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The Fiscal Impact of the Trump Administration's Medicaid Block Grant Initiative

Cindy Mann
Partner
Manatt Health

Jocelyn Guyer
Managing Director
Manatt Health

Adam Striar
Manager
Manatt Health

Devin Stone
Manager
Manatt Health

ABSTRACT

ISSUE The Trump administration recently invited states to apply for the new Healthy Adult Opportunity Medicaid demonstration initiative, which lets states opt into a block grant funding model in exchange for fewer federal rules. By capping federal funding, the initiative exposes the Medicaid program to unprecedented financial risk.

GOALS To estimate the financial impact of the new block grant model.

METHODS Using historical data and projections of cost and enrollment growth, we estimate Medicaid expenditures under current law on a state-by-state basis and compare these to funding available under a block grant. We also demonstrate the sensitivity of our estimates to fluctuations in costs and enrollment.

KEY FINDINGS States that take up the block grant would see substantial reductions in Medicaid funding. Under our baseline scenario, the median state would face a reduction of 5.7 percent in fiscal year (FY) 2021; 14.6 percent in FY 2025; and 10.5 percent over the 2021–2025 period. The five-year median reduction in funding would be significantly larger if per enrollee spending growth is 1 percentage point above projections (13.9%), if enrollment grows at recent historical levels rather than projections (19.7%), or if a state reduces expenditures to capture "shared savings" (27.6%). Under all scenarios, the vast majority of Medicaid savings resulting from the funding reductions accrue to the federal government.

TOPLINES

- The Trump administration's new Medicaid block grant option will result in significantly less federal funding and greater financial risks for states that opt in.
- States that accept caps in federal Medicaid funding would need to cut coverage, reduce benefits, increase cost-sharing, lower provider payment rates, or otherwise steeply reduce their current Medicaid expenditures.
- Most of the savings from Medicaid spending reductions would accrue to the federal government, not the states.

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INTRODUCTION

On January 30, the Centers for Medicare and Medicaid Services (CMS) announced a new Medicaid demonstration initiative that places a cap on states' federal Medicaid funding in exchange for less federal oversight and the ability to impose reductions in coverage, benefits, payment rates, and access to care to keep costs below the cap.[1] Called the Healthy Adult Opportunity, the nearly 60-page guidance advances an optional Medicaid block grant akin to proposals that Congress rejected in the 2017 debate over repeal of the Affordable Care Act (ACA).[2]

The new policy applies to adults covered under the ACA's expansion of Medicaid eligibility for people with incomes up to 133 percent of the federal poverty level, which to date has been taken up by 35 states and the District of Columbia. It also applies to a relatively small number of pregnant women and parents covered by Medicaid at state option. States may convert their existing eligible populations to the demonstration or they may use the demonstration to newly cover those populations.

The funding caps may take the form of either a per person cap or an aggregate cap, also known as a block grant. In return for accepting a cap on federal funding, the federal government would take a hands-off approach to overseeing expenditures under the demonstration and permit states to jettison many of the beneficiary protections that would otherwise apply. An additional feature, referred to as "shared savings," allows states to divert some of the capped federal dollars into other state priorities, resulting in additional cuts to Medicaid.[3] States using the block grant to cover new populations (for example, states that use the demonstration to newly expand Medicaid) must rely on the per capita cap model for at least two years, deferring their access to shared savings. (For more detail on the block grant option as described in the administration's guidance, see box on page 3.)

The introduction of a block grant option for state Medicaid programs represents a sharp departure from current law. We used the Manatt Medicaid Financing Model to assess how each state would fare under the block grant compared to current law, assuming that Medicaid enrollment and costs grow consistent with projections made by the Congressional Budget Office and CMS Office of the Actuary.

Because most states that have not expanded Medicaid cover only very small numbers of people who could be covered through the demonstration, we compare how these states would fare if they were to expand as currently allowed under the ACA versus under the new initiative. In addition, since block grants would expose states and the Medicaid program to new risks when costs grow faster than anticipated, we estimate the fiscal impact under alternate scenarios. These estimates provide data-driven insight into the level of risk and the associated reduction in funding for states that take up the demonstration. The actual impact in any given state will depend on factors that are not accounted for in this analysis, including when a state might opt into the block grant model and what the historical spending and trend rates are at that time. The appendix provides a full description of the study's methods.

Many states are unlikely to pursue the new block grant option given that the cap is designed to cut federal support for the program and, by definition, will shift additional financial risks onto states. As described below, the flexibility offered, while vast, has mostly been permitted by the administration in waivers that do not cap Medicaid funding. In addition, any state that pursues the policy can expect a time-consuming and costly legal fight.[4] Nevertheless, at least one governor has expressed an intention to apply.[5] Careful review and analysis are warranted in light of the potentially sweeping implications for Medicaid beneficiaries, providers, and other stakeholders.

KEY ELEMENTS OF THE BLOCK GRANT POLICY

The Healthy Adult Opportunity demonstration allows states to choose between a per capita cap or an aggregate cap (block grant) in exchange for fewer federal rules and less federal oversight. These are the key elements applicable to the block grant:

Eligible population: People covered under the ACA's Medicaid expansion, as well as pregnant women and parents or caretaker relatives covered at states' option, can be covered under the demonstration. These populations represent approximately 28 percent of Medicaid beneficiaries and 20 percent of Medicaid expenditures (FY 2019).[6]

Setting the cap: CMS will compute an aggregate cap based on a state's historical spending for the target group in a base period; aggregate total expenditures for the group are then trended forward by the lesser of the Consumer Price Index for Medical Care plus 0.5 percentage points or the state's historical growth rate. Annual caps, which do not adjust for either health costs or enrollment, are established when the waiver is approved.

Continued state spending requirement: States still must spend state funds to draw down federal funds. The applicable match rate applies (including the 90 percent match rate, if the block grant covers the ACA expansion group). If spending exceeds the cap in any year, CMS will recoup the overage the next year (unless the state has available shared savings rolled over from a previous year).

Flexibility: States would have discretion to make changes for the demonstration population that would lower costs and restrict beneficiary access to care; to keep costs below the cap they could limit coverage (for example, by eliminating retroactive eligibility), drop or reduce benefits (for example, by adopting a closed drug formulary), increase premiums and cost-sharing, and impose work requirements. Most of these policies have been approved by the administration under Section 1115 waivers that do not include funding caps (see box on page 8). Notably, CMS will not allow states to implement a partial Medicaid expansion or cap enrollment and still receive the enhanced federal match rate for expansions.

80 percent requirement: CMS will rebase or reduce a state's caps if the state does not spend at least 80 percent of its capped allocations.

Diversion of federal funds (shared savings): States that spend less than their cap in a given year will be able to divert up to 50 percent of unused federal funds to state-funded health-related programs outside the Medicaid program. States must provide matching dollars at the state's applicable matching rate to draw down these funds. Diverted funds can replace state spending in these health-related programs, as long as there is enough spending to serve as the state match for the diverted federal funds.[7]

Special policies for newly expanding states: States that newly expand through a demonstration must adhere to a per capita cap for at least two years before converting to a block grant. This defers access to shared savings until the fourth year of implementation.

Adjustments to the base: States may see their caps reduced if they implement policies that significantly reduce enrollment. In the event of a public health crisis or major economic event, they may seek an upward cap adjustment. Neither adjustment is spelled out or guaranteed by the guidance.

FINDINGS

Exhibit 1 below provides a summary of our key findings.

Beneficiaries Potentially Impacted

Our estimates show that, in FY 2019, adult Medicaid beneficiaries who could be subject to the block grant represented a little more than a quarter (28%) of all beneficiaries and 20 percent of expenditures.[8] In states that have fully implemented their Medicaid expansion, the share of current beneficiaries subject to the block grant ranges from 25 percent (North Dakota) to 57 percent (District of Columbia).[9] By contrast, almost all states that have not expanded Medicaid cover very small numbers of potentially eligible individuals. In Alabama and Mississippi, for example, less than 1 percent of current beneficiaries could be subject to the block grant. It is therefore unlikely that a state would take up the block grant option unless it has implemented the Medicaid expansion or decides to use this demonstration to do so (Table 1).

Exhibit 1. Change in Total Medicaid Expenditures Under Block Grant Demonstrations, Selected Scenarios, FYs 2021–2025 ($ millions)

	National impact		State impacts			
				Median		
	$	%	Lowest (%)	$	%	Highest (%)
States spend up to their caps (baseline assumptions)*	–$110,394	–10.5%	–6.5%	–$1,459	–10.5%	–24.1%
Varied trend rate assumption: medical CPI is 2.25% instead of 3.0%	–$134,247	–12.8%	–8.4%	–$1,815	–13.0%	–24.1%
Varied cost growth assumption: per enrollee spending growth is 1 percentage point above projections	–$152,168	–14.0%	–9.2%	–$2,021	–13.9%	–27.0%
Varied enrollment growth assumption: enrollment grows in line with 1998–2013 average (3.6% per year)	–$220,568	–18.4%	–13.3%	–$2,973	–19.7%	–32.9%
States reduce Medicaid spending to 80% of their caps to capture shared savings (baseline assumptions)*	–$277,467	–26.5%	–21.3%	–$3,492	–27.6%	–39.3%
Varied trend rate assumption: medical CPI is 2.25% instead of 3.0%	–$296,806	–28.3%	–23.4%	–$3,642	–29.4%	–39.3%
Varied cost growth assumption: per enrollee spending growth is 1 percentage point above projections	–$319,286	–29.3%	–24.4%	–$4,010	–30.4%	–41.6%
Varied enrollment growth assumption: enrollment grows in line with 1998–2013 average (3.6% per year)	–$393,064	–32.8%	–24.2%	–$4,521	–35.5%	–46.4%

* See appendix for the parameters applicable to the baseline assumptions.

Note: Medical CPI = Consumer Price Index for Medical Care.

Data: Manatt Medicaid Financing Model.

