

**CANCELLED**



**HEALTH AND HUMAN SERVICES COMMITTEE  
INFORMATIONAL MEETING AGENDA**

Date & Time of Meeting: **Tuesday, January 10, 2017 at 7:00 p.m.**

Meeting Location: **Courthouse Assembly Room – B-105 – Courthouse**

**Health & Human Services Committee Members:** Matt Bootz, Chair, John Robinson, Vice-chair, Bill Miller; Orval Quamme; Katie Rosenberg, Maynard Tremelling, Dave Wysong

**Marathon County Mission Statement:** *Marathon County Government serves people by leading, coordinating, and providing county, regional, and statewide initiatives. It directly or in cooperation with other public and private partners provides services and creates opportunities that make Marathon County and the surrounding area a preferred place to live, work, visit, and do business. (Last updated: 12-20-05)*

**Health & Human Services Committee Mission Statement:** *Provide leadership for the implementation of the strategic plan, monitoring outcomes, reviewing and recommending to the County Board policies related to health and human services initiatives of Marathon County.*

1. **Call Meeting to Order**
2. **Public Comment (15 minute limit)**
3. **Educational Presentations/Outcome Monitoring Reports**
  - A. The Changes in the Law Authorizing Long-Term Care Districts to Convert to Private Non-Profit Corporations:
    1. The Benefit of this Change
    2. The Impact on People Needing Long-Term Care Service
  - B. Letter to Governor Walker Regarding Lincoln Hills
4. **Policy Issues Discussion and Committee Determination to the County Board for its Consideration**
  - A. Department of Social Services
    1. Position Upgrade to Administrative Coordinator
    2. Management Restructure to Create:
      - One FTE IM Consortia Manager Position
      - One FTE Business Manager
      - One .625 Accountant Position
  - B. Authorizing the Dissolution of Community Care Connection of Wisconsin (formerly Community Care of Central Wisconsin)
  - C. What is the Expected Impact on Marathon County if Federal Medicaid Funds are Block Granted to the State?
  - D. Letter of Support for Active Aging Center in Rib Mountain
5. **Next Meeting Logistics and Topics:**
  - A. Committee members are asked to bring ideas for future discussion
  - B. Next Scheduled Meeting: Monday, January 16, 2017 at 4:30 p.m.
6. **Announcements**
7. **Adjournment**

*“Any person planning to attend this meeting who needs some type of special accommodation in order to participate should call the County Clerk’s Office at 715-261-1500 or e-mail [infomarathon@mail.co.marathon.wi.us](mailto:infomarathon@mail.co.marathon.wi.us) one business day before the meeting.*

**SIGNED** /s/ Matt Bootz \_\_\_\_\_  
Presiding Officer or Designee

FAXED TO: Wausau Daily Herald, City Pages, and  
FAXED TO: Other Media Groups  
FAXED BY: M. Palmer  
FAXED DATE: \_\_\_\_\_  
FAXED TIME: \_\_\_\_\_

NOTICE POSTED AT COURTHOUSE  
BY: M.. Palmer  
DATE: \_\_\_\_\_  
TIME: \_\_\_\_\_



January 3, 2017

Governor Scott Walker  
115 East Capitol  
Madison, WI 53702

Dear Governor Walker:

I understand that there have been discussions regarding Lincoln Hills Juvenile Correctional Institution, and the potential exploration of regionally-based alternatives for juvenile corrections.

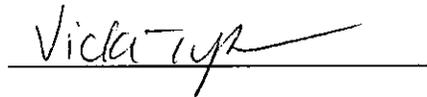
As the Director of Marathon County's Social Services Department, I strongly support the continued evaluation of juvenile justice reforms, including alternative correctional models, which are grounded in evidenced-based research. However, as alternative regional models are explored, I ask that your office continue to be particularly mindful of the potential statewide implications of a regional juvenile correctional model. In the event that current state allocations to Lincoln Hills would be diverted to pursue a regional correctional model, the potential financial impact to those counties that would continue to utilize Lincoln Hills as a correctional placement would be significant. The relative cost for such counties would increase dramatically. Like most other counties, which do not have suitable placement alternatives for children with such high levels of correctional need, Marathon County would find it extremely difficult to absorb these increased costs given available tax levy resources. For that reason, any changes to our existing state juvenile correctional placement model need to be thoroughly examined and considered from the vantage point of all counties that currently utilize Lincoln Hills as a correctional placement for their youth.

