregnant

[1] https://www.asco.org/sites/new-www.asco.org/files/content-files/ASCO-Medicaid-Waivers-Statement-2018.pdf

women, elderly adults, and people with disabilities. Since its creation in 1965, Medicaid has grown to cover a large proportion of Americans. In 2019, Medicaid covered more than 72 million individuals, over 20% of the U.S. population.[2] Recent growth in the Medicaid program is largely due to the expansion of state Medicaid programs to cover childless adults, made possible by the Patient Protection and Affordable Care Act (ACA). Research suggests states that chose to expand Medicaid under this option have seen improved access to care, including improved early-stage cancer diagnosis, increased utilization of certain types of cancer surgery, and reduced health disparities.[3,4]

As rising health care costs continue to outpace growth in state revenues, the proportion of state budgets dedicated to Medicaid services is a major challenge for states with increasingly limited resources. Medicaid is obligated to pay for covered health services for any individuals who meet eligibility criteria, and must do so without annual expenditure caps.[5] Responsibility for payment is shared with the federal government, whose contribution (known as the Federal Matching Rate Assistance Percentage [FMAP]) is based on the state per capita income, published annually by the US Department of Health and Human Services (HHS). These rates vary by state, and in 2020 states will pay between 23-50% of total costs for traditional Medicaid beneficiaries, with the FMAP covering the remainder of expenditures. Importantly, for beneficiaries covered under Medicaid expansion, the majority of costs are covered by the federal government (by statute, states will never pay more than 10% of these costs). According to the Kaiser Family Foundation, in 2017 the federal government paid more than 60% of total Medicaid costs nationwide; states funded the remaining 40%. Even though state funds comprised less than half of the overall program's expenditures, the proportion of individual state budgets devoted to Medicaid remains substantial.[6]

These fiscal burdens have led to calls for new ways to help states control or limit their costs in the Medicaid program. One proposal gaining traction is to transform the Medicaid program into federally funded block grants to states and the District of Columbia, which would be subject to an annual cap. In contrast to the current FMAP mechanism, a block grant provides a pre-determined, fixed amount of money to the states to administer the Medicaid program. This capped amount

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[2] https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[3] Jemal A, Lin CC, Davidoff AJ, et al: Changes in insurance coverage and stage at diagnosis among nonelderly patients with cancer after the Affordable Care Act. Journal of Clinical Oncology 35:3906-3915, 2017.

[4] Adamson BJS, Cohen AB, Estevez M, et al: Affordable Care Act (ACA) Medicaid expansion impact on racial disparities in time to cancer treatment. Journal of Clinical Oncology 37:LBA1-LBA1, 2019.

[5] This is due to its status as an entitlement program; Medicaid spending is disproportionately focused on persons with disabilities (40%) and the elderly (21%). However, waiting lists do exist for Home and Community-Based Services under Medicaid, and some states have also adopted optional cost-sharing/premium requirements. Those changes have been made in accordance with federal guidelines and regulation.

[6] Note that, unlike states and the District of Columbia, federal funding in the US territories (Puerto Rico, Virgin Islands, Commonwealth of Northern Mariana Islands, American Samoa & Guam) is subject to a statutory cap and fixed matching rates.

would be the only contribution from the federal government, and it is unclear whether or how it would be adjusted for changes in enrollment, costs or program needs.[7]

It is also assumed that with block grants, states will receive increased flexibility in administering their Medicaid programs. Proponents of this approach believe that this expanded flexibility would allow states to make changes to their Medicaid programs that reduce its budgetary impact. ASCO is concerned that those changes under a block grant will result in limiting care and access to services for beneficiaries. In fact, states already possess wide latitude to define their Medicaid programs—as long as they are in accordance with federal minimum standards. This includes the ability to modify beneficiary eligibility criteria, optional inclusion of acute and long-term care benefits, setting provider payment rates, and other program waiver demonstrations. Under block grants, states could seek even more flexibility to control their own costs through locally based changes to enrollment, payment rates, and other programmatic adjustments without needing to obtain federal approval. Additionally, a block grant funding structure could allow states to reinterpret or remove important federal guardrails and accountability measures such as: prohibitions against provider discrimination, beneficiary support systems, network adequacy standards, grievance and appeals processes, and program integrity safeguards, among others. Since the fiscal and programmatic parameters around block grants have yet to be determined, potential savings to states and the federal government cannot accurately be calculated.