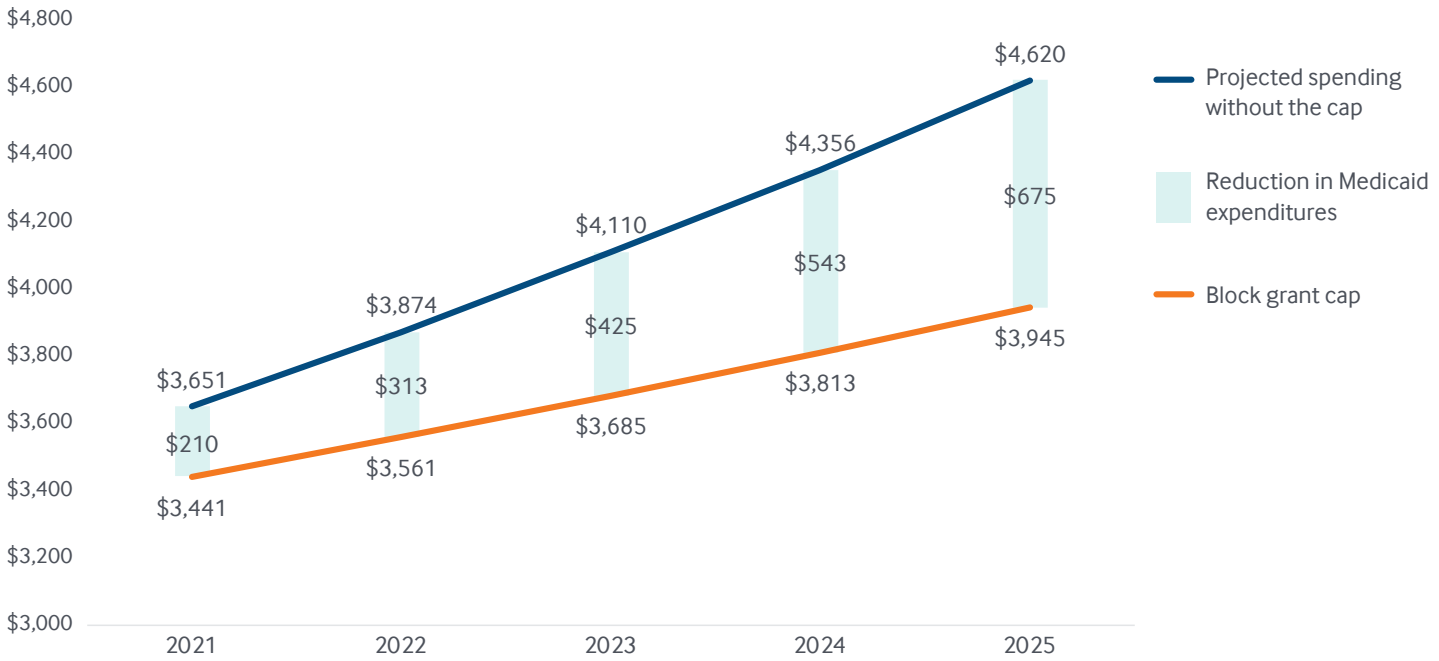
All States Opting for a Block Grant Would Need to Make Significant Cuts to Medicaid

Given that the block grant cap is set below current projections of Medicaid spending, states would need to make substantial cuts to avoid violating their caps. To illustrate: if all states expand Medicaid, implement a block grant, and spend their full capped allocations, the reduction in Medicaid expenditures would be $110.4 billion relative to projected spending without the block grant for FYs 2021 to 2025 — a 10.5 percent cut.[10] The magnitude of cuts increases steadily over time as the capped allotments fail to keep up with enrollment growth and health care cost increases. In 2021, when the block grant first goes into effect, the median state (Washington) would need to reduce its Medicaid expenditures by 5.7 percent ($210 million) to remain below its caps.[11] By 2025, it would need to reduce expenditures by 14.6 percent to remain below the $675 million cap (Exhibit 2).

Some states would need to make deeper cuts than others. As shown in Table 2, states such as Tennessee and Vermont would need to reduce expenditures by 25.0 percent and 33.6 percent, respectively — much deeper cuts than for the median state. This wide variation is driven in large part by CMS's use of each state's recent Medicaid growth rate as a key factor in establishing and trending forward the state's capped allocation.[12] Some states have had extremely low or even negative growth in Medicaid in recent years. While likely not sustainable over time, this drives down their caps under the CMS formula. Even if, in an attempt to induce block grant take-up, CMS were to selectively ignore state growth rates and calculate the annual caps strictly based on the Consumer Price Index for Medical Care (medical CPI) plus 0.5 percentage points (a substantial divergence from the guidance), it would not change the fundamental picture. All states would still face sizable and growing cuts, with the median state facing a reduction of 10.2 percent in FYs 2021 to 2025 (Table 3).

Exhibit 2. Projected Total Computable Medicaid Expenditures vs. Block Grant Caps for the Median State (Washington), FYs 2021–2025, Using Baseline Assumptions

Total computable (federal and state) Medicaid expenditures, Healthy Adult Opportunity–eligibles ($ millions)



Note: Estimates assume that the state elects to implement an aggregate cap in all years and spends only as much as allowed under the cap.
Data: Manatt Medicaid Financing Model.

Most of the Savings Accrue to the Federal Government

The federal government would be the primary beneficiary of the reductions in Medicaid spending that would follow implementation of a block grant. The simple reason is that the federal government finances 90 percent of the cost of covering expansion adults. If a state's block grant includes only the expansion population, fully 90 percent of all savings from the cuts accrue to the federal government. Even after considering that a block grant may include other populations covered at a lower federal Medicaid matching rate (optional pregnant women and low-income parents), the federal government would still realize 83 percent of the savings associated with states taking up the block grant. This share represents $92.0 billion of the $110.4 billion in total Medicaid cuts (Table 2).

Shared-Savings Policy Deepens Cuts, and Still Leaves the Federal Government as Primary Beneficiary

Since the administration points to the shared-savings component of its policy as generating financial opportunities for states, it is important to evaluate the policy in the context of the total Medicaid spending reductions and the federal savings generated by capped funding. For states to access any federal "savings," they must reduce their total Medicaid expenditures for the block grant population beyond what is required to simply live within the caps while meeting CMS's performance standards. If states reduce spending to 80 percent of their caps to take advantage of the shared-savings option, the size of the cuts in the median state for FYs 2021 to 2025 would balloon from 10.5 percent to 27.6 percent.[13] In that state, 89 percent of the reductions in Medicaid expenditures would represent savings to the federal government.

States could divert a share of the unspent federal Medicaid funds to other state priorities under the shared-savings option (at a lower match rate, assuming they are covering expansion adults in the block grant). Even under this scenario, the federal government retains more than three-quarters of the total savings (Table 4).

Impact on Expansion States

Expansion states already have a significant group of enrollees whose coverage could be converted to the block grant. If such states were to pursue block grant demonstrations, they would see significant reductions in Medicaid expenditures relative to current law. The median expansion state would see total cuts of 10.2 percent from FYs 2021 to 2025, and all expansion states would see cuts of at least 6.5 percent. One state, Vermont, would see a cut of more than 30 percent (Table 2).

Impact on Nonexpansion States

In states that have not yet expanded Medicaid, an expansion implemented via the block grant option could be seen as allowing a state to provide at least some coverage and draw down some federal Medicaid dollars at the enhanced federal match rate. This alternative path to expanding Medicaid, however, would come at a substantial cost to states and coverage.

States that expand through a block grant option are giving up a significant portion of the 90 percent match they would otherwise receive. If all nonexpansion states expanded Medicaid under current law without a cap, they could expect to receive $270.1 billion in federal funds between 2021 and 2025 (and potentially more if costs grow more rapidly than current projections). If, instead, they used the block grant option, they would receive 11.9 percent less, a $32.7 billion reduction across all nonexpansion states (Table 2).[14]

The reduction in federal dollars relative to expansion without a cap would be deeper in some states. For example, Oklahoma would receive 17.2 percent less federal funding compared to expansion without a cap ($1.9 billion fewer dollars through 2025). In addition, as noted above, newly expanding states taking up the block grant would not have access to the shared-savings feature for at least two years. Nor could they cap enrollment or implement a partial expansion without giving up the enhanced matching rate, flexibilities that have been sought by some states to reduce their expansion costs.[15]

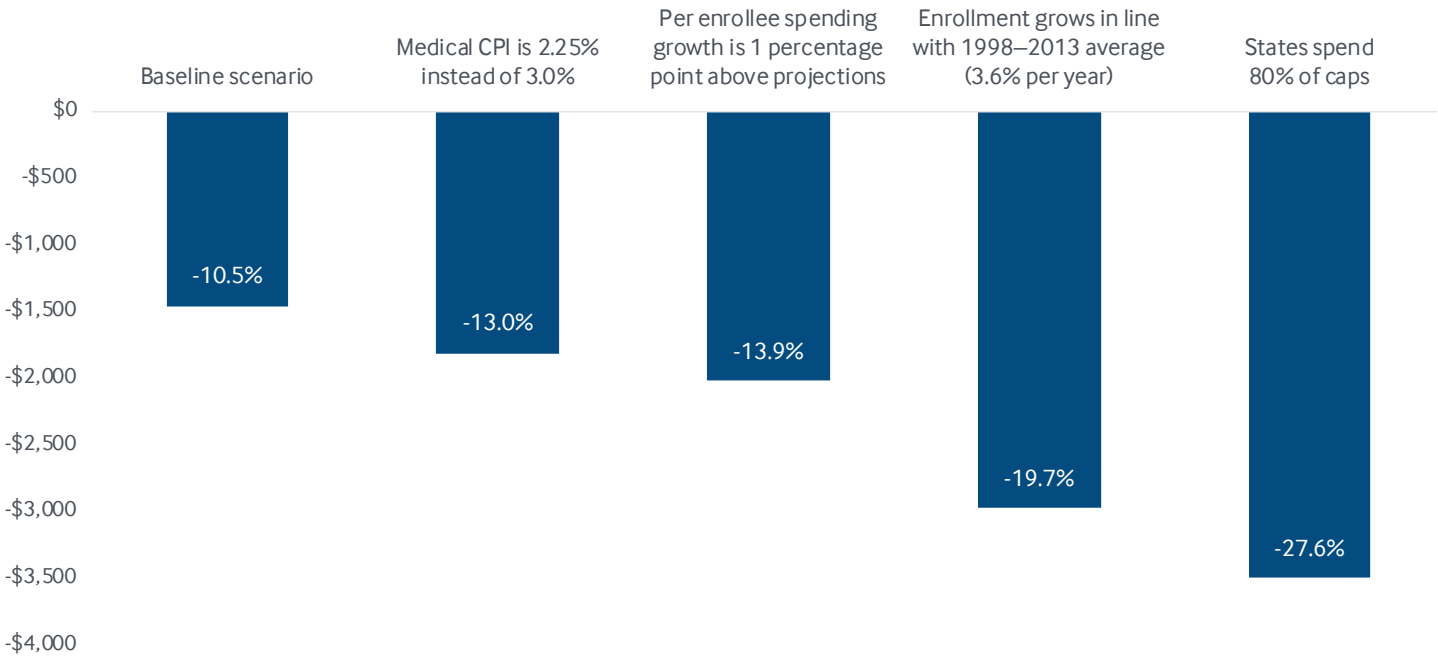
Risk Under the Block Grant

The estimates reviewed above all reflect the size of Medicaid cuts relative to current law based on projections of per enrollee Medicaid expenditures from the CMS Office of the Actuary and enrollment growth from the Congressional Budget Office, adjusted for state-specific population trends. Real-world events, however, could lead to significantly sharper cuts. If any of the projections used in the baseline scenario are off to even a minor degree — a near certainty given the difficulty of predicting the direction of the economy and health care costs — the size of the cuts would be much higher (Exhibit 3).

