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Senate Fiscal Agency

## AN OVERVIEW OF MEDICAID BLOCK GRANTS AND PER CAPITA CAPS AND A HYPOTHETICAL EXAMPLE OF MICHIGAN

by

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Please contact John Maxwell, SFA Associate Director, with any comments or questions on this paper.

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## INTRODUCTION

Recently, attention has grown on the increase in Federal debt and deficits. One area of Federal spending pursued in the past for reform is the Medicaid program. Past reform efforts centered around ways to control future cost growth. Two proposals that include Federal cost containment are converting Medicaid to a block grant and altering Medicaid to a "per capita cap" program style.

It would be difficult to derive an exact fiscal impact on the State of Michigan from any given change in the Federal-State Medicaid financing structure without exact policy proposals. Given no definitive proposed changes, this paper makes no fiscal impact determination on the State of Michigan for currently pending Federal legislation. Rather this paper aims to explain past reform proposals to assist others in understanding the intricacies of Medicaid block grants and per capita caps by using prior proposals and actual historical data for a hypothetical analysis of implementation.

Using past Congressional proposals and actual Michigan Medicaid expenditures, under a hypothetical block grant model implemented in fiscal year (FY) 2019-20, there would have been significant costs to the State to maintain the Medicaid expansion program at similar programmatic levels.

Under a hypothetical per capita cap system, it appears that though the per capita cap was exceeded for the disabled eligibility type for two of the years covered by the model, the total cost of implementation was not excessive relative to total state spending on the Medicaid program.

## BRIEF BACKGROUND ON THE MEDICAID PROGRAM

Medicaid was created by Congress in 1965 as a health insurance program for low-income individuals.[i] As a safety-net health insurer, Medicaid covers low-income individuals older than 65 years of age, low-income people with disabilities, low-income children and their families, and low-income pregnant women. Medicaid eligibility varies by state, and historically most adults (especially those without children) were ineligible for coverage. The original Medicaid program that covers the aged, disabled, children, and certain qualifying adults is referred to as Traditional Medicaid.

In 2014, as part of the Affordable Care Act (ACA), Medicaid eligibility was expanded to uninsured adults under age 65 in families with incomes below 133% of the Federal Poverty Level.[1] Michigan's version of Medicaid expansion is known as the Healthy Michigan Program.

Medicaid is jointly funded by both the Federal government and the states and is administered by states. The costs are split between the Federal and state governments through a formula called Federal Medical Assistance Percentage (FMAP). The FMAP is calculated annually based on each state's per capita income compared to the national average. The non-Federal portion of Medicaid funding is referred to as the state share.[ii]

The FMAP differs between Traditional Medicaid and Medicaid expansion. From FY 2017-18, Michigan's FMAP for Traditional Medicaid has averaged 64.6%. The FMAP for Medicaid expansion for all states started at 100% and gradually dropped to 90% by FY 2019-20. For FY 2024-25, the Traditional Medicaid FMAP is 65.13% and the FMAP for Medicaid expansion remains at 90%.

[1] Though statute states up to 133% of Federal poverty limit, because of calculations of a 5% income disregard, the actual income limit for Medicaid expansion is 138%.

## INTRODUCTION TO BLOCK GRANTS AND PER CAPITA CAPS

From calendar year 2000 through calendar year 2022, total (Federal and state) nationwide Medicaid spending increased from $203 billion to $829 billion, an increase of 308%.[iii] As a percentage of overall United States health spending, Medicaid's share increased from 14.9% to 18.6%.[iv] Medicaid funding reformers support changing the Medicaid Federal cost-sharing mechanics to limit the risk of future spending growth by modifying Medicaid from an open-ended categorical grant to a different cost-sharing structure with a more prescribed Federal share. Two proposals that would limit future Federal cost growth are changing Medicaid to a block grant and a per capita cap allocation.

### *Block Grants*

A block grant is a type of grant-in-aid from the Federal government to state or local governments. Block grants are a predetermined amount of funding set by Congress to achieve a broad purpose such as a reduction in poverty or improving public health. The two other broad types of Federal grant-in-aid programs are categorical grants and revenue sharing. For further explanation of Federal grant types, please see Appendix I.

One of the dominant features of block grants is that the funding is fixed for a given year and is not tied to the number of participants in the program. One example of a block grant is the Temporary Assistance for Needy Families (TANF) block grant. The program's broad intent is to assist low-income families with economic security and stability. Under this grant design, the Federal government provides a block grant or annual fixed amount to each state to operate state-designed programs that achieve the broad aim of economic security and stability. In Michigan, the TANF block grant is used for various purposes, but one of the State-run programs is a cash assistance program known as the Family Independence Program.