While the financial viability our correctional model is a significant consideration, the most important factor in evaluating our juvenile correctional systems must be the quality of care afforded to the juvenile and the ultimate protection afforded the community by meaningful and effective treatment within the institution. As a member of the Wisconsin Human Service Counties Association (WCHSA), I have received updated information from John Pacquin, Division Administrator, regarding the current policies and procedures being utilized by staff at Lincoln Hills.

In my professional judgement, it appears that many improvements have been put in place to address safety and programming concerns and to achieve better communication with placing counties. I was particularly impressed with the current operations and future planning regarding the integration of trauma informed practices and utilization of evidence-based programs and interventions.

The Department of Social Services in Marathon County is responsible for processing intake and disposition of juvenile cases. As such, we support programs that will provide positive results for youth and keep the community safe. We ask that the discussions around juvenile justice reform continue and, as decisions are made, quality of service, access and cost are considered from all counties' perspectives.

Sincerely,

A handwritten signature in cursive script, appearing to read "Vicki Tylka", written over a horizontal line.

Vicki Tylka  
Director

As Chair of the Marathon County Board, I concur with the content of this letter.

A handwritten signature in cursive script, appearing to read "Kurt Gibbs", written over a horizontal line.

Kurt Gibbs  
County Board Chair

# **Marathon County Social Services Request for Management Team Restructure**

December 8, 2016

## **Program**

The management team currently consists of three managers and eight supervisors to oversee the operations of the agency and programs. In the past five years, there has been three structural changes to the management team. In 2012, the Accounting Supervisor position was downgraded to Accountant with supervisory duties transferred to the Fiscal Services Manager and the Deputy Director position was increased from .75 to full time with oversight of the social work section and renamed Child Welfare Manager. Also, in 2013, two new supervisory positions were added, one in Economic Support to support staffing increases with the Affordable Care Act; and the second as a social work supervisor to split the Child Protective Services – Ongoing and Children’s Long Term Support programs into two programs based on the growth in each area.

## **Staffing Opportunities**

The current Support Programs Manager oversees two economic support supervisors and one child support supervisor for Marathon County, in addition to coordinating and attending operational meetings on behalf of the IM Consortium. The current occupant of this position has announced her retirement for February, 2016.

Additionally, the current Fiscal Services Manager has expressed her desire to work part-time in an accounting role.

## **Solutions**

With the anticipated changes in management, structural changes were evaluated. The goal was to realign ratio of direct reports to supervisors to a more manageable level, and build capacity in Administrative and Child Support Management, as well as to enhance the IM Central Consortium program. This comprehensive proposal includes changes to three positions that are intertwined. See attached revised management restructure organizational chart.

First, development of the Income Maintenance Manager to oversee Economic Support operations for Marathon County and the IM Central Consortia. This position will supervise the two ES Supervisors for Marathon County and coordinate operations with ES management for the three partner counties – Langlade, Oneida and Portage. This position will replace the current Support Programs Manager, with Child Support transferring under a different member of DSS management. (See Request for Income Maintenance Consortium Manager for more details)

Second, the current Fiscal Services Manager position will be renamed Business Manager and will directly supervise eight fiscal and two executive staff as well as oversee the Administrative Programs Supervisor and Child Support Supervisor. This position assumes authority over all financial staff, including transfer of two Child Support Financial Specialists to relieve the workload of the current Child Support

Supervisor. The Business Manager position has enhanced capacity to oversee Child Support, with the creation of the .65 FTE (25 hour per week) senior accounting professional. This position will provide lead worker support, and complete tasks such as budget preparation, State/County contract monitoring and Uniform Grant Guidance oversight which are currently performed by the Fiscal Services Manager.

With the acquisition of the senior accounting professional, the Business Manager will oversee two four-year degreed accountants to support the fiscal integrity of the department and budget preparation and will provide oversight to their workload.

**Financial**

Administrative positions are funded through a variety of sources including Federal, State and Local funds, depending on which unit the staff is providing support services. The variation of funding sources is not a straight line conversion of the costs savings due to the differences of matching sources.

The current Support Program Manager position is funded with both IM Funding and Child Support Funding. The proposed Consortium Manager will be fully funded using incentive funds earned by all four partner counties, pooled and utilized for funding the position.

The current Fiscal Manager is allocated 100% to Agency Management, Support and Overhead, which has a blended rate of 37% reimbursement for 2017. With oversight of Child Support, additional revenues can be drawn down, to achieve a blended rate of 51.5% federal reimbursement.