For example, the baseline projections assume that medical CPI (a key factor in the trend rate for the block grant) will be 3.0 percent, an average of medical CPI over the past four years. Depending on the year, this is approximately 2 percentage points lower than projected growth in per enrollee expenditures. If, however, the gap between growth in medical CPI and actual Medicaid expenditures turns out to be larger than projected, the size of the cuts would grow substantially. If, for example, medical CPI were 2.25 percent instead of 3.0 percent, the reductions in Medicaid expenditures in the median state would jump to 13.0 percent for FYs 2021 to 2025, compared to 10.5 percent under the baseline scenario.[16]

Similarly, the reductions are more substantial if health care costs grow faster than projections. If costs increase such that per enrollee spending growth is just 1 percentage point higher than expected, the spending reductions necessary for the median state to stay below the cap would increase to 13.9 percent.[17]

Exhibit 3. Change in Total Medicaid Expenditures in Median State Under Block Grant Demonstrations, Selected Scenarios, FYs 2021–2025 (% of baseline)



Notes: Medical CPI = Consumer Price Index for Medical Care. Median state may change depending on the scenario.
Data: Manatt Medicaid Financing Model.

States also could face additional cuts if enrollment grows faster than projections but is still in line with historical experience. Though the Congressional Budget Office projects that adult Medicaid enrollment will rise by 0.7 percent per year from 2019 through 2029, which is the growth rate used in the estimates presented above, total Medicaid enrollment rose by an average of 3.6 percent per year from 1998 to 2013 (the years prior to the effective date of the Medicaid expansion) and often varies considerably across states.[18] If this were the rate of enrollment growth across all states between FYs 2021 and 2025, the median state cut would rise to 19.7 percent (Table 5).

States would face the largest cuts if any of these scenarios occurred simultaneously with a state reducing spending to access shared savings. If medical CPI were 2.25 percent instead of 3.0 percent or if per enrollee spending growth were 1 percentage point higher than projected, assuming all states spend 80 percent of their capped allocations, the median state would see cuts of 29.4 percent and 30.4 percent, respectively. Alternatively, if enrollment were to grow faster than expected (3.6 percent across all states), the median state cut would increase to 35.5 percent, with some states seeing reductions of nearly 50 percent (Exhibit 1).

FLEXIBILITY UNDER THE BLOCK GRANT: WHAT'S NEW? WHAT'S NOT? AND WHAT'S STILL OFF THE TABLE?

CMS has already used its Section 1115 demonstration authority to allow states to impose new conditions of Medicaid eligibility and undo beneficiary protections in waivers without funding caps. States taking up these same policies as part of the Healthy Adult Opportunity block grant option would be required to accept reduced and capped federal funding. Many of these previously approved demonstrations are now caught up in litigation, and states considering the new block grant option also should anticipate legal challenges.

Already Available Under Waivers That Do Not Cap Federal Funding

- Work requirements (subject of litigation)
- Discretion to reduce or eliminate benefits, such as nonemergency medical transportation and EPSDT services for people ages 19 or 20 (subject of litigation)
- Higher premiums (subject of litigation)
- Elimination of retroactive eligibility (subject of litigation)
- Use of Medicaid funds to connect people to and provide health-related social services[19]

Newly Offered in Block Grant Guidance (likely to prompt litigation)

- Ability to divert share of unused federal dollars to other health-related initiatives
- Limits on payments to federally qualified health centers
- Use of closed drug formulary while retaining access to federal rebates
- Ability to implement Medicaid managed care capitation rates and establish network adequacy standards without advance federal review
- Ability to make changes to benefits, premiums, and other policies with limited federal review[20]
- Charge copayments above statutory limits and without regard to Section 1916(f) of the Social Security Act, which specifically restricts federal waiver authority in this area
- Elimination of hospital presumptive eligibility

***Not* Allowed Under Guidance If State Claims Enhanced Matching Rate**

- Partial expansion of Medicaid, such as to 100 percent of federal poverty level
- Enrollment caps
- Asset tests

DISCUSSION AND POLICY IMPLICATIONS

Consistent with the fundamental "bargain" of all block grant proposals, our estimates show that states would receive significantly less federal funding and be subject to increased financial risks if they take up the block grant option. The magnitude of the cuts would vary based largely on each state's recent expenditure growth, but the basic picture is the same across the country: the caps would require states to cut coverage, reduce benefits, increase cost-sharing, lower provider payment rates, or otherwise reduce Medicaid expenditures as compared to current law spending levels or expected spending levels for states implementing new expansions.

The cuts grow over time, and they deepen still further if states pursue shared savings or if health care costs or enrollment grow at rates that, while higher than projected, are well within recent historical experience. And under all scenarios, the financial benefits of spending cuts accrue overwhelmingly to the federal government, not states.

Once they take a close look, most states are likely to decide that the block grant is not an appealing option. It requires them to give up the financial partnership under which the federal government shares the risk for all Medicaid expenditures, including those driven by rising prices, breakthrough technologies, economic downturns, and other health care factors.[21] Meanwhile, much of the "flexibility" that CMS offers under the guidance is already available through waivers that do not cap funding while strategies that some states have sought to limit their financial exposure — partial expansion and enrollment caps — are off the table for the expansion population unless states give up the enhanced matching rate. And if enrollment drops too steeply with the flexibility permitted (for example, as a result of implementing work requirements or higher premiums), the state's cap could be adjusted downward to reflect reduced enrollment.

CMS is seeking to make the block grant option more appealing by allowing states to divert federal Medicaid funds into other state priorities if they underspend the block grant. This policy, however, would further deepen the Medicaid cuts, add to the access issues beneficiaries face under a block grant, and squeeze already thin Medicaid margins for providers and managed care plans. Our analysis also suggests that the diversion option is not likely to be as fiscally attractive to states as it might initially sound. Shared savings are not available to newly expanding states until the fourth year of the demonstration; even then, they are available only if a state somehow manages to keep expenditures well below its capped allotment. And, in the end, the federal government still retains more than three-quarters of all of the savings resulting from the cuts that states will need to make to stay within the caps.

Finally, a Medicaid block grant established through administrative action rather than legislation, with sweeping fiscal and programmatic implications, is certain to be the subject of extensive litigation.

WHAT IF A STATE WANTS TO LEAVE THE BLOCK GRANT?

The guidance notes that states can terminate their participation in the block grant demonstration, but it is important to be aware of potential constraints on early exits. CMS likely will face significant pressure not to allow states to opt in/opt out of the block grant at will. Budget officials and watchdog groups will likely express concern if CMS allows states to divert a share of federal Medicaid dollars to other priorities when all is going well, but then lets them drop out of the block grant when their spending exceeds the cap. Even if CMS permits states to opt out, it would take months to effectuate an exit. Standard CMS waiver terms require states to provide beneficiaries with at least six months of notice before a waiver is terminated.

CONCLUSION

The concept of turning the Medicaid program into a block grant has been debated for decades, most recently during the unsuccessful effort in 2017 to repeal and replace the Affordable Care Act. The Trump administration's Healthy Adult Opportunity initiative — advanced through Section 1115 demonstrations instead of legislation — offers the same fundamental "bargain": less federal funding and more risk in exchange for flexibility.

Our estimates of the policy's impact highlight that the administration's block grant model requires significant cuts in Medicaid under the best of scenarios, and that still deeper cuts are necessary if a state experiences an economic slowdown or continues to see the introduction of new treatments and medications that increase Medicaid cost pressures beyond current projections. Blunt instruments such as enrollment caps, which can help keep spending below the caps, are off the table if states want to retain the 90 percent enhanced match. Many expansion states are likely to take a pass, because the cuts are steep, the financial risks are great, and the promise of shared savings is likely to be less appealing than it may sound at first blush. Although proponents of Medicaid expansion may wonder whether expansion through a block grant is better than nothing, it is important to consider the significant federal dollars lost and the likely diminution of coverage and care under this option.