ASCO supports Medicaid program reforms provided they are consistent with this over-arching principle: that any such efforts at the national, state, or local levels allow individuals continued access to affordable insurance and high-quality cancer care without interruption. Given previous experience with transitioning federally funded programs to block grant funding, it is unlikely that Medicaid block grants would ensure adequate care for cancer patients. For example, transformation of the former Aid to Families with Dependent Children (AFDC) program to a block grant entitled Temporary Assistance for Needy Families (TANF) has resulted in an erosion of access to services and an inability to respond adequately to crises (e.g. economic recessions). It also resulted in the redirection of funds away from core program obligations in order to fill other state budget gaps.[8] One study found that since TANF was established in 1996, its funding has been frozen, resulting in a 40% decline in its value due to inflation alone.[9] Flat funding has meant that the program has not been adjusted for population growth, demographic changes, economic shifts, or increasing health care costs over time. A recent Avalere study estimated that if states were to enact a block grant structure in Medicaid the reduction in federal funding for children alone would be in excess of $163 billion from 2020-2029, simply due to overall inflation and predicted population growth.[10] Because the majority of states are required by law to maintain balanced budgets, and are similarly prevented from deficit spending, it is unclear how they would compensate for shortfalls—and likewise easy to see how services, benefits and eligibility would be likely targets for cuts.

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[7] Rudowitz, R: 5 Key Questions: Medicaid Block Grants & Per Capita Caps. Kaiser Family Foundation. Accessed on 11.11.2019 at https://www.kff.org/medicaid/issue-brief/5-key-questions-medicaid-block-grants-per-capita-caps/

[8] https://www.cbpp.org/sites/default/files/atoms/files/1-5-17tanf.pdf

[9] Brumfield C, Aderonmu F, Grant K, Carr A, Dutta-Gupta I, Camacho-Craft I, Steiger D, Edelman P. Structurally Unsound – The Impact of Using Block Grants to Fund Economic Security Programs. Georgetown Law Center on Poverty and Inequality. February 2019.

[10] Avalere Health. Medicaid Block Grants and Per Capita Caps: Projected Impact on Children. July 2019.

The current administration has been clear in its desire to move Medicaid funding to federal block grants[11], although it is not certain that such a dramatic change could be made without new statutory authority. The Centers for Medicare and Medicaid Services (CMS) has indicated it is working on block grant guidance but has not released any information to date. Nonetheless, states have taken steps to propose block grants through the CMS waiver authority. In early September 2019, the first such proposal was made by Tennessee. As other states potentially follow suit, it will be important to evaluate their proposals to ensure they remain consistent with the objective of the Medicaid program: to serve the health and wellness of our nation's vulnerable and low-income individuals and families.

ASCO joins others in the medical professional community, health policy experts and several public health organizations in expressing deep concern about the potential for harm if Medicaid funding is redeployed in the form of block grants.

IMPACT ON PATIENTS

Beneficiaries in current Medicaid programs already experience access barriers and disparities in outcomes, and the proposed block grant funding could worsen the existing challenges. One study of pediatric patients with acute lymphoblastic leukemia found that children insured under Medicaid at diagnosis were four times more likely to experience a gap in insurance coverage during the first two years of treatment, leading to a disruption in their care.[12] The authors hypothesized that this was likely due to the added burden of periodic re-enrollment that is required by many Medicaid programs, which results in coverage gaps. Numerous other studies have pointed to the link between coverage gaps and poor cancer outcomes in the Medicaid population.[13,14] These coverage gaps are predicted to become more commonplace under a block grant structure because the state would theoretically no longer have to comply with federal requirements on retroactive eligibility, continuous enrollment or lock-outs.

We can forecast how states might manage a shift to block grants by examining the Commonwealth of Puerto Rico, where the Medicaid program is capped by federal statute. By law, the federal government bears responsibility for 55% of Puerto Rico's Medicaid costs, up to an annual limit or cap. Because of this funding structure, Puerto Rico is often forced to cover 100% of Medicaid program costs for months because annual federal funding limits have been reached. In some years, when needs are especially great (e.g., health crises such as the zika virus, or natural disasters such as hurricanes), the federal government's effective share of annual Medicaid costs can be as low as

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[11] A Budget for a Better America: Fiscal Year 2020 Budget of the United States of America. Office of Management and Budget. March 2019. Accessed online at https://www.whitehouse.gov/wp-content/uploads/2019/03/budget-fy2020.pdf

[12] Smits-Seemann, R. R., Kaul, S., Hersh, A. O., Fluchel, M. N., Boucher, K. M., Kirchhoff, A. C., … Kirchhoff, A. C. (2016). ReCAP: Gaps in Insurance Coverage for Pediatric Patients With Acute Lymphoblastic Leukemia. *Journal Of Oncology Practice*, *12*(2), 175. https://doi-org.proxygw.wrlc.org/10.1200/JOP.2015.005686

[13] Freund KM, Reisinger SA, LeClair AM, et al. Insurance Stability and Cancer Screening Behaviors. Health equity. 2019;3(1):177-182.

[14] Bradley CJ, Given CW, Roberts C. Late stage cancers in a Medicaid-insured population. Medical care. 2003;41(6):722-728.