The new .625 FTE accountant will be allocated to Agency Management, Support and Overhead, which will draw down 37% in Federal revenues.

The fiscal impact of this restructure is a cost savings of \$35,546 levy to Marathon County.

<b>Proposed Modifications to DSS Leadership Structure</b>				
<b>Current Structure</b>				
Position Description	Expenses	Revenues	Levy	
Senior Social Service Manager	118,074	67,716	50,358	(1)
Senior Social Service Manager	111,659	41,314	70,345	(2)
<b>Total Levy Needed - Current Structure</b>			120,703	
<b>Future Structure</b>				
Position Description	Expenses - Mid	Revenues- Mid	Levy- Mid	
IM Manager	107,886	107,886	-	(3)
Business Manager	107,886	55,561	52,325	(4)

Senior Acctg. Professional (.625 FTE)	52,116	19,283	32,833	(5)
<b>Total Levy Needed - Future Structure</b>			85,158	
<b>Levy Savings</b>			<b>35,546</b>	
(1) Revenues: 62% Reimbursed at 50%, 38% Reimbursed at 66%				
(2) Revenues: 100% Reimbursed at 37%				
(3) Revenues: 100% Reimbursed at 100%				
(4) Revenues: 50% Reimbursed at 37%, 50% Reimbursed at 66%				
(5) Revenues: 100% Reimbursed at 37%				

# **Marathon County Social Services Request for Administrative Position Upgrade**

December 8, 2016

## **Program**

The Administrative Unit supports the three major program areas – Child Support, Economic Support and Social Work and has a wide variety of staff skill sets and job classifications. The Administrative Unit has participated in many lean projects and has reduced their workforce by 6.825 FTE staff (26.4%) since 2008 through attrition and streamlining processes.

## **Staffing Issues**

Our current staffing level is at 19.0 FTE. Additionally, the administrative section has two part-time senior aides through the Senior Community Service Employment Program who provide 1.0 FTE of service to the unit for minimal cost. We also utilize the summer intern program through the Department of Public Instruction to complete additional projects.

The administrative unit began a team restructuring in 2014 to provide consistent services to their internal customers. Throughout the restructure process, administrative staff have been able to identify additional services to provide to the agency. In addition to increasing support to the social work section to accommodate high volume of cases and the economic support section for the Affordable Care Act open enrollment, the administrative section is leading the implementation of a new software, The Clinical Manager (TCM), to replace an existing system.

Fifty percent of a Social Service Specialist in the administrative section was dedicated to supporting TCM to assist in process evaluation, procedure documentation, testing and system support for the social work section. The other portion of the position supported General Access and Economic Support. Due to programmatic changes, job duties shifted to other staff for the General Access and Economic Support job tasks. From May 2016 through October 2016, this position was assigned to support the social work section and in October 2016 the individual was promoted to Social Worker and the administrative social service specialist position is now vacant.

The team restructuring in 2014 did not address the executive assistance support team. Currently, there is one individual, an administrative coordinator, who provides the primary support to the management team for confidential matters, coordinating meetings/interviews, and processing agency payroll. Since this position is greatly relied upon by the management team and the agency, coverage must consistently exist and currently there are as many as four backups for the administrative coordinator on the various tasks.

## **Solutions**

After evaluating the current workload and needs of not only the administrative section, but the agency

as the whole, additional support is needed in an administrative coordinator role and the TCM software build and transition must continue. The proposed change is to upgrade the vacant Social Service Specialist position (B22 pay grade) to an Administrative Coordinator (B23 pay grade). The upgraded position will include fifty percent support to TCM as well as fifty percent coverage for the current Administrative Coordinator. This new structure will provide more continuous support for essential duties as well as allow for the TCM software build to continue, with a goal of having all units operational by January 1, 2018.

**Financial**

Administrative positions are funded through a variety of sources including Federal, State and Local funds, depending on the program for which the staff provides support services. The variation of funding sources is not a straight line conversion of cost savings due to the differences of matching sources.