Table 1. Share of Medicaid Beneficiaries and Expenditures Subject to the Block Grant Option, Selected Years Assuming Nonexpansion States Choose to Expand in FY 2021

	FY 2019				FY 2021			
	Number of block-grant-eligible beneficiaries	Share of Medicaid beneficiaries who are block-grant-eligible	Projected expenditures — block-grant-eligible beneficiaries ($ millions)	Share of total Medicaid expenditures on block-grant-eligibles	Number of block-grant-eligible beneficiaries	Share of Medicaid beneficiaries who are block-grant-eligible	Projected expenditures — block-grant-eligible beneficiaries ($ millions)	Share of total Medicaid expenditures on block-grant-eligibles
All states	**20,255,559**	**27.6%**	**$118,195**	**20.0%**	**26,536,799**	**33.1%**	**$173,910**	**24.7%**
Alabama	6,040	0.6%	$36	0.6%	267,413	22.5%	$1,747	22.7%
Alaska	73,557	35.6%	$800	32.6%	74,406	35.1%	$894	32.1%
Arizona	695,349	36.4%	$4,637	36.6%	714,019	36.5%	$5,259	36.8%
Arkansas	273,066	31.3%	$1,754	27.7%	277,775	31.5%	$1,971	27.8%
California	4,799,862	37.9%	$25,505	28.7%	4,864,131	37.8%	$28,547	28.6%
Colorado	501,791	40.1%	$2,215	28.1%	511,445	40.2%	$2,493	28.1%
Connecticut	404,611	43.0%	$2,744	32.8%	407,072	43.0%	$3,050	32.6%
Delaware	91,247	43.2%	$782	33.2%	92,126	43.1%	$873	33.1%
District of Columbia	150,630	57.2%	$740	24.0%	151,900	56.2%	$824	23.7%
Florida	141,081	3.8%	$710	3.1%	1,222,572	25.1%	$6,795	21.4%
Georgia	67,357	3.5%	$423	3.8%	651,179	26.0%	$4,513	27.6%
Hawaii	145,813	46.8%	$868	35.8%	147,933	46.3%	$973	35.6%
Idaho	6,375	2.2%	$44	2.4%	116,341	28.7%	$894	30.1%
Illinois	997,956	37.7%	$5,140	34.2%	1,008,232	37.7%	$5,735	34.2%
Indiana	363,902	27.4%	$2,018	17.7%	367,986	27.5%	$2,254	17.6%
Iowa	199,027	32.6%	$848	18.7%	201,929	32.6%	$950	18.7%
Kansas	14,022	4.0%	$87	2.7%	135,690	28.3%	$927	20.9%
Kentucky	468,750	36.5%	$2,952	30.0%	472,225	36.4%	$3,285	30.0%
Louisiana	477,769	29.8%	$3,206	29.6%	488,035	29.9%	$3,617	29.6%
Maine	47,987	18.4%	$275	9.9%	86,859	28.7%	$551	16.4%
Maryland	487,093	40.0%	$4,051	33.2%	492,486	40.0%	$4,524	33.1%
Massachusetts	579,984	33.8%	$3,132	19.0%	587,853	33.7%	$3,506	18.9%
Michigan	771,127	32.2%	$5,235	27.8%	775,482	32.2%	$5,815	27.7%
Minnesota	358,417	33.7%	$3,013	25.5%	363,107	33.7%	$3,372	25.4%
Mississippi	3,651	0.5%	$26	0.5%	173,516	20.9%	$1,343	18.0%
Missouri	19,835	2.3%	$149	1.6%	282,709	24.6%	$2,352	18.4%
Montana	96,918	38.6%	$820	39.3%	97,353	38.5%	$910	39.1%
Nebraska	13,780	5.7%	$100	4.6%	87,547	27.4%	$702	23.0%
Nevada	226,002	38.3%	$1,256	33.4%	229,237	38.5%	$1,407	33.4%
New Hampshire	58,946	32.3%	$412	22.1%	59,240	32.2%	$458	21.8%
New Jersey	554,786	34.3%	$3,140	21.9%	562,340	34.3%	$3,515	21.8%
New Mexico	271,409	32.7%	$1,482	30.7%	275,384	32.8%	$1,661	30.9%
New York	2,819,182	45.9%	$13,924	16.9%	2,855,667	45.8%	$15,578	16.8%
North Carolina	39,441	1.9%	$322	2.3%	520,963	20.5%	$4,699	23.6%
North Dakota	22,379	25.0%	$306	23.7%	23,155	24.7%	$350	23.6%
Ohio	902,248	31.7%	$5,954	27.0%	911,479	31.8%	$6,644	27.0%
Oklahoma	25,540	4.0%	$173	3.5%	234,781	29.4%	$1,752	25.4%
Oregon	473,480	48.9%	$2,502	28.3%	480,032	48.9%	$2,802	28.2%
Pennsylvania	820,902	30.0%	$5,951	20.3%	828,214	29.9%	$6,632	20.3%
Rhode Island	102,767	34.4%	$658	24.7%	104,063	34.3%	$736	24.6%
South Carolina	78,223	6.2%	$445	7.4%	334,120	23.0%	$2,101	25.5%
South Dakota	1,775	1.8%	$13	1.4%	36,288	27.1%	$292	22.9%
Tennessee	213,854	13.4%	$966	10.8%	514,424	26.9%	$2,566	22.3%
Texas	56,694	1.4%	$364	1.2%	1,678,413	28.7%	$11,903	26.1%
Utah	15,390	5.1%	$108	3.9%	206,343	41.5%	$1,597	34.5%
Vermont	55,787	32.9%	$215	13.3%	56,336	32.7%	$240	13.2%
Virginia	319,167	25.0%	$2,590	21.4%	446,796	31.5%	$4,005	27.3%
Washington	569,953	32.8%	$3,251	27.0%	579,505	32.7%	$3,651	27.0%
West Virginia	162,305	31.0%	$956	23.5%	164,304	31.0%	$1,069	23.5%
Wisconsin	206,384	17.5%	$881	10.2%	292,470	24.3%	$1,379	14.0%
Wyoming	1,949	3.5%	$15	2.4%	23,924	30.7%	$201	23.0%

Notes: Estimates assume that current Medicaid expansion states elect to implement an aggregate cap, and current nonexpansion states expand Medicaid in 2021 under a per capita cap and transition to an aggregate cap in 2023. In all years, states spend only as much as allowed under their caps.

Data: Manatt Medicaid Financing Model.

Table 2. Change in Total and Federal Medicaid Expenditures Under the Block Grant Option Relative to Current Law, Selected Years ($ millions)

	2021			2025			2021–2025		
	Total	Federal	% reduction	Total	Federal	% reduction	Total	Federal	% reduction
All states	**–$10,058**	**–$8,309**	**–5.8%**	**–$34,632**	**–$28,907**	**–14.6%**	**–$110,394**	**–$91,990**	**–10.5%**
Alabama	–$100	–$90	–5.7%	–$495	–$445	–16.5%	–$1,465	–$1,315	–11.5%
Alaska	–$87	–$68	–9.8%	–$191	–$148	–17.1%	–$687	–$532	–13.7%
Arizona	–$430	–$355	–8.2%	–$1,202	–$994	–17.8%	–$3,998	–$3,307	–13.4%
Arkansas	–$73	–$65	–3.7%	–$319	–$286	–12.8%	–$956	–$855	–8.6%
California	–$1,606	–$1,302	–5.6%	–$4,905	–$3,974	–13.7%	–$15,960	–$12,931	–10.0%
Colorado	–$136	–$109	–5.5%	–$460	–$367	–14.6%	–$1,459	–$1,163	–10.4%
Connecticut	–$211	–$155	–6.9%	–$512	–$376	–13.6%	–$1,778	–$1,306	–10.5%
Delaware	–$55	–$44	–6.3%	–$153	–$122	–14.0%	–$511	–$407	–10.4%
District of Columbia	–$49	–$40	–5.9%	–$141	–$116	–13.7%	–$466	–$384	–10.1%
Florida	–$388	–$340	–5.7%	–$1,714	–$1,510	–14.8%	–$5,253	–$4,626	–10.7%
Georgia	–$315	–$277	–7.0%	–$1,230	–$1,088	–16.0%	–$3,967	–$3,508	–12.2%
Hawaii	–$44	–$36	–4.5%	–$162	–$134	–13.2%	–$502	–$417	–9.2%
Idaho	–$52	–$46	–5.8%	–$159	–$142	–14.1%	–$514	–$460	–10.2%
Illinois	–$163	–$131	–2.8%	–$765	–$612	–10.7%	–$2,264	–$1,809	–7.0%
Indiana	–$141	–$116	–6.3%	–$394	–$323	–14.0%	–$1,314	–$1,078	–10.4%
Iowa	–$75	–$64	–7.9%	–$191	–$163	–16.0%	–$655	–$557	–12.3%
Kansas	–$53	–$46	–5.7%	–$218	–$192	–13.9%	–$685	–$602	–10.3%
Kentucky	–$134	–$119	–4.1%	–$469	–$419	–11.5%	–$1,475	–$1,319	–8.0%
Louisiana	–$250	–$224	–6.9%	–$759	–$682	–16.4%	–$2,470	–$2,217	–12.0%
Maine	–$53	–$41	–9.6%	–$136	–$107	–19.8%	–$464	–$365	–15.1%
Maryland	–$273	–$218	–6.0%	–$787	–$627	–13.9%	–$2,602	–$2,072	–10.2%
Massachusetts	–$171	–$128	–4.9%	–$647	–$482	–14.7%	–$2,000	–$1,491	–10.1%
Michigan	–$282	–$240	–4.9%	–$854	–$727	–11.9%	–$2,788	–$2,373	–8.6%
Minnesota	–$163	–$121	–4.8%	–$550	–$407	–13.0%	–$1,743	–$1,291	–9.2%
Mississippi	–$77	–$69	–5.7%	–$353	–$317	–15.1%	–$1,073	–$965	–10.8%
Missouri	–$149	–$133	–6.4%	–$573	–$511	–14.4%	–$1,865	–$1,662	–10.9%
Montana	–$57	–$51	–6.2%	–$153	–$137	–13.5%	–$515	–$462	–10.1%
Nebraska	–$40	–$34	–5.7%	–$165	–$142	–14.2%	–$517	–$443	–10.4%
Nevada	–$86	–$76	–6.1%	–$256	–$226	–14.4%	–$836	–$738	–10.6%
New Hampshire	–$19	–$16	–4.1%	–$63	–$54	–11.1%	–$199	–$172	–7.8%
New Jersey	–$182	–$162	–5.2%	–$585	–$521	–13.3%	–$1,879	–$1,673	–9.5%
New Mexico	–$112	–$99	–6.7%	–$320	–$283	–15.3%	–$1,058	–$934	–11.3%
New York	–$1,011	–$688	–6.5%	–$2,861	–$1,946	–14.6%	–$9,498	–$6,461	–10.8%
North Carolina	–$327	–$291	–7.0%	–$1,255	–$1,121	–15.6%	–$4,093	–$3,654	–11.9%
North Dakota	–$24	–$20	–6.8%	–$80	–$68	–17.6%	–$253	–$216	–12.6%
Ohio	–$230	–$185	–3.5%	–$930	–$749	–11.2%	–$2,833	–$2,281	–7.6%
Oklahoma	–$104	–$91	–5.9%	–$846	–$747	–28.4%	–$2,181	–$1,925	–17.2%
Oregon	–$209	–$176	–7.5%	–$560	–$471	–15.9%	–$1,888	–$1,590	–12.0%
Pennsylvania	–$383	–$339	–5.8%	–$1,112	–$985	–13.4%	–$3,667	–$3,250	–9.9%
Rhode Island	–$39	–$31	–5.4%	–$126	–$100	–13.7%	–$406	–$321	–9.8%
South Carolina	–$136	–$116	–6.5%	–$506	–$439	–14.9%	–$1,640	–$1,419	–11.2%
South Dakota	–$17	–$14	–5.7%	–$101	–$89	–20.6%	–$280	–$245	–13.3%
Tennessee	–$309	–$247	–12.1%	–$984	–$802	–25.0%	–$3,375	–$2,746	–19.8%
Texas	–$682	–$608	–5.7%	–$3,150	–$2,817	–15.1%	–$9,549	–$8,537	–10.9%
Utah	–$91	–$81	–5.7%	–$309	–$274	–15.1%	–$962	–$853	–10.6%
Vermont	–$30	–$27	–12.6%	–$101	–$90	–33.6%	–$324	–$291	–24.1%
Virginia	–$84	–$72	–2.1%	–$513	–$442	–10.2%	–$1,450	–$1,247	–6.5%
Washington	–$210	–$187	–5.7%	–$675	–$601	–14.6%	–$2,165	–$1,928	–10.5%
West Virginia	–$55	–$49	–5.1%	–$183	–$165	–13.6%	–$581	–$523	–9.7%
Wisconsin	–$79	–$61	–5.7%	–$366	–$289	–16.3%	–$1,094	–$863	–11.3%
Wyoming	–$11	–$10	–5.7%	–$91	–$80	–26.8%	–$236	–$208	–16.3%