15-20%.[15] The capped funding has resulted in a program that is less robust than even the lowest-spending state, with expenditures per beneficiary reaching only 31% of the median state Medicaid program.[16]

The Medicaid experience in Puerto Rico is a stark demonstration, and reinforces previous studies of the consequences of block grant funding: programs often respond to limited federal support by reducing Medicaid eligibility and benefits.[17] Taken together with the negative outcomes associated with underinsurance and gaps in Medicaid coverage, block grants are a particular concern in the case of patients with cancer, whose lives depend on reliable access to high-quality care.

IMPACT ON PROVIDERS

Provider acceptance of new Medicaid patients varies widely by state,[18] with lagging acceptance rates (compared to other insurance types) often attributed to inadequate reimbursement rates. Evidence demonstrates that increased Medicaid reimbursement leads to improvements in access to care and outcomes.[19] However, to the degree that Medicaid block grants would constrain state budgets further, it is expected states would react by freezing reimbursement levels, instituting waiting lists for care, and creating per-capita spending caps.[20] Therefore, provider participation in the program could decline further, exacerbating existing access issues for vulnerable patients.

Recent estimates have projected a bleak financial picture for community health centers if block grants become the funding mechanism for Medicaid. Community health centers predominantly care for underserved populations. In a block grant scenario, health center executives anticipate having to make cuts to services and staff in order to make up for lost revenue, thus directly impacting quality and access to care.[21] These health centers currently provide the bulk of cancer screening and referral for further treatment for Medicaid populations.[22]

Reduced provider participation in Medicaid may also jeopardize clinical cancer research. ASCO and many other cancer care stakeholders have paid increasing attention to ensuring clinical trial populations accurately reflect the broader population, in order to ensure the generalizability of

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[15] https://www.cbpp.org/research/health/puerto-ricos-medicaid-program-needs-an-ongoing-commitment-of-federal-funds

[16] https://www.macpac.gov/wp-content/uploads/2019/03/Medicaid-in-Puerto-Rico-Financing-and-Spending-Data-Analysis-and-Projections.pdf

[17] Mager-Mardeusz, H., Lenz, C., & Kominski, GF. (2017). A "Cap" on Medicaid: How Block Grants, Per Capita Caps, and Capped Allotments Might Fundamentally Change the Safety Net. *Policy Brief UCLA Cent Health Policy Res*, PB2017-2, 1-10.

[18] https://www.kff.org/medicaid/issue-brief/data-note-a-large-majority-of-physicians-participate-in-medicaid/

[19] Cunningham PJ, Hadley J. Effects of changes in incomes and practice circumstances on physicians' decisions to treat charity and Medicaid patients. Milbank Q. 2008;86:91–123.

[20] Mager-Mardeusz, H., Lenz, C., & Kominski, GF. (2017). A "Cap" on Medicaid: How Block Grants, Per Capita Caps, and Capped Allotments Might Fundamentally Change the Safety Net. *Policy Brief UCLA Cent Health Policy Res*, PB2017-2, 1-10.

[21] Ibid.

[22] Markus, A. R., Gianattasio, K. , Luo, E., and Strasser, J. (2019), Predicting the Impact of Transforming the Medicaid Program on Health Centers' Revenues and Capacity to Serve Medically Underserved Communities. The Milbank Quarterly. doi:10.1111/1468-0009.12426.

research findings and to understand how treatments work in diverse patient populations. The populations that have been historically underrepresented in clinical trials also tend to be overrepresented in the Medicaid beneficiary populations. Medicaid is the only major payer not required to cover routine care costs associated with participation in clinical trials, which often provide patients with the most appropriate treatment option for their condition. Any downward pressure exerted on access for these patients, through decreased provider participation under block granted reimbursement or a state deciding to opt out of clinical trial coverage under a block grant, threatens to undo recent progress to improve the diversity of cancer clinical research participants.

CONCLUSION AND RECOMMENDATIONS

ASCO recognizes state and federal budgets are confronted with mounting fiscal pressures, but transforming the Medicaid program into a capped block grant program has significant potential to jeopardize the health and outcomes for people with cancer. Further, reduced access to care could add program cost, as patients would present with more complex and late stage illness if they were not able to obtain recommended cancer screenings. As the world's leading professional organization for physicians and oncology professionals that care for people with cancer, ASCO offers the following recommendations to state and federal policymakers:

ASCO RECOMMENDATIONS

- **Congress should not enact a block grant structure for the Medicaid program, either as an optional demonstration program or a permanent change to the program.**
- **CMS should not allow for states to apply for block grants through any of its existing regulatory authority and should not approve state waivers to establish block grants, enact lockout periods, lifetime limits, the elimination of retroactive eligibility or mandatory work requirements on beneficiaries.**
- **States should not seek waivers or other proposals that would establish federal block grant funding structures for their Medicaid programs, or otherwise seek to circumvent statutory obligations under the Social Security Act. Instead, states should seek to take advantage of full Medicaid program expansion.**

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