The current Social Service Specialist position funding is 100% county tax levy. The current Administrative Coordinator position is funded with 37% matching sources. By allocating 50% of the upgraded position to Administrative Coordinator position, levy savings will occur:

<b>2017 Budget</b>				
<b>Proposed Modifications to Admin Support</b>				

<b>Current Structure - No Matching Revenues Available</b>				
Employee Name	Position Description	Expenses -Mid	Revenues - Mid	Levy - Mid
Vacant - SS	Social Service Specialist	67,757	-	67,757
<b>Total Levy Needed - Current Structure</b>				<b>67,757</b>

<b>Future Structure - 37% Matching Revenues Available on 50% of Position</b>				
Employee Name	Position Description	Expenses -Mid	Revenues - Mid	Levy - Mid
Vacant - SS	Administrative Coordinator	71,869	13,296	58,573
<b>Total Levy Needed - Future Structure</b>				<b>58,573</b>

<b>Levy Savings</b>				<b>9,184</b>
---------------------	--	--	--	--------------

# **Marathon County Social Services Request for Income Maintenance Consortium Manager**

December 8, 2016

## **Program**

The IM Central Income Maintenance Consortium was created in 2012, with Marathon, Langlade, Oneida and Portage counties. Since inception, Marathon County has been the lead county for state/county contracts and fiscal administration, under County Board Resolution. During the past six years, the consortium has accommodated numerous workload and programmatic changes primarily due to the Affordable Care Act, by varying staffing levels between 53 and 63 FTEs. The IM Central Consortium has met the vast majority of performance expectations, and will continue to need to build efficiencies to remain and improve on those outcomes.

In the IM Central Consortium model, each county has retained employment of their staff, and state and federal revenues are distributed by Marathon County back to member counties based upon actual expenses.

In 2015, the Department of Health Services, which administers the Income Maintenance program, completed an Income Maintenance Operational Analysis report, which compared the 10 consortia on a variety of measures. DHS has required each consortium to develop a work plan to improve efficiencies. One item identified during the IM Central work plan is to build consistency among the four counties. The current model assigns Marathon County's Support Program Manager to oversee the Consortium's Operational committee. Barriers exist in effectively addressing programmatic changes for efficiencies as the manager does not have position authority within the counties other than Marathon. Consortium meetings and strategic planning occur to develop teamwork and implement changes; however supervisors and staff tend to advocate for their individual county's perspective and way of doing business rather than being consistently united for the best interest of the consortium.

## **Staffing Opportunities**

The current Support Programs Manager oversees two economic support supervisors and one child support supervisor for Marathon County, in addition to coordinating and attending operational meetings on behalf of the IM Consortium. The current occupant of this position has announced her retirement for February, 2016.

## **Solutions**

Evaluation of the current structure included evaluation of IM Central's performance outcomes as contracted with the Department of Health Services, as well as reviewing operations and structures of other existing consortia. Three out of ten consortia have managers to oversee operations at a consortia level, rather than county based.

The creation of an IM Central consortia manger is supported by all four county Directors, to more effectively manage operations and improve efficiencies and program outcomes. The position would directly supervise Marathon County ES supervisors and provide guidance and direction to the other ES supervisors, as overseen by the County Directors.

**Financial**

Economic Support is funded heavily by state and federal sources. In the 2017 budget, nearly 80% of costs associated with ES are funded by non-levy sources. Currently, the Support Programs Manager oversees both ES and Child Support programs. In the proposed structure, the IM Manager would only oversee the ES program, but not solely for Marathon County; the focus is on the consortium.

In addition, DHS has secured Federal Incentive dollars, which have been passed along to the counties. All four member counties earned these incentives which will be combined and reinvested to draw down an additional 50% match for the purpose of funding the new IM Manager position. For the IM Consortia, the anticipated Federal Incentives for July 1, 2014 through December 31, 2016 would fully fund this position for over four years. Incentive funding is anticipated to be stable in the future, according to the Department of Health Services. However, if the incentive funding becomes unavailable in the future, the IM Central Consortium Directors would need to evaluate the effectiveness of the IM Manager position to determine if it should be maintained, with financial adjustments made elsewhere in the programming budget.

<b>Proposed Modifications to IM Manager</b>
---

Position Description	Expenses -Mid	Revenues - Mid	Levy - Mid
Program Manager	107,886	107,886	-
<b>Total Levy Needed - Future Structure</b>			-

Federal Incentives - 2014, 2015 & 2016		249,235.00
Federal Match (50%)		249,234.00
Total Available		498,469.00
Years Position Funding Available		4.62

## **Economic Support: Program Overview**

**January 2017**

The Economic Support Program determines eligibility and maintains benefits for the following federal and state programs:

- Medicaid (BadgerCare Plus, BadgerCare Core, Family Planning Only Services, Nursing Home and Long Term Care Medical Assistance) provides health care coverage to individuals and families that meet financial and non-financial eligibility criteria.
- FoodShare helps low-income individuals and families to purchase food to obtain a more nutritious diet.
- Caretaker Supplement provides a cash supplement to households where all caretakers are receiving Supplemental Security Income (SSI) payment.
- Child Care assists working families with the cost of daycare for their children; certification of individuals to provide child care services.