Notes: Medical CPI = Consumer Price Index for Medical Care. Estimates assume that current Medicaid expansion states elect to implement an aggregate cap, and current nonexpansion states expand Medicaid in 2021 under a per capita cap and transition to an aggregate cap in 2023. In all years, states spend only as much as allowed under their caps. Cost growth/trend rate assumptions are in line with the baseline scenario: medical CPI grows at 3.0%, consistent with the average annual growth rate in medical CPI from 2016–2019 as reported by the Bureau of Labor Statistics; enrollment grows in line with state-specific population growth projections developed by AARP, adjusted to align with overall enrollment growth projections from the Congressional Budget Office; per enrollee spending grows in line with national, eligibility group-specific projections from the CMS Office of the Actuary; and CMS considers historical, state-specific growth rates when establishing block grant trend rates (i.e., states will not automatically receive medical CPI or medical CPI plus 0.5 percentage points as their trend rates).

Data: Manatt Medicaid Financing Model.

Table 3. Change in Total and Federal Medicaid Expenditures Under the Block Grant Option Relative to Current Law If CMS Disregards Recent State-Specific Expenditure Trends When Setting Capped Allocations,* Selected Years

	2021			2025			2021–2025		
	Total	Federal	% reduction	Total	Federal	% reduction	Total	Federal	% reduction
All states	**–$9,690**	**–$8,002**	**–5.6%**	**–$32,980**	**–$27,497**	**–13.9%**	**–$105,332**	**–$87,685**	**–10.1%**
Alabama	–$100	–$90	–5.7%	–$416	–$373	–13.8%	–$1,309	–$1,175	–10.2%
Alaska	–$87	–$68	–9.8%	–$191	–$148	–17.1%	–$687	–$532	–13.7%
Arizona	–$430	–$355	–8.2%	–$1,202	–$994	–17.8%	–$3,998	–$3,307	–13.4%
Arkansas	–$73	–$65	–3.7%	–$319	–$286	–12.8%	–$956	–$855	–8.6%
California	–$1,606	–$1,302	–5.6%	–$4,905	–$3,974	–13.7%	–$15,960	–$12,931	–10.0%
Colorado	–$136	–$109	–5.5%	–$460	–$367	–14.6%	–$1,459	–$1,163	–10.4%
Connecticut	–$211	–$155	–6.9%	–$512	–$376	–13.6%	–$1,778	–$1,306	–10.5%
Delaware	–$55	–$44	–6.3%	–$153	–$122	–14.0%	–$511	–$407	–10.4%
District of Columbia	–$49	–$40	–5.9%	–$141	–$116	–13.7%	–$466	–$384	–10.1%
Florida	–$388	–$340	–5.7%	–$1,681	–$1,481	–14.5%	–$5,189	–$4,569	–10.5%
Georgia	–$258	–$227	–5.7%	–$1,099	–$972	–14.3%	–$3,412	–$3,017	–10.5%
Hawaii	–$44	–$36	–4.5%	–$162	–$134	–13.2%	–$502	–$417	–9.2%
Idaho	–$51	–$46	–5.7%	–$158	–$141	–14.0%	–$508	–$454	–10.1%
Illinois	–$163	–$131	–2.8%	–$765	–$612	–10.7%	–$2,264	–$1,809	–7.0%
Indiana	–$141	–$116	–6.3%	–$394	–$323	–14.0%	–$1,314	–$1,078	–10.4%
Iowa	–$75	–$64	–7.9%	–$191	–$163	–16.0%	–$655	–$557	–12.3%
Kansas	–$53	–$46	–5.7%	–$218	–$192	–13.9%	–$685	–$602	–10.3%
Kentucky	–$134	–$119	–4.1%	–$469	–$419	–11.5%	–$1,475	–$1,319	–8.0%
Louisiana	–$250	–$224	–6.9%	–$759	–$682	–16.4%	–$2,470	–$2,217	–12.0%
Maine	–$48	–$38	–8.7%	–$109	–$85	–15.8%	–$385	–$303	–12.5%
Maryland	–$273	–$218	–6.0%	–$787	–$627	–13.9%	–$2,602	–$2,072	–10.2%
Massachusetts	–$144	–$108	–4.1%	–$555	–$414	–12.6%	–$1,707	–$1,273	–8.7%
Michigan	–$282	–$240	–4.9%	–$854	–$727	–11.9%	–$2,788	–$2,373	–8.6%
Minnesota	–$163	–$121	–4.8%	–$550	–$407	–13.0%	–$1,743	–$1,291	–9.2%
Mississippi	–$77	–$69	–5.7%	–$339	–$305	–14.5%	–$1,046	–$940	–10.5%
Missouri	–$134	–$120	–5.7%	–$538	–$480	–13.5%	–$1,717	–$1,531	–10.1%
Montana	–$57	–$51	–6.2%	–$153	–$137	–13.5%	–$515	–$462	–10.1%
Nebraska	–$40	–$34	–5.7%	–$165	–$142	–14.2%	–$517	–$443	–10.4%
Nevada	–$86	–$76	–6.1%	–$256	–$226	–14.4%	–$836	–$738	–10.6%
New Hampshire	–$19	–$16	–4.1%	–$63	–$54	–11.1%	–$199	–$172	–7.8%
New Jersey	–$182	–$162	–5.2%	–$585	–$521	–13.3%	–$1,879	–$1,673	–9.5%
New Mexico	–$112	–$99	–6.7%	–$320	–$283	–15.3%	–$1,058	–$934	–11.3%
New York	–$1,011	–$688	–6.5%	–$2,861	–$1,946	–14.6%	–$9,498	–$6,461	–10.8%
North Carolina	–$269	–$239	–5.7%	–$1,119	–$999	–13.9%	–$3,517	–$3,140	–10.3%
North Dakota	–$24	–$20	–6.8%	–$80	–$68	–17.6%	–$253	–$216	–12.6%
Ohio	–$230	–$185	–3.5%	–$930	–$749	–11.2%	–$2,833	–$2,281	–7.6%
Oklahoma	–$100	–$88	–5.7%	–$432	–$381	–14.5%	–$1,334	–$1,177	–10.5%
Oregon	–$209	–$176	–7.5%	–$560	–$471	–15.9%	–$1,888	–$1,590	–12.0%
Pennsylvania	–$383	–$339	–5.8%	–$1,112	–$985	–13.4%	–$3,667	–$3,250	–9.9%
Rhode Island	–$39	–$31	–5.2%	–$123	–$98	–13.3%	–$396	–$314	–9.6%
South Carolina	–$120	–$103	–5.7%	–$472	–$408	–13.8%	–$1,492	–$1,291	–10.2%
South Dakota	–$17	–$14	–5.7%	–$70	–$61	–14.2%	–$219	–$191	–10.4%
Tennessee	–$147	–$117	–5.7%	–$552	–$450	–14.0%	–$1,746	–$1,421	–10.2%
Texas	–$681	–$607	–5.7%	–$3,147	–$2,814	–15.1%	–$9,533	–$8,523	–10.8%
Utah	–$91	–$81	–5.7%	–$309	–$274	–15.1%	–$962	–$853	–10.6%
Vermont	–$10	–$9	–4.1%	–$36	–$33	–12.1%	–$113	–$101	–8.4%
Virginia	–$84	–$72	–2.1%	–$513	–$442	–10.2%	–$1,450	–$1,247	–6.5%
Washington	–$210	–$187	–5.7%	–$675	–$601	–14.6%	–$2,165	–$1,928	–10.5%
West Virginia	–$55	–$49	–5.1%	–$183	–$165	–13.6%	–$581	–$523	–9.7%
Wisconsin	–$79	–$61	–5.7%	–$291	–$230	–13.0%	–$949	–$748	–9.8%
Wyoming	–$11	–$10	–5.7%	–$46	–$41	–13.7%	–$147	–$130	–10.1%

* All state block grants are trended at the rate of medical CPI or medical CPI plus 0.5 percentage points, regardless of historical growth in state spending.