Block grants have been used in the past to supplement service levels for existing state and local funding priorities such as education but also to implement broad national objectives with state and local entities (law enforcement), create national minimum standards (substance use and mental health services), and devolution of authority to state and local governments.[v]

One feature of block grants is a concept called maintenance of effort. Maintenance of effort requires a state not to decrease its expenditures below a specified level in the areas in which the Federal government is providing the block grant funding. This is to ensure that a state does not use the Federal money to replace existing state expenditures in that area.

According to the Congressional Research Service, in FY 2021-22, the Federal government awarded $60.4 billion in block grants to state and local governments. The largest block grant that the Federal government disburses is the TANF grant at $16.5 billion in FY 2021-22.[vi]

### *Per Capita Caps*

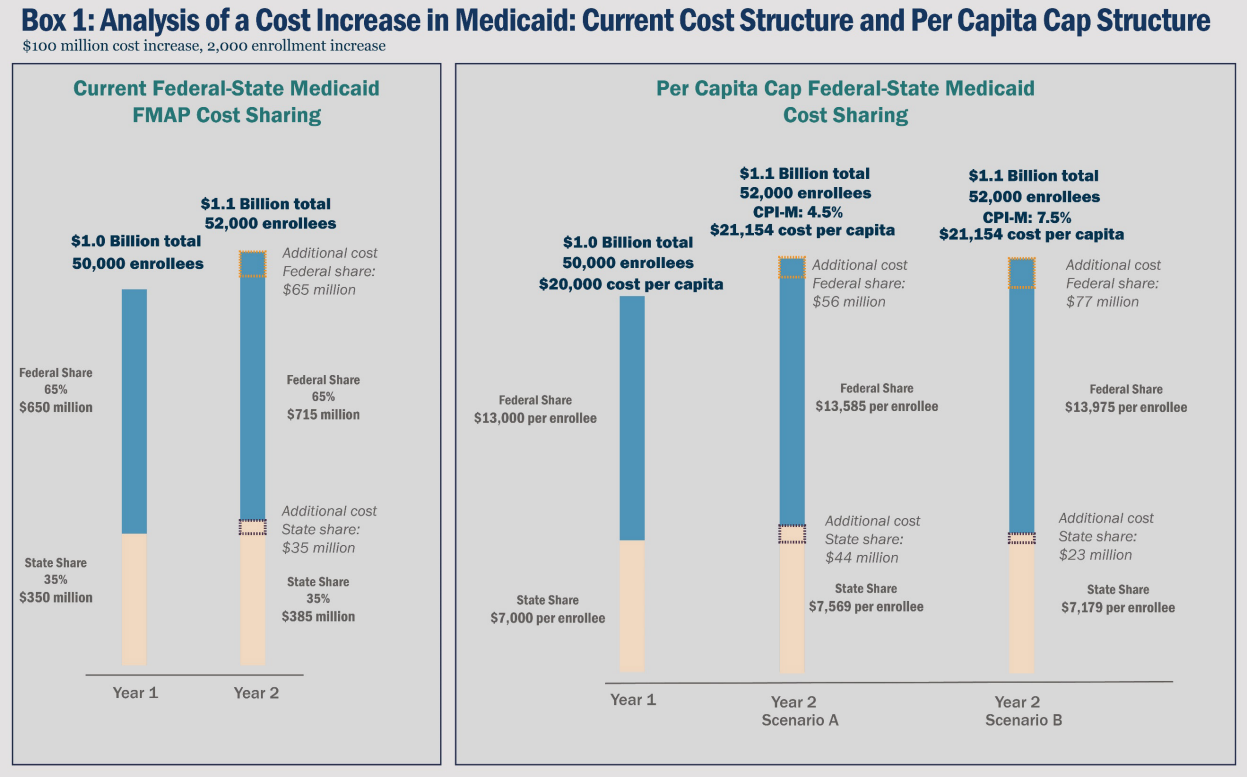
Per capita caps on Medicaid function like block grants with an upper limit on Federal spending and any spending on services above the limit must be absorbed by the state. In a per capita cap system, there are several different ways to enforce a cap. The Federal government could set a baseline amount for all Medicaid recipients, differentiate caps for each eligibility category, or impose a cap for certain eligibility categories.

Past proposals include increasing the Federal amount of the per capita cap year to year based on changes to healthcare prices (the Consumer Price Index – Medical (CPI-M)).[vii] The per capita cap would set a ceiling or cap on what the Federal government spends for a given

individual. Some of the proposals differentiate the cap amount based on eligibility group; this means, for example, that people with disabilities may have a higher cap amount than children.