Economic Support is an important factor in accessing Medical Assistance benefits for people who require insurance to pay for needed therapy and medical supports undergoing treatment for alcohol and drug issues, as well as to determine financial eligibility for public long term care services, such as nursing home and Family Care.

Economic Support ensures proper medical insurance and FoodShare assistance for the most vulnerable populations in our community. Without the assurance of basic needs, families are unable to successfully nurture and guide their children into a full productive life.

The foundation of Economic Support is ensuring basic needs. In addition, the specialists refer to community services that can further support the families in gaining financial stability.

This program is performed within the IM Central Consortium which consists of Langlade, Marathon, Oneida and Portage Counties. Marathon County is the Lead County for the Consortium.

## **Child Support: Program Overview**

**January 2017**

The Child Support Program is a cooperative county, state and federal effort designed to ensure that all children are financially and medically supported by their parents. Through the collection of both financial and medical support, the Child Support Program helps to ensure the economic well-being of children who reside in single parent households, helps to reduce their welfare dependence and helps to reduce the costs related to welfare. Components of the program include paternity establishment, location of missing non-custodial parents, establishing child support and medical support obligations, setting income withholding, collecting current and past-due support and enforcing court ordered support.

As noted in Wisconsin Statute 59.53, the county is mandated to provide this program. The Child Support Unit at DSS provides services that are required by the Department of Children and Families to meet this mandate.

Child Support helps families to receive needed financial support which is essential for parents to be able to provide a nurturing and enriched experience for their children. Child Support Program results in less reliance on public assistance programs, which bring better outcomes to children over their lifetime in educational, social, and health outcomes.

Child Support is an essential service to ensure families receive the support that is due them, to diminish the need to rely on public assistance. Sufficient income supports the acquisition of basic needs. The program has a strong connection with the Economic Support program for those receiving public assistance. Child Support specialists also refer to community services to ensure their client's basic needs are met.

**MEMORANDUM**

**TO:** Hon. Members of the County Boards of Marathon, Portage, and Wood Counties

**FROM:** Andrew T. Phillips, Patrick C. Henneger  
von Briesen & Roper, s.c.

**DATE:** December 9, 2016

**RE:** Dissolution of Community Care Connections of Wisconsin (formerly Community Care of Central Wisconsin)

---

**BACKGROUND**

As you recall, Community Care Connections of Wisconsin (“CCCW”) (formerly named Community Care of Central Wisconsin) is a long-term care district formed by Marathon, Portage, and Wood counties by resolution pursuant to Wis. Stat. § 46.2895 for purposes of delivering services as a managed care organization (MCO) under the State of Wisconsin’s Family Care program.

In 2016, the Wisconsin State Legislature enacted 2015 Wisconsin Act 215 authorizing long-term care districts to convert to private, nonprofit corporations. In April 2016, CCCW’s Board of Directors passed a resolution to jointly create a non-profit corporation and merge operations with two other long-term care districts, ContinuUs and Western Wisconsin Cares (“WWC”). The non-profit corporation was created in August 2016 following approval from the Department of Health Services (DHS). In November 2016, DHS approved the transfer of the assets and liabilities each long-term care district to the non-profit corporation and certified the corporation as an MCO effective January 1, 2017.

As of January 1, 2017, CCCW will cease active operations and will begin the process of winding down its organizational and financial affairs. The final step of winding down operations is the dissolution of the district, which requires joint action by CCCW’s Board and the county boards that formed the district. This memo describes the dissolution process including dissolution resolutions that must be passed by each county board that formed the district.