Notes: CMS = Centers for Medicare and Medicaid Services. Medical CPI = Consumer Price Index for Medical Care. Estimates assume that current Medicaid expansion states elect to implement an aggregate cap, and current nonexpansion states expand Medicaid in 2021 under a per capita cap and transition to an aggregate cap in 2023. In all years, states spend only as much as allowed under their caps. Cost growth trend rate assumptions are in line with the baseline scenario: medical CPI grows at 3.0%, consistent with the average annual growth rate in medical CPI from 2016–2019 as reported by the Bureau of Labor Statistics; enrollment grows in line with state-specific population growth projections developed by AARP, adjusted to align with overall enrollment growth projections from the Congressional Budget Office; per enrollee spending grows in line with national, eligibility group-specific projections from the CMS Office of the Actuary; and CMS disregards historical, state-specific growth rates when establishing block grant trend rates (i.e., states will not automatically receive Medical CPI or Medical CPI plus 0.5 percentage points as their trend rates).

Data: Manatt Medicaid Financing Model.

Table 4. Impact of States Spending 80 Percent of Caps and Availability of Federal Savings, FY 2025 ($ millions)

	Total reductions from baseline	Total reductions from cap	Weighted average match rate for demonstration population	Federal share of reductions from cap	Maximum potential shared savings (assuming 50% savings rate)	Share of total cuts retained by federal government*
All states	**–$73,880**	**–$40,901**	**83%**	**–$34,080**	**–$17,040**	**76.9%**
Alabama	–$933	–$517	90%	–$464	–$232	75.1%
Alaska	–$376	–$185	77%	–$143	–$72	80.9%
Arizona	–$2,309	–$1,107	83%	–$916	–$458	80.2%
Arkansas	–$755	–$435	89%	–$389	–$195	74.2%
California	–$11,083	–$6,177	81%	–$5,005	–$2,502	77.4%
Colorado	–$1,001	–$540	80%	–$431	–$215	78.5%
Connecticut	–$1,163	–$651	73%	–$478	–$239	79.4%
Delaware	–$340	–$187	80%	–$149	–$75	78.0%
District of Columbia	–$319	–$178	82%	–$146	–$73	77.0%
Florida	–$3,660	–$1,979	88%	–$1,744	–$872	76.2%
Georgia	–$2,412	–$1,313	88%	–$1,162	–$581	75.9%
Hawaii	–$375	–$213	83%	–$177	–$88	76.4%
Idaho	–$351	–$194	89%	–$173	–$87	75.3%
Illinois	–$2,043	–$1,278	80%	–$1,021	–$510	75.0%
Indiana	–$878	–$484	82%	–$397	–$199	77.4%
Iowa	–$391	–$201	85%	–$171	–$85	78.2%
Kansas	–$487	–$269	88%	–$236	–$118	75.7%
Kentucky	–$1,192	–$723	89%	–$646	–$323	72.9%
Louisiana	–$1,531	–$772	90%	–$693	–$346	77.4%
Maine	–$224	–$115	79%	–$91	–$45	79.8%
Maryland	–$1,762	–$975	80%	–$776	–$388	78.0%
Massachusetts	–$1,326	–$771	75%	–$574	–$287	78.3%
Michigan	–$2,123	–$1,269	85%	–$1,079	–$540	74.6%
Minnesota	–$1,286	–$736	74%	–$545	–$272	78.8%
Mississippi	–$739	–$400	90%	–$360	–$180	75.7%
Missouri	–$1,229	–$691	89%	–$616	–$308	74.9%
Montana	–$349	–$196	90%	–$175	–$88	74.8%
Nebraska	–$366	–$200	86%	–$172	–$86	76.5%
Nevada	–$559	–$303	88%	–$267	–$134	76.1%
New Hampshire	–$163	–$101	87%	–$87	–$44	73.3%
New Jersey	–$1,350	–$764	89%	–$681	–$340	74.8%
New Mexico	–$675	–$355	88%	–$314	–$157	76.8%
New York	–$6,201	–$3,340	68%	–$2,272	–$1,136	81.7%
North Carolina	–$2,503	–$1,384	89%	–$1,236	–$618	75.3%
North Dakota	–$154	–$75	86%	–$64	–$32	79.3%
Ohio	–$2,400	–$1,471	81%	–$1,184	–$592	75.3%
Oklahoma	–$941	–$510	88%	–$450	–$225	76.1%
Oregon	–$1,154	–$594	84%	–$500	–$250	78.3%
Pennsylvania	–$2,545	–$1,433	89%	–$1,270	–$635	75.0%
Rhode Island	–$283	–$160	79%	–$127	–$63	77.6%
South Carolina	–$1,058	–$587	87%	–$508	–$254	76.0%
South Dakota	–$155	–$85	87%	–$74	–$37	76.1%
Tennessee	–$1,230	–$678	82%	–$553	–$276	77.5%
Texas	–$6,683	–$3,536	89%	–$3,162	–$1,581	76.3%
Utah	–$657	–$348	89%	–$308	–$154	76.5%
Vermont	–$89	–$53	90%	–$47	–$24	73.4%
Virginia	–$1,412	–$899	86%	–$773	–$387	72.6%
Washington	–$1,464	–$789	89%	–$703	–$351	76.0%
West Virginia	–$415	–$232	90%	–$209	–$105	74.8%
Wisconsin	–$682	–$391	79%	–$309	–$154	77.4%
Wyoming	–$105	–$59	88%	–$52	–$26	75.4%

* Assumes states capture the maximum potential shared savings. "Total cuts" are measured as the difference between baseline expenditures and 80% of the cap.

Notes: Medical CPI = Consumer Price Index for Medical Care. Estimates assume that current Medicaid expansion states elect to implement an aggregate cap, and current nonexpansion states expand Medicaid in 2021 under a per capita cap and transition to an aggregate cap in 2023. We assume states spend 80% of their aggregate cap allotments. For states operating under the per capita cap, we assume these states spend to 100% of their capped allotment. Cost growth/trend rate assumptions are in line with the baseline scenario: medical CPI grows at 3.0%, consistent with the average annual growth rate in medical CPI from 2016–2019 as reported by the Bureau of Labor Statistics; enrollment grows in line with state-specific population growth projections developed by AARP, adjusted to align with overall enrollment growth projections from the Congressional Budget Office; per enrollee spending grows in line with national, eligibility group-specific projections from the CMS Office of the Actuary; and CMS considers historical, state-specific growth rates when establishing block grant trend rates (i.e., states will not automatically receive medical CPI or medical CPI plus 0.5 percentage points as their trend rates).

Data: Manatt Medicaid Financing Model.

Table 5. Change in Total Medicaid Expenditures Under Block Grant Demonstrations, Selected Scenarios, State-by-State Detail, FYs 2021–2025 ($ millions)