If an eligibility group experienced a large cost increase that exceeded the pledged Federal share of the costs, the State would have to increase revenue to make up the cost difference or decrease costs by potentially changing the types of services offered in order to maintain the level of services.

Box 1 shows the mechanics of how an additional cost would be treated under the current Medicaid financing structure and a general per capita cap process.




Cost increase under the current Federal-state Medicaid process:

- State A has 50,000 individuals enrolled in the Medicaid program and FMAP was 65%.
- In Year 1, the total cost of coverage for the 50,000 people was $1.0 billion with the Federal government paying $715.0 million and the State paying the remaining $350.0 million.
- In Year 2, the enrollment increased to 52,000 and the total cost increased by $100.0 million to $1.1 billion. The FMAP remains at 65%, so of the $100 million increase, $65 million is funded by the Federal government and $35 million from State A. The 10% increase is passed on to both entities with a constant level of cost sharing.

Cost Increase under Per Capita Allotment Cost-Sharing Scenario A:

- State A has 50,000 individuals enrolled in the Medicaid program at a cost of $1.0 billion. This works out to be $20,000 per individual.
- Under this example, the cap starts out with $13,000 per individual Federal share and $7,000 state share.

- In Year 2 - Scenario A, the Medicaid enrollment increased to 52,000 per individual and spending increased to $1.1 billion for a total of $21,154 cost per capita an increase of 5.8% from $20,000. The increase is made up of an enrollment increase of 4% and acuity cost increase of 1.8%.
- CPI-M increased by 4.5%, so the Federal portion of the cost increases from $13,000 to $13,585 per individual. The remaining $7,569 is funded by state funds.
- Under the conventional cost sharing method, the state's share of a $100 million increase was $35 million. Under the per capita cap methodology, the state's share is $44 million.

Cost Increase under Per Capita Allotment Cost-Sharing Scenario B:

- State A has 50,000 individuals enrolled in the Medicaid program at a cost of $1.0 billion. This works out to be $20,000 per individual.
- Under this example, the cap starts out with $13,000 per individual Federal share and $7,000 State share.
- In Year 2 - Scenario B, Medicaid enrollment increased to 52,000 per individual and spending increased to $1.1 billion for a total of $21,154 cost per capita an increase of 5.8% from $20,000. The increase is made up of an enrollment increase of 4% and acuity cost increase of 1.8%.
- In Scenario B, CPI-M increased by 7.5%, so the Federal portion of the capita allotment increased from $13,000 to $13,975 per individual. The remaining $7,179 is funded by state funds.
- Under the conventional cost-sharing method the state's share of a $100.0 million increase was $35 million. Under the per capita cap methodology, the state's share is $23.0 million.

The total cost difference between Scenario A and Scenario B is $0, but the $21.0 million difference in State funding is due to a 3.0% difference in CPI-M (7.5% - 4.5%). A higher CPI-M in Scenario B means the Federal government bears a higher percentage of the costs.

In fact, under Scenario B, State A is better off than under the conventional Medicaid cost-sharing method if other circumstances remain the same (a 66% Federal share versus 65% Federal share).

**FEDERAL MEDICAID FUNDING PROPOSALS**

There is a more-than-40-year history of proposals to change Medicaid from an open-ended reimbursement program into a block grant. There have been four major proposals in the past to modify Medicaid into a block grant type of program:[viii]

- 1981: President Ronald Reagan proposed placing a state-by-state cap on Federal Medicaid expenditures with growth in future years capped based on a price index factor.[ix]
- 1995: Congress passed a Medicaid block grant proposal that started with an annual cap on Federal Medicaid spending with a state-by-state allocation formula determination. The variables in the formula were designed to allocate funding based on a measure of "Medicaid neediness" within each state. Because of an overall cap on Medicaid spending, a state with an increase in "Medicaid neediness" may not have received a 1:1 Federal payment increase.[x]
- 2003: President George W. Bush's FY 2003-04 budget proposed granting states the option of accepting Medicaid as a block grant with a short-term increase in total Federal spending and greater program flexibility. For those states that opted into the block grant,

future grant increases would have been limited based on an overall aggregate cap of expenditures.

- 2017: Congress introduced Senate Amendment 1030 to the American Health Care Act of 2017.[xi] This plan, also known as Graham-Cassidy, (named after Senators Graham and Cassidy who introduced the amendment) among other healthcare-related changes would have repealed the Affordable Care Act (ACA), along with individual insurance market subsidies, and Medicaid expansion.[xii] The plan would have replaced both the individual insurance market and Medicaid expansion with a combined block grant program. The traditional Medicaid program with the lower FMAP would have been converted from an open-ended reimbursement categorical program to a per capita cap type of program.