**THE DISSOLUTION PROCESS**

The procedure for dissolving a long-term care district is set forth in Wis. Stat. § 46.2895(13). It states:

(13) Dissolution. Subject to the performance of the contractual obligations of a long-term care district and if first approved by the

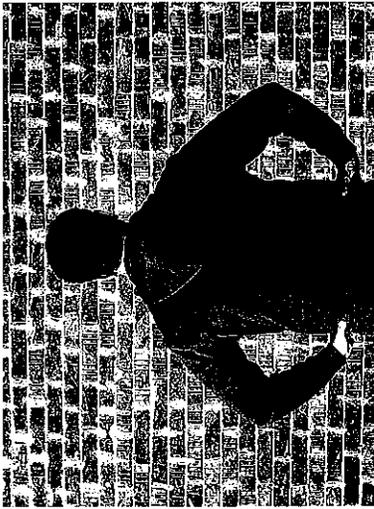
secretary of the department, the long-term care district may be dissolved by the joint action of the long-term care district board and each county or tribe or band that created the long-term care district and has not withdrawn or been removed from the district under sub. (14). If a long-term care district that is created by one county or tribe or band is dissolved, the property and assets of the district shall be transferred to the department. If a long-term care district is created by more than one county or tribe or band, all of the counties or tribes or bands that created the district and that have not withdrawn or been removed from the district under sub. (14) shall transfer the property and assets of the district to the department. If the long-term care district operates a care management organization under s. 46.284, disposition of any remaining funds in the risk reserve under s. 46.284 (5) (d) shall be made under the terms of the district's contract with the department.

In sum, there are three necessary actions for dissolution of a long-term care district: (1) approval for the dissolution from the Secretary of DHS; (2) approval from the district board; and (3) approval from each of the counties that formed the district. In our experience, and notwithstanding the statute's contemplated order of events, the Secretary of DHS will not take action authorizing dissolution unless and until a district board and the county boards that formed the district have taken action authorizing dissolution.

### **THE DISSOLUTION RESOLUTIONS**

The CCCW Board of Directors requests that the three county boards that formed CCCW authorize CCCW's dissolution by resolution of each board. A copy of a template resolution is provided with this memorandum. We ask that the counties adopt the resolutions as soon as practicable and return them to Attorney Andrew Phillips, von Briesen & Roper, s.c., 411 E. Wisconsin Ave., Suite 1000, Milwaukee, WI 53202. Once the resolutions are adopted, CCCW's Board will pass a final resolution dissolving the district and will file the resolutions with the Secretary of DHS to complete the dissolution process.

If you have any questions concerning this memorandum or the dissolution process, please do not hesitate to contact us.



## Medicaid

Turning Medicaid into a block grant is not a new or innovative idea—it is just another way to cut Medicaid. Block granting Medicaid would ultimately mean cuts in services to people who need health care the most. It would also put states completely on the hook for unanticipated health care costs—instead of sharing the risk of higher Medicaid spending with the federal government.

# Block Grants: A Bad Idea for Medicaid

## Medicaid Block Grants Put States and Medicaid Enrollees at Risk

A “block grant” is a fixed amount of money that the federal government gives to a state for a specific purpose. If Medicaid was turned into a block grant, the federal government would set its Medicaid spending amount in advance. That amount would presumably be based on some estimate of state Medicaid costs, but most block grant proposals start with significant reductions in federal Medicaid support.

Once the amount is set by the federal government, it will not change, even if a state’s actual program costs are greater than the allotted amount. If a state’s costs exceed the amount of the block grant, it will have to use its own funds to make up the difference or, more likely, cut services for low-income residents, including children, seniors, and people with disabilities.

## Medicaid Block Grants Don’t Give States More Flexibility

States already have a lot of flexibility in their Medicaid programs. They have flexibility in

- » the services covered
- » the way health care providers are paid for those services
- » how services are delivered, such as whether managed care is used and how managed care contracts are structured
- » eligibility levels<sup>1</sup>

Each state can design a program that fits its particular health care system and that best meets the needs of its residents.

If a block grant proposal includes reductions in federal Medicaid spending, as most do, states will start out with less federal funding than they have now. States will have to either make up

that lost funding or cut insurance benefits or program eligibility. At the end of the day, the only real “flexibility” a Medicaid block grant would give states is the flexibility to decide how to make up Medicaid funding shortfalls: which services to cut, which hospital or doctor payments to cut, which taxes to raise, or which non-health care programs to cut.

### **Medicaid Block Grants Would Make It Harder for States to Serve Their Residents**

The federal government has been a reliable partner for state Medicaid programs since Medicaid was created in 1965. The federal match rate for the traditional Medicaid program

is always at least half of all Medicaid costs, and for the Medicaid expansion population, it is much higher. This structure insulates states from unexpected cost increases and ensures coverage for low-income residents.