	Baseline scenario		Medical CPI is lower than expected (2.25%)		Per enrollee spending growth is 1 percentage point faster than expected		Enrollment growth equal to historical Medicaid enrollment growth from 1998–2013 (3.6% per year)		States spend 80% of caps	
	$	%	$	%	$	%	$	%	$	%
All states	**–$110,394**	**–10.5%**	**–$134,247**	**–12.8%**	**–$152,168**	**–14.0%**	**–$220,568**	**–18.4%**	**–$277,467**	**–26.5%**
Alabama	–$1,465	–11.5%	–$1,692	–13.2%	–$1,988	–14.9%	–$2,291	–14.9%	–$2,935	–22.9%
Alaska	–$687	–13.7%	–$808	–16.1%	–$886	–17.0%	–$1,345	–23.7%	–$1,551	–31.0%
Arizona	–$3,998	–13.4%	–$4,728	–15.8%	–$5,191	–16.7%	–$7,457	–22.1%	–$9,175	–30.7%
Arkansas	–$956	–8.6%	–$1,242	–11.2%	–$1,399	–12.1%	–$2,253	–18.1%	–$2,990	–26.9%
California	–$15,960	–10.0%	–$20,028	–12.5%	–$22,341	–13.4%	–$36,274	–20.1%	–$44,840	–28.0%
Colorado	–$1,459	–10.4%	–$1,815	–12.9%	–$2,021	–13.8%	–$3,057	–19.5%	–$3,986	–28.3%
Connecticut	–$1,778	–10.5%	–$2,207	–13.0%	–$2,453	–13.9%	–$4,224	–21.7%	–$4,822	–28.4%
Delaware	–$511	–10.4%	–$634	–13.0%	–$705	–13.9%	–$1,162	–21.0%	–$1,387	–28.4%
District of Columbia	–$466	–10.1%	–$583	–12.6%	–$650	–13.5%	–$1,204	–22.1%	–$1,297	–28.1%
Florida	–$5,253	–10.7%	–$6,465	–13.1%	–$7,264	–14.2%	–$8,015	–13.8%	–$10,981	–22.3%
Georgia	–$3,967	–12.2%	–$4,259	–13.0%	–$5,299	–15.6%	–$5,897	–15.3%	–$7,700	–23.6%
Hawaii	–$502	–9.2%	–$642	–11.7%	–$720	–12.6%	–$1,171	–19.0%	–$1,498	–27.3%
Idaho	–$514	–10.2%	–$636	–12.6%	–$714	–13.6%	–$811	–13.5%	–$1,075	–21.3%
Illinois	–$2,264	–7.0%	–$3,105	–9.7%	–$3,541	–10.6%	–$6,545	–18.0%	–$8,237	–25.6%
Indiana	–$1,314	–10.4%	–$1,633	–12.9%	–$1,816	–13.8%	–$2,973	–20.8%	–$3,579	–28.3%
Iowa	–$655	–12.3%	–$787	–14.7%	–$867	–15.6%	–$1,317	–21.9%	–$1,592	–29.8%
Kansas	–$685	–10.3%	–$859	–12.9%	–$958	–13.8%	–$1,091	–13.7%	–$1,466	–22.0%
Kentucky	–$1,475	–8.0%	–$1,951	–10.6%	–$2,205	–11.5%	–$4,023	–19.2%	–$4,853	–26.4%
Louisiana	–$2,470	–12.0%	–$2,979	–14.5%	–$3,289	–15.4%	–$4,662	–20.5%	–$6,080	–29.6%
Maine	–$464	–15.1%	–$464	–15.1%	–$562	–17.5%	–$712	–21.2%	–$987	–32.1%
Maryland	–$2,602	–10.2%	–$3,244	–12.8%	–$3,611	–13.7%	–$5,914	–20.6%	–$7,158	–28.2%
Massachusetts	–$2,000	–10.1%	–$2,215	–11.2%	–$2,786	–13.6%	–$4,460	–20.1%	–$5,545	–28.1%
Michigan	–$2,788	–8.6%	–$3,624	–11.2%	–$4,077	–12.1%	–$7,433	–20.0%	–$8,719	–26.9%
Minnesota	–$1,743	–9.2%	–$2,228	–11.8%	–$2,497	–12.7%	–$4,146	–19.4%	–$5,183	–27.4%
Mississippi	–$1,073	–10.8%	–$1,304	–13.1%	–$1,479	–14.3%	–$1,643	–14.0%	–$2,228	–22.5%
Missouri	–$1,865	–10.9%	–$2,162	–12.7%	–$2,561	–14.4%	–$3,003	–14.5%	–$3,848	–22.5%
Montana	–$515	–10.1%	–$644	–12.7%	–$717	–13.6%	–$1,236	–21.3%	–$1,430	–28.1%
Nebraska	–$517	–10.4%	–$646	–13.0%	–$720	–13.9%	–$810	–13.7%	–$1,098	–22.0%
Nevada	–$836	–10.6%	–$1,036	–13.1%	–$1,152	–14.0%	–$1,815	–20.4%	–$2,253	–28.4%
New Hampshire	–$199	–7.8%	–$265	–10.4%	–$300	–11.3%	–$567	–19.4%	–$670	–26.2%
New Jersey	–$1,879	–9.5%	–$2,382	–12.1%	–$2,664	–13.0%	–$4,375	–19.7%	–$5,452	–27.6%
New Mexico	–$1,058	–11.3%	–$1,292	–13.8%	–$1,431	–14.7%	–$2,194	–20.9%	–$2,719	–29.0%
New York	–$9,498	–10.8%	–$11,698	–13.4%	–$12,984	–14.3%	–$20,554	–20.8%	–$25,113	–28.7%
North Carolina	–$4,093	–11.9%	–$4,409	–12.9%	–$5,492	–15.4%	–$6,289	–15.3%	–$8,028	–23.4%
North Dakota	–$253	–12.6%	–$302	–15.1%	–$333	–16.0%	–$421	–19.4%	–$602	–30.1%
Ohio	–$2,833	–7.6%	–$3,802	–10.2%	–$4,313	–11.1%	–$7,804	–18.5%	–$9,708	–26.1%
Oklahoma	–$2,181	–17.2%	–$2,354	–18.6%	–$2,698	–20.5%	–$3,020	–20.2%	–$3,492	–27.5%
Oregon	–$1,888	–12.0%	–$2,280	–14.4%	–$2,517	–15.3%	–$3,828	–21.6%	–$4,667	–29.6%
Pennsylvania	–$3,667	–9.9%	–$4,611	–12.4%	–$5,145	–13.3%	–$8,665	–20.6%	–$10,366	–27.9%
Rhode Island	–$406	–9.8%	–$502	–12.1%	–$570	–13.3%	–$934	–20.0%	–$1,152	–27.9%
South Carolina	–$1,640	–11.2%	–$1,871	–12.8%	–$2,235	–14.7%	–$2,553	–14.6%	–$3,322	–22.7%
South Dakota	–$280	–13.3%	–$317	–15.1%	–$366	–16.7%	–$415	–16.5%	–$514	–24.4%
Tennessee	–$3,375	–19.8%	–$3,375	–19.8%	–$4,065	–22.9%	–$4,474	–22.2%	–$5,108	–30.0%
Texas	–$9,549	–10.9%	–$11,811	–13.4%	–$13,150	–14.4%	–$13,981	–13.7%	–$19,802	–22.5%
Utah	–$962	–10.6%	–$1,191	–13.1%	–$1,324	–14.0%	–$1,393	–13.3%	–$1,970	–21.7%
Vermont	–$324	–24.1%	–$324	–24.1%	–$378	–27.0%	–$502	–32.9%	–$528	–39.3%
Virginia	–$1,450	–6.5%	–$1,898	–8.4%	–$2,143	–9.2%	–$3,658	–14.8%	–$5,653	–25.2%
Washington	–$2,165	–10.5%	–$2,685	–13.0%	–$2,986	–13.9%	–$4,587	–19.9%	–$5,854	–28.4%
West Virginia	–$581	–9.7%	–$735	–12.2%	–$821	–13.1%	–$1,336	–19.7%	–$1,668	–27.7%
Wisconsin	–$1,094	–11.3%	–$1,266	–13.1%	–$1,488	–14.8%	–$1,730	–15.2%	–$2,199	–22.7%
Wyoming	–$236	–16.3%	–$260	–17.9%	–$295	–19.5%	–$343	–19.6%	–$388	–26.8%

Notes: Medical CPI = Consumer Price Index for Medical Care. Estimates assume that current Medicaid expansion states elect to implement an aggregate cap, and current nonexpansion states expand Medicaid in 2021 under a per capita cap and transition to an aggregate cap in 2023. Unless specified otherwise in a given scenario, cost growth/trend rate assumptions are in line with the baseline scenario: medical CPI grows at 3.0%, consistent with the average annual growth rate in medical CPI from 2016–2019 as reported by the Bureau of Labor Statistics; enrollment grows in line with state-specific population growth projections developed by AARP, adjusted to align with overall enrollment growth projections from the Congressional Budget Office; per enrollee spending grows in line with national, eligibility group-specific projections from the CMS Office of the Actuary; and CMS considers historical, state-specific growth rates when establishing block grant trend rates (i.e., states will not automatically receive medical CPI or medical CPI plus 0.5 percentage points as their trend rates).

Data: Manatt Medicaid Financing Model.

APPENDIX. MEDICAID FINANCING MODEL METHODS

OVERVIEW

Using historical Medicaid spending and enrollment data and publicly available projections of Medicaid spending and enrollment, the Manatt Medicaid Financing Model estimates the impact of capped funding arrangements outlined by the Centers for Medicare and Medicaid Services (CMS) in its guidance for the Healthy Adult Opportunity (HAO) demonstration program for FYs 2021 through 2025. The model projects total Medicaid spending and enrollment across all 50 states plus the District of Columbia under current law and compares it to expenditures if each state were to take up the block grant option.

Unless they already have expanded or pair the block grant with a new expansion, there are relatively few optional parents and pregnant women whom states can put into a block grant. Accordingly, the estimates in this analysis, unless otherwise noted, assume that nonexpansion states will adopt the Affordable Care Act (ACA) Medicaid expansion if they take up the block grant. Along with estimating the impact of caps on each state, we also conduct sensitivity analyses to evaluate the impact of the block grant option if health care costs, enrollment pressures, or medical CPI are different than anticipated.

ESTIMATING ENROLLMENT

Enrollment baseline. We estimate baseline Medicaid enrollment for each state using several data sources. We use CMS-64 Quarterly Enrollment reports[22] to establish total enrollment and expansion adult enrollment for FY 2018 and assume a distribution across remaining eligibility groups based on tabulations from the Medicaid and CHIP Payment and Access Commission (MACPAC) of Medicaid Statistical Information System (MSIS) data from FY 2013.[23] For FY 2019 and beyond, we use a combination of CMS Monthly Medicaid and Children's Health Insurance Program (CHIP) enrollment reports[24] and national enrollment growth projections from the Congressional Budget Office, adjusted on a state-by-state basis using population growth estimates prepared by AARP.[25] In three states (Maine, Virginia, and Wisconsin), we supplement the model with state-specific data sources because of recent policy changes not otherwise captured in the state-by-state data available from national sources.

Populations subject to the block grant. The guidance allows states to put some or all optional nonaged, nondisabled Medicaid adults into a capped funding demonstration, using either a per capita cap or a block grant. We therefore exclude all enrollees in the aged, disabled, and child eligibility groups from the analysis.[26] We treat ACA expansion adults as optional and potentially subject to the block grant.[27] Unless otherwise noted, the baseline block grant estimates also assume that nonexpansion states take up expansion, reflecting that otherwise only approximately 4.5 percent of Medicaid beneficiaries would potentially be eligible for the block grant in nonexpansion states. To estimate expansion enrollment in nonexpansion states, we begin with tabulations of data from the Census Bureau's American Community Survey (ACS) provided by the State Health Access Data Assistance Center[28] on the number of individuals potentially eligible for the Medicaid expansion in each state; then we apply an expected take-up rate based on the experience of states with recent expansions.[29] For estimates of the number of other optional beneficiaries who could be subject to the block grant (optional parents and pregnant women), we analyze each state's eligibility thresholds for pregnant women and parents or caretaker relatives to determine state-specific income levels for those who are mandatorily versus optionally enrolled.[30] We then use the ACS Public Use Microdata Sample to estimate the share of nonexpansion adults who are optionally enrolled in each state.[31]

ESTIMATING EXPENDITURES

To estimate baseline expenditures on the block-grant-eligible population in each state, we start with MACPAC tabulations derived from MSIS data of full-year equivalent (FYE) per enrollee Medicaid spending by eligibility group by state for FY 2013.[32] Next, we derive aggregate Medicaid

expenditures by state in each year through FY 2017 using total net expenditures as reported by the CMS-64 Financial Management Report (FMR) and applying certain exclusions as instructed by the administration's guidance.[33] We then calibrate per enrollee expenditures such that within each state, spending per enrollee by group multiplied by total enrollment by group matches adjusted total net Medicaid expenditures in FY 2017. To project future per enrollee expenditures by eligibility group, we apply a trend rate derived from national per enrollee spending growth estimates from FYs 2018 through 2025 in the most recent CMS Medicaid Actuarial Report.[34] Finally, we project aggregate expenditures in each state and year by multiplying projected per enrollee spending by projected enrollment.

ESTIMATING HAO CAPS

While this analysis focuses on the aggregate cap option, the guidance requires that states covering new populations (expansion adults) operate under a per capita cap for the first two demonstration years. Therefore, our model assumes all nonexpansion states will start with a per capita cap for two years before switching to the block grant option in FY 2023. We assume that current expansion states will choose the aggregate cap option for all demonstration years.