## MICHIGAN'S MEDICAID PROGRAM UNDER HYPOTHETICAL REFORMS: FY 2019-20 THROUGH FY 2023-24

The following section describes a simple hypothetical representation of Medicaid reform starting in FY 2017-18 (but not enforced until FY 2019-20) with Michigan's Medicaid theoretical spending compared with Michigan's actual Medicaid expenditures.

This example assumes that the Traditional Medicaid program was transformed into a per capita cap program and the Medicaid expansion was converted to a block grant style program. Under this assumed scenario, there was no change to the number of Medicaid enrollees or the services offered. This hypothetical example does not assume any changes to the individual health insurance marketplace or health insurance premium tax credits provided under the ACA.

As the per capita cap transformation requires additional explanation, this example is presented first.

### *Per Capita Cap Assumptions*

- The Traditional Medicaid program was modified to a per capita allotment with a limitation on spending growth beginning in FY 2019-20.
- Using a three-year average of expenditures (FY 2014-15 through FY 2016-17), an initial baseline amount was established for the four Traditional Medicaid population coverage groups: aged, disabled, children, and nonexpansion adults.

Baseline amounts then grow by annual CPI-M rate per eligibility group for two fiscal years before enforcement of eligibility-based cap.

In the hypothetical example, this phase-in of the State's absorption of cost overages during FY 2017-18 and FY 2018-19 is for states to adjust Medicaid programs or revenue to the implementation of the capped allotment method.

### *Per Capita Cap Results*

Table 1 shows the difference between the hypothetical allotment and actual expenditures multiplied by the actual enrollment, which shows the total, Federal, and State costs by eligibility category. In the example, there are two years in which an allotment for an eligibility group was in deficit: FY 2019-20 and FY 2020-21 for the individuals with disabilities category. The additional costs during those two years are $333.8 million (the State costs plus any Federal overages as the allotment is capped). The aged group allotment was in deficit in FY

2017-18 and in FY 2018-19 for the disability group, but since these deficits were during the phase-in period, there was no additional State cost.