The current federal Medicaid funding structure also helps states provide better health insurance to their residents than they could do on their own. States can do more to help kids get a healthy start in life, provide long-term and home care to seniors and people with disabilities, and provide health care to pregnant women and low-income working families. Turning the program into a block grant would put states—and their residents—at risk.

Turning Medicaid into a block grant would put states and Medicaid enrollees at financial risk, and it would make it harder for states to serve their residents’ health care needs. There is no reason for politicians to change a federal funding structure that has worked well for more than 50 years.

### **Endnotes**

<sup>1</sup> All states must cover several specific groups of people, including low-income children, pregnant women, and certain seniors and people with disabilities. But states have significant flexibility in the coverage they provide to other adults and in the eligibility levels they set for the remaining seniors and people with disabilities.

This fact sheet was written by:  
**Dee Mahan**, Director of Medicaid Advocacy, Families USA

The following Families USA staff contributed to the preparation of this material (listed alphabetically):

Nichole Edralin, Senior Graphic Designer  
William Lutz, Director of Communications  
Ingrid VanTuinen, Director of Editorial

A complete list of Families USA publications is available at:  
[www.familiesusa.org/publications](http://www.familiesusa.org/publications)  
© Families USA 2016 / MCD041516

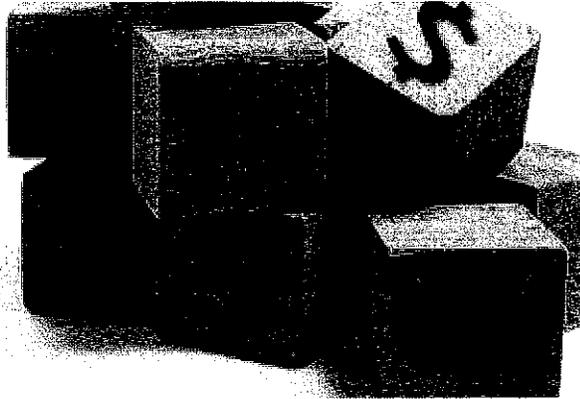
**FAMILIESUSA**  
THE VOICE FOR HEALTH CARE CONSUMERS

1201 New York Avenue NW, Suite 1100  
Washington, DC 20005  
202-628-3030  
[info@familiesusa.org](mailto:info@familiesusa.org)  
[www.FamiliesUSA.org](http://www.FamiliesUSA.org)  
facebook / FamiliesUSA  
twitter / @FamiliesUSA



## How Medicaid Block Grants Would Work

By Marilyn Werber Serafini and Mary Agnes Carey | March 6, 2011



Mississippi Gov. Haley Barbour and other Republican governors recently demanded that Medicaid, the state-federal health program that covers 50 million poor and disabled, be transformed into block grants. "Y'all would save a lot of money if you let us run the program," Barbour told a congressional committee.

Such statements are being embraced by House Republicans, who are vowing to tackle costly programs to reduce federal spending. But any

effort to turn Medicaid into block grants federal lump-sum payments to states raises a host of questions. Democrats argue such a move could result in loss of health care coverage for millions of people who are poor, sick and old.

Beyond the argument is a deeper debate: What should the federal government do to help states maintain a safety net? How should Washington handle fast-growing entitlement programs such as Medicaid, Medicare (the federal health program for seniors and disabled) and Social Security? The issues could have a big impact on the 2012 elections. Here's how the battle is playing out:

### **How would a Medicaid block grant work?**

Democrats and Republicans agree that turning Medicaid, which in fiscal 2009 cost state and federal governments \$366 billion, into a block grant would fundamentally alter the program.

Because Medicaid is an entitlement program, everyone who is eligible is guaranteed a spot. The federal government, which pays for nearly 60 percent of the cost, has an open-ended commitment to help states cover costs; in return, it requires them to cover certain groups of people and to provide specific benefits. For example, children, pregnant women who meet specific income criteria and parents with dependent children must be covered.

A block grant would effectively end this open-ended approach and provide states with annual lump sums. States would be freer to run the program as they wanted. But states would also be responsible for covering costs beyond the federal allotment.

### **I'm not on Medicaid. Why should I care about this?**

First, under the new health care law, an estimated 16 million more people will become eligible for

Medicaid in 2014. So, before long, a lot more people will be in the program or know someone who is.