To estimate each state's cap under the block grant option, we assume that states will include all optional nondisabled, nonaged adults in their block grant. We then develop a base amount for each state's cap using projected annualized expenditures from FYs 2018 and 2019, per the guidance requirement to use the eight most recent quarters of expenditure data. To set the caps in each year, we then apply to the base amount a trend rate set at the lower of 1) a state's annual spending growth rate between FY 2014 through FY 2019 or 2) medical CPI, as projected by the Medicaid Office of the Actuary, plus 0.5 percentage points (or medical CPI for current nonexpansion states under the per capita cap in 2021 and 2022).[35]

ESTIMATING THE IMPACT OF THE HAO CAPS

For each demonstration year in the model (FYs 2021–2025), we compare each state's capped allotment against baseline spending for the demonstration population in each state. This allows us to estimate potential reductions in both total and federal Medicaid spending relative to a current law scenario under which each state has expanded Medicaid. In this baseline block grant scenario, we estimate that states will spend up to, but not above, their block grant caps. We also test the sensitivity of these estimates to modest variations in different inputs relating to medical CPI, per enrollee spending growth, and enrollment growth. Finally, we estimate the impact of states seeking to take full advantage of the shared-savings option by evaluating the effect of each state reducing its expenditures to 80 percent of the cap.

NOTES

1. Centers for Medicare and Medicaid Services, "Trump Administration Announces Transformative Medicaid Healthy Adult Opportunity," press release, Jan. 30, 2020.

2. In 2017, Congress considered several bills that repealed elements of the Affordable Care Act and capped some or all Medicaid financing, including the American Health Care Act, Better Care Reconciliation Act, and Senate Amendment 1030 to the American Health Care Act (known as "Graham–Cassidy").

3. References to "cuts" throughout represent reductions in Medicaid expenditures relative to baseline (i.e., not reductions relative to the cap). Percentages are expressed as a share of the demonstration-eligible population.

4. Sara Rosenbaum et al., "The Medicaid Block Grant (Experiment) Cometh," *Health Affairs Blog,* Feb. 7, 2020.

5. Office of Oklahoma Governor Kevin Stitt, "Governor's Remarks at Trunp Administration Announcement on Medicaid," press release, Jan. 30, 2020.

6. Estimates derived from the Manatt Medicaid Financing Model.

7. The guidance explicitly allows 30 percent of the shared savings to be used to replace existing state spending. The guidance suggests that the remaining dollars should be used for new investments, but nothing in the guidance prevents a state from subverting that requirement by remaking or relabeling existing state programs as new initiatives for the target population.

8. Estimates derived from the Manatt Medicaid Financing Model.

9. This excludes states that implemented expansions beginning in 2019 or 2020 (Idaho, Maine, Utah, and Virginia).

10. Cuts for newly expanding states are measured against the level of funding (and therefore coverage and services) that would be available under expansions without a cap.

11. Unless specified otherwise, "median state" refers to the state with the median percent cut.

12. Specifically, CMS's guidance says it will apply the lower of a state's historical growth rate over the previous five years or medical CPI plus an additional 0.5 percentage points, whichever is lower, when establishing and trending forward a state's capped allocation.

13. States must spend at least 80 percent of their block grant in each year or CMS may reduce their base amount in subsequent years. For illustrative purposes, we assume in this scenario that states spend exactly 80 percent of their block grants in order to maximize shared savings. In reality, states are unlikely to target spending to exactly 80 percent of the cap, as this risks states inadvertently having their block grants rebased.

14. Pursuant to the guidance, nonexpansion states opting for an HAO demonstration would need to adopt a per capita cap for at least the first two years; these calculations reflect that policy.

15. Last summer, in response to state requests to implement partial expansions or enrollment caps for the expansion population, CMS announced that these policies would not be available if the state was also seeking to access the enhanced federal matching rate for the expansion group (see Centers for Medicare and Medicaid Services, "CMS Statement on Partial Medicaid Expansion Policy," press release, July 29, 2019). The HAO guidance maintains this policy.

16. Assuming per enrollee spending growth does not change. Historically, there is a weak correlation between growth in medical CPI, which is intended to capture price growth across a range of health care services and commodities, and growth in per adult enrollee Medicaid expenditures.

17. Spending per Medicaid enrollee commonly fluctuates from year to year. From 2000 to 2012, growth in Medicaid spending per nondisabled adult enrollee ranged from

under 1 percent per year to more than 11 percent. See Christian J. Wolfe, Kathryn E. Rennie, and Christopher J. Truffer, *2017 Actuarial Report on the Financial Outlook for Medicaid* (CMS Office of the Actuary, Oct. 2018), Table 22.

18. Wolfe, Rennie, and Truffer, *2017 Actuarial Report,* 2018; and Robin Rudowitz et al., *Medicaid Enrollment & Spending Growth: FY 2019 & 2020* (Henry J. Kaiser Family Foundation, Oct. 2019).

19. The cost of any new spending on social determinants of health would not be built into the caps but would be subject to the cap. The flexibility to use block grant funds for such spending, therefore, would likely come at the expense of traditional medical care.

20. Kentucky's waiver approval, invalidated in federal court, permitted the state to change premium amounts without having to seek additional federal approval.

21. The guidance states that CMS may adjust block grants in the case of a "major economic event." Such events are not defined, nor is the adjustment assured.

22. Medicaid.gov, "Medicaid Enrollment Data Collected Through MBES," Centers for Medicare and Medicaid Services, n.d.

23. Medicaid and CHIP Payment and Access Commission, "MACStats, Section 3, Exhibit 15," MACPAC, Dec. 2019.

24. Medicaid.gov, "Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data," Centers for Medicare and Medicaid Services, n.d.

25. Congressional Budget Office, "Medicaid — CBO's May 2019 Baseline," CBO, May 2019; and AARP DataExplorer, "Population Projections by Age, Sex, and Race/Ethnicity," AARP Public Policy Institute, n.d.

26. The guidance does not explicitly rule out that these populations could be subject to HAO caps. However, for purposes of this modeling, we do not assume that states will propose or that CMS will approve putting optional members of these groups into HAOs.

27. The ACA established the new adult group as a mandatory eligibility category. However, the U.S. Supreme Court ruling in *National Federation of Independent Business v. Sebelius* (2012) made coverage of this group voluntary with states. For the purposes of this analysis, we consider the new adult group to be optional.

28. State Health Access Data Assistance Center, "State Health Compare," SHADAC, n.d.

29. We relied on the experiences of Louisiana and Montana to identify an expected ramp up rate in expansion enrollment.

30. The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) required states, by April 1, 1990, to provide Medicaid coverage to pregnant women with income up to 133 percent of the federal poverty level (or the state's income threshold at the time of enactment, if higher). Therefore, all individuals enrolled in Medicaid on the basis of a pregnancy with incomes below each state's OBRA '89 income threshold are considered mandatorily enrolled, while those with incomes above this level but below each state's current upper income eligibility limit for pregnant women are considered optionally enrolled. Section 1931 of the Social Security Act provides authority for states to provide medical assistance to families (including parents) and requires states to extend Medicaid eligibility to families meeting July 16, 1996, Aid to Families with Dependent Children (AFDC) eligibility criteria. It also provides states the option to lower income standards to the standards effective under each state's state plan on May 1, 1988. For the purposes of this analysis, we consider the 1988 income threshold to be the "mandatory" threshold for individuals enrolled in Medicaid on the basis of being a parent/caretaker relative. All such individuals below this threshold are considered mandatory, while those with incomes above this level but below each state's current upper income eligibility limit for parents/caretaker relatives are considered optional.

31. American Community Survey, "PUMS Data," U.S. Census Bureau, last updated Jan. 21, 2020.

32. Medicaid and CHIP Payment and Access Commission, "MACStats, Section 3, Exhibit 22," MACPAC, Dec. 2019.

33. Medicaid.gov, "Expenditure Reports from MBES/CBES," Centers for Medicare and Medicaid Services, n.d.

34. Wolfe, Rennie, and Truffer, *2017 Actuarial Report,* 2018.

35. Wolfe, Rennie, and Truffer, *2017 Actuarial Report,* 2018.

ABOUT THE AUTHORS

Cindy Mann is a partner with Manatt Health. She has more than 30 years of experience in federal and state health policy, focused on health coverage, financing, access and operational issues. She guides states, providers, plans, consumer organizations and foundations on creating and implementing strategies around federal and state health reform, Medicaid, Children's Health Insurance Program (CHIP), and delivery and payment system transformation. Ms. Mann joined Manatt from the Centers for Medicare and Medicaid Services (CMS), where she served as deputy administrator and director of the Center for Medicaid and CHIP Services. At CMS, she led the administration of Medicaid, CHIP, and the Basic Health Program at the federal level for more than five years during the implementation of the Affordable Care Act.

Jocelyn Guyer, M.P.A., a managing director with Manatt Health, provides policy expertise, strategic advice, and technical support to states, foundations, and a range of clients on the implementation of the Affordable Care Act, delivery system reform, Medicaid, and the Children's Health Insurance Program. She has served as an advisor to the National Governors Association Center for Best Practices, the National Academy for State Health Policy, and the American Academy of Pediatrics, among others. Ms. Guyer received her M.P.A. from the Princeton University Woodrow Wilson School of Public Policy and International Affairs.

Adam Striar is a manager with Manatt Health. He provides policy analysis, operational, research, and project management support to health care stakeholders, including health care providers, payers, foundations, life sciences companies, and federal and state governments. Mr. Striar joined Manatt from his role as project assistant in the Office of the Dean at the New York University Robert F. Wagner Graduate School of Public Service.

Devin Stone is a manager in Manatt Health's Washington, D.C., office. An economist with a strong understanding of both health care policy and the industry at large, he supports analytics related to payment and delivery system reform, redesign and innovation, as well as health reform implementation for hospitals, health systems, states, and local communities. Prior to joining Manatt, Mr. Stone worked as an economist in the Centers for Medicare and Medicaid Services' Office of the Actuary.

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For more information about this brief, please contact:
Cindy Mann
Partner
Manatt Health
cmann@manatt.com

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