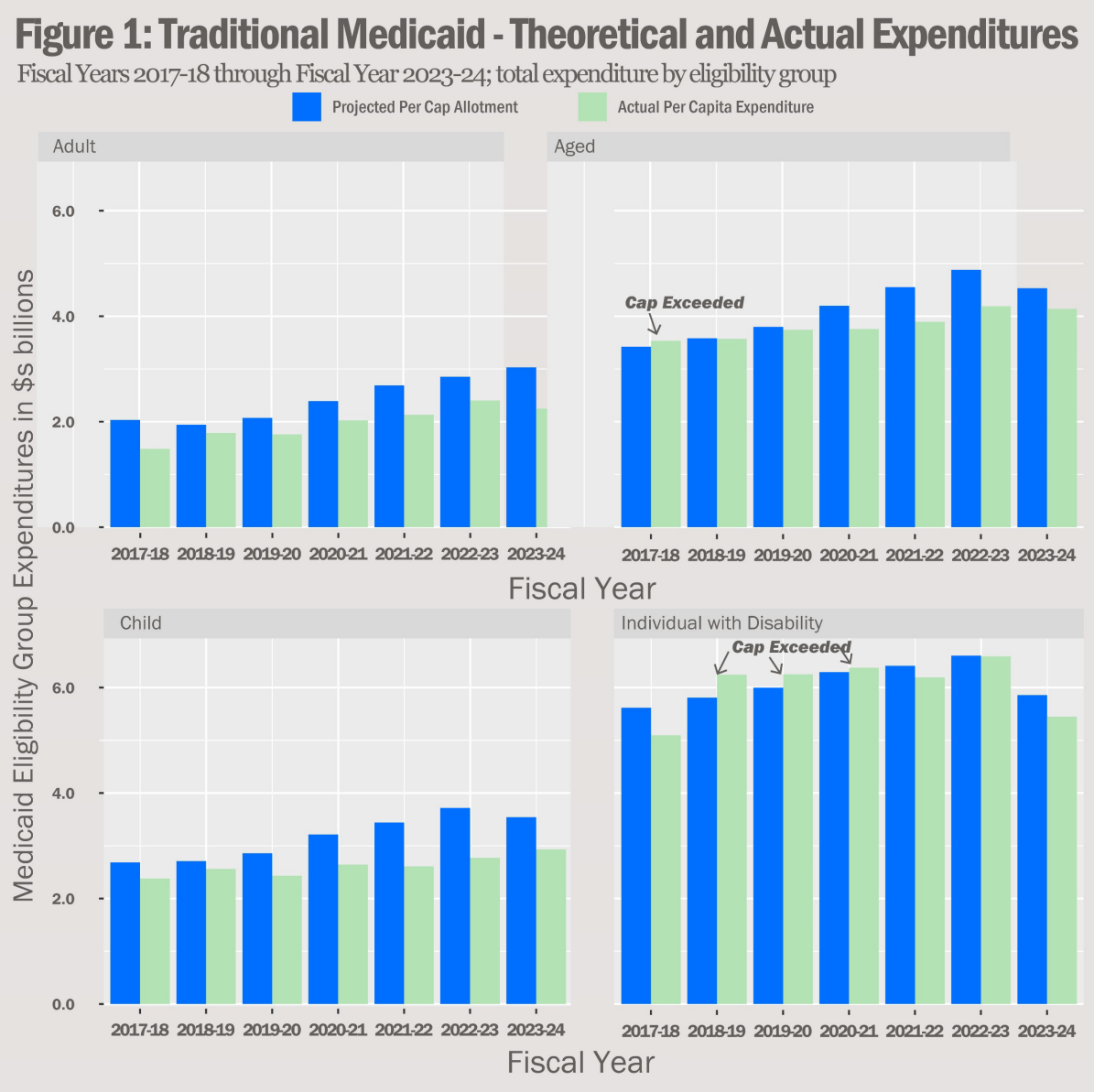
**Table 1**

| Medicaid Per Capita Allotments<br>Total Surplus/(Deficit) ($'s millions) by Traditional Medicaid Eligibility Group FY 2014-15 through FY 2023-24 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Eligibility Group** | **Projected FY 2017-18** | **Projected FY 2018-19** | **Projected FY 2019-20** | **Projected FY 2020-21** | **Projected FY 2020-21** | **Projected FY 2022-23** | **Projected FY 2023-24** |
| Adult | $546,130,400 | $155,736,000 | $312,050,700 | $368,649,200 | $555,059,300 | $451,259,000 | $784,665,000 |
| Aged | ($110,566,800) | $9,453,400 | $55,634,600 | $442,815,800 | $655,968,800 | $686,360,700 | $392,440,000 |
| Children | $303,921,900 | $147,939,100 | $426,398,700 | $573,227,300 | $831,910,500 | $943,779,100 | $607,920,300 |
| Persons with disabilities | $520,659,300 | ($431,850,400) | ($252,144,600) | ($81,668,500) | $219,076,100 | $12,575,600 | $410,479,200 |
| **Medicaid Per Capita Allotments**<br>**Federal Funds Surplus/(Deficit) ($'s millions) by Traditional Medicaid Eligibility Group FY 2014-15 through FY 2023-24** | | | | | | | |
| **Eligibility Group** | **Projected FY 2017-18** | **Projected FY 2018-19** | **Projected FY 2019-20** | **Projected FY 2020-21** | **Projected FY 2020-21** | **Projected FY 2022-23** | **Projected FY 2023-24** |
| Adult | $353,783,300 | $100,371,800 | $199,899,700 | $236,230,400 | $363,452,800 | $292,009,700 | $509,561,400 |
| Aged | ($71,625,200) | $6,092,700 | $35,639,500 | $283,756,400 | $429,528,400 | $444,144,000 | $254,850,500 |
| Children | $196,880,600 | $95,346,800 | $273,151,000 | $367,324,100 | $544,735,000 | $610,719,400 | $394,783,500 |
| Persons with disabilities | $337,283,100 | ($278,327,600) | ($161,523,800) | ($52,333,100) | $143,451,000 | $8,137,600 | $266,565,200 |
| **Medicaid Per Capita Allotments**<br>**State Funds Surplus/(Deficit) ($'s millions) by Traditional Medicaid Eligibility Group FY 2014-15 through FY 2023-24** | | | | | | | |
| **Eligibility Group** | **Projected FY 2017-18** | **Projected FY 2018-19** | **Projected FY 2019-20** | **Projected FY 2020-21** | **Projected FY 2020-21** | **Projected FY 2022-23** | **Projected FY 2023-24** |
| Adult | $192,347,100 | $55,364,100 | $112,151,000 | $132,418,800 | $191,606,500 | $159,249,300 | $275,103,500 |
| Aged | ($38,941,600) | $3,360,700 | $19,995,100 | $159,059,500 | $226,440,400 | $242,216,700 | $137,589,500 |
| Children | $107,041,300 | $52,592,400 | $153,247,700 | $205,903,300 | $287,175,500 | $333,059,600 | $213,136,900 |
| Persons with disabilities | $183,376,200 | ($153,522,800) | ($90,620,800) | ($29,335,300) | $75,625,100 | $4,437,900 | $143,914,000 |