Second, the debate, which gets to the core of the social contract between the government and its citizens, has implications for the other big entitlement programs — Social Security and Medicare. Last year, the federal government spent \$1.5 trillion on those programs, which consumed about 43 percent of the federal budget, according to the Congressional Budget Office.

In a March 3 interview with The Wall Street Journal, House Speaker John Boehner said House Republicans' upcoming budget proposal would curb entitlements, including Social Security and Medicare, despite the political risk of taking on such popular programs.

Democrats are skeptical. Turning Medicaid into a block grant means "you have no guarantee that people who are now covered will continue to be covered, or whether [the states] will simply cut back on their Medicaid program," says Rep. Henry Waxman, D-Calif., a longtime champion of the program.

### **Why are Republican governors pushing for block grants?**

Governors have long lobbied for a freer hand on Medicaid, which they say would result in a cheaper, more effective program. Lately, Republican governors have more aggressively pursued the block-grant idea, partly because they're worried about the cost of adding millions more people to the program beginning in 2014. (The federal government will pick up the whole tab for new enrollees for the first three years, tapering down to 90 percent in 2020 and beyond.) Governors also are alarmed at Medicaid's growth rate, which the CBO estimates at 7 percent annually over the next decade. The program, some state officials say, is crowding out other needs, such as education.

The Republican governors also have other reasons to complain about Medicaid's costs. They're pushing hard to get leeway from the Obama administration on a rule barring them from tightening Medicaid eligibility before 2014. Some governors want to cut people from the rolls right away.

Matt Salo, executive director of the National Association of Medicaid Directors, says that talk of block grants is a "distraction. The real issue, as the president said to [governors at their Washington meeting] is, if there are Medicaid flexibilities we can do, let's do them."

Critics of block granting argue it wouldn't solve states' fiscal woes. "Governors keep talking about how [block grants] would improve predictability and stability for Medicaid and their budgets," says Edwin Park, vice president for health policy at the liberal Center on Budget and Policy Priorities. But block grants, he says, are intended primarily to produce savings for the federal government.

### **What are the prospects for block granting Medicaid?**

Not good at the moment. Even if such legislation passed the House, which is dominated by Republicans, the Democratic-controlled Senate would kill it. But things could change if the GOP were to take control of Congress and the White House in 2012.

## **Haven't Republicans proposed Medicaid block grants before?**

Yes. Block grants were pushed by President Ronald Reagan in 1981, House Speaker Newt Gingrich in 1995 and President George W. Bush in 2003. Gingrich came the closest to succeeding. Congress passed legislation to turn Medicaid and the welfare system into block grants, but President Bill Clinton ultimately agreed only to block grant welfare, which became the Temporary Assistance for Needy Families program.

## **What exactly are House Republicans proposing now?**

They haven't unveiled any proposal yet, but one idea getting serious consideration is a proposal developed by House Budget Committee Chairman Paul Ryan, R-Wis., and Alice Rivlin, a senior fellow at the Brookings Institution, who served as director of the Office of Management and Budget under Clinton.

Under their plan, the federal share of Medicaid would be converted to a block grant in 2013, and be indexed to increase with the size of the Medicaid population as well as the growth in the gross domestic product per capita plus 1 percentage point. States would have more flexibility to administer the program. According to the CBO, the plan would reduce federal spending by \$180 billion over the next decade.

## **What do people think about it?**

Liberals say the Rivlin-Ryan plan wouldn't keep up with rising Medicaid costs. Edwin Park of the Center on Budget and Policy Priorities says that federal Medicaid funding would grow up to 1.5 to 2 percentage points less each year than under the current system, and not provide additional funding if there were a recession.

But Brian Blase, a policy analyst at the conservative Heritage Foundation, says that the Ryan-Rivlin proposal would get rid of "perverse incentives for states to bring as much into their Medicaid umbrella as possible."

He also dismisses Park's assumption that a block grant would be so rigid that it would not allow for additional federal contributions to account for population growth and recessions.

*Marilyn Werber Serafini is the Kaiser Family Foundation's Robin Toner Distinguished Fellow based at Kaiser Health News. The fellowship honors the late Robin Toner, The New York Times' long-time health and politics reporter whose work often framed the public debate on health issues. KHN is an editorially independent program of the foundation.*

**CATEGORIES: Medicaid, States, The Health Law**

**maryagnesc@kff.org | @MaryAgnesCarey**

© 2016 Kaiser Family Foundation. All rights reserved.

Add your thoughts   
here (optional)  **Post to**  