Source: Medicaid and CHIP Payment and Access Commission, MACStats Archive Reports June 2013 through December 2024 and Centers for Medicare and Medicaid Services CMS-64 Medicaid Budget & Expenditure System (MBES) Expenditure Reports FY 2014 through FY 2023; State of Michigan SIGMA System Actual Expenditures

In Appendix II, Tables A – D show the development of projected and actual figures in a hypothetical per capita cap implementation.

Figure 1 shows the results of the total spending by eligibility group with the four instances in which the per capita allotment was breached. Under this hypothetical example, the adult and child eligibility groups did not exceed the allotment threshold.



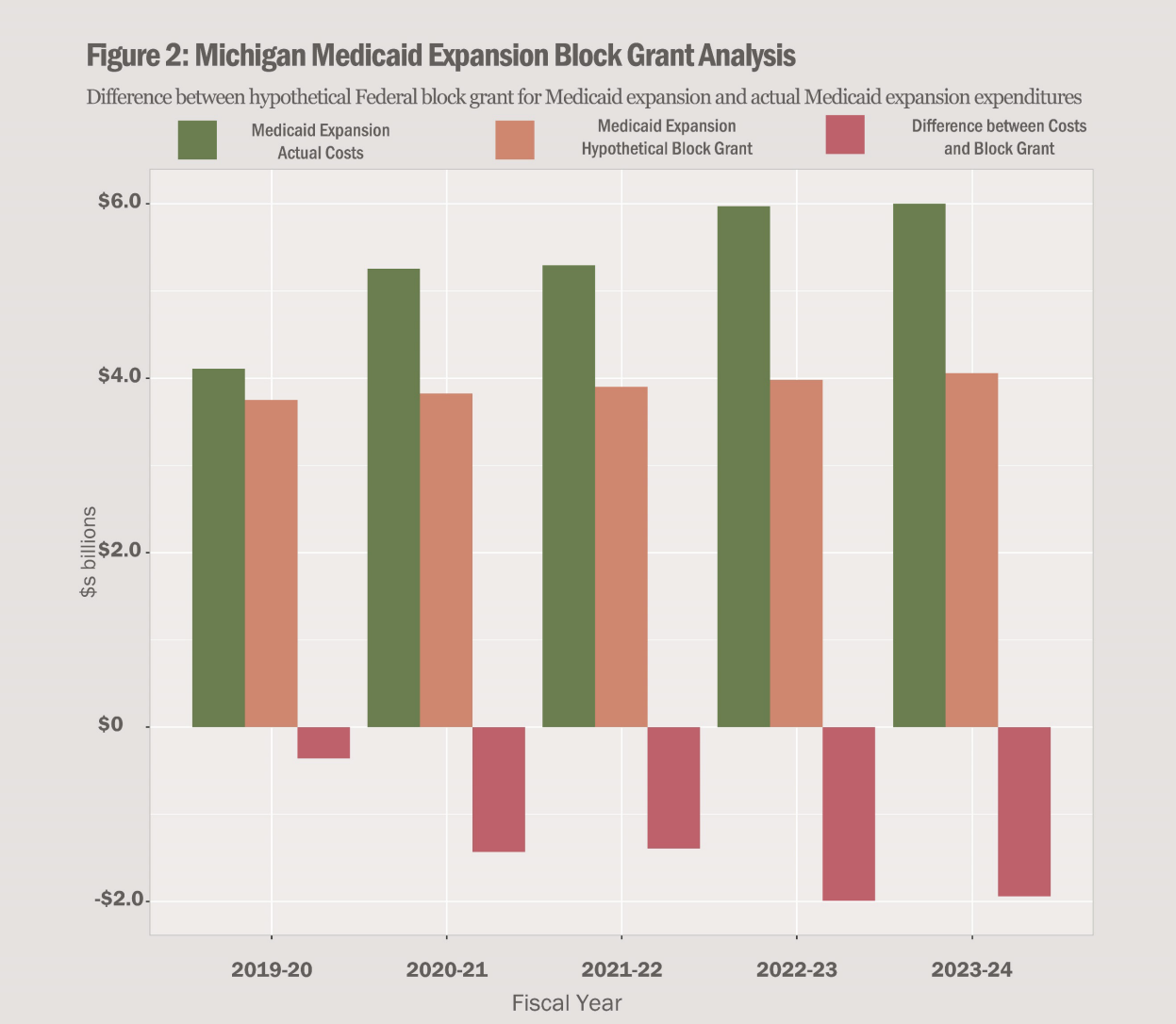

***Block Grant Assumptions***

In this hypothetical example, the Medicaid expansion program begins with a $125.0 billion block grant for the entire country and allocates the per-state amount based on an allocation of a state's share of the total population in the 50-138% of Federal poverty guidelines as of 2016. Michigan has approximately 3.0% of this population so the beginning share of the block grant is $3.75 billion. Each year, the block grant amount will grow 2.0% under this hypothetical exercise. This percentage increase (2.0%) was chosen as a long term inflation measure that has been part of past block grant discussion. For no net cost across this theoretical period, the block grant growth rate would need to have been approximately 17.65% annually.

***Block Grant Results***

Figure 2 shows that in the hypothetical example, the State of Michigan's Medicaid expansion would be in a substantial deficit from the beginning of the block grant period. The total five-

year deficit would be $7.1 billion, as the average growth rate in Michigan's Medicaid expansion program was 10.4% versus the 2% block grant growth rate.




The actual Medicaid expansion spending exceeded the block grant allocation of $3.75 billion in FY 2019-20 by $359.5 million. The initial deficit between the block grant and actual costs continues. For no deficit to occur during this hypothetical five-fiscal-year window, Michigan's initial allocation would need to be $5.1 billion. Assuming Michigan remains at 3% of the total block grant allocation, the total nationwide block grant would need to increase from $125.0 billion to $170.6 billion. That level of block grant would exceed total Federal Medicaid expansion expenditures in FY 2022-23 by $158.3 billion.[xiii] While a pursuit of deficit reduction seemingly would make absolute increases of actual spending levels unlikely, it is possible under a block grant format that non-Medicaid expansion states such as Texas and Florida could be added to the block grant pool.

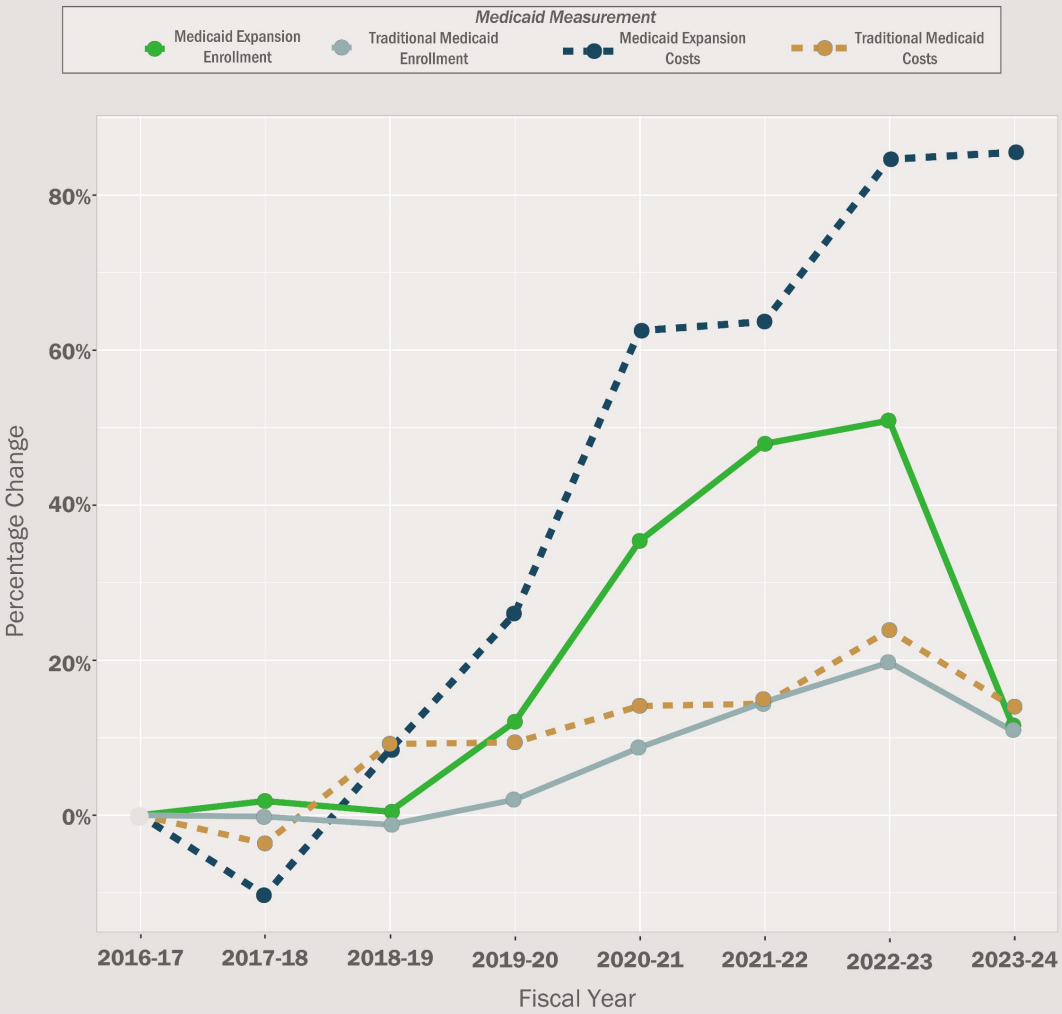
Part of the explanation for the large deficits in the hypothetical example Medicaid expansion block grant versus large deficits in the Traditional Medicaid per capita cap example is from the large increase in costs for the Medicaid expansion population in comparison to the Traditional Medicaid population. As shown in Figure 3, the enrollment for both Medicaid expansion and Traditional Medicaid increased by 11%. There was a large increase in the Medicaid expansion population during the COVID-19 public health emergency, but Medicaid

redetermination activities over the past two years have returned the Medicaid expansion population to a little more than pre-pandemic levels.

The percentage change in costs between Traditional Medicaid and Medicaid expansion have substantial differences. Medicaid expansion spending increased by 86% while the Traditional Medicaid spending has increased by only 14%. As Medicaid expansion funding increases are covered 90% by the Federal government, large increases in spending are not borne by state governments to the same degree as Traditional Medicaid.

**Figure 3: Michigan Medicaid Trends in Costs and Enrollment**

Percentage Change in Cohort Enrollment Type from Base School Year 2013-14 through 2022-23




The large increase in Medicaid expansion costs from FY 2016-17 to FY 2023-24 most likely would have looked different in a real-world block grant scenario as either the State would have modified the program, the pandemic may have changed Federal enforcement of a block grant implementation, or there may have been Federal modification in the growth of the block grant awards if deficits were a common experience among states.

There are a couple of flaws in this simple hypothetical analysis. The first flaw is there is a limitation in comparing actual costs to theoretical costs because in a true allotment of a block grant, it is highly likely Michigan would have made different policy and coverage choices for

the Medicaid expansion population. The example given in the hypothetical scenario ignores adjustments that likely would be taken to reduce the scope of the program, so the projected deficits are very large.

However, even in a scenario in which coverage or eligibility decisions were modified, if the block grant was set at $125 billion with a 2% annual growth in the overall grant, Michigan's Medicaid expansion program likely would have needed additional State resources to maintain coverage. The deficit shown in the hypothetical example is likely in excess of an actual block grant situation as the constraints of Michigan's budget would have prevented the increase in expenditures that occurred over the theoretical period.

Another flaw in the analysis for both the block grant and per capita cap scenarios is the inclusion of increased coverage requirements and additional Federal funding participation due to the COVID-19 pandemic and associated Federal statutory changes. These changes have likely increased both the enrollment and expenditures above what would have likely occurred absent these restrictions. However, a hypothetical example assuming no COVID-19 pandemic is more subjective than one that does include it. It is not certain what the implementation of a Medicaid block grant or a per capita cap would have looked like during a pandemic, so this analysis uses only the actual expenditures and enrollment as they existed.

One last identified flaw in this simple example is the assumption that the only source of the State's share is State General Purpose/General Fund and Federal Medicaid matching funds. This model does not include Medicaid provider taxes, such as the Quality Assurance Assessment Program or the Insurer Provider Assessment. These provider taxes are considered State Restricted funds and are a significant portion of State spending on the Medicaid program: $3.0 billion out of $7.9 billion in FY 2023-24. For the sake of demonstrating the concepts of block grants and per capita caps, including provider taxes complicates the issues and therefore was not part of the hypothetical calculations.

**CONCLUSION**

In this hypothetical example, Michigan's Medicaid expansion program faced a large gap between a presumed block grant amount and the actual Medicaid expansion expenditures. For reasons discussed earlier in the paper, it is not clear that the State would need to absorb the entire deficit identified through this hypothetical example. The Traditional Medicaid program does not face as great of a deficit under this scenario largely due to higher-than-average increases in the CPI-M index during 2021 through 2024. Nevertheless, if there is an enacted Federal reform of the Medicaid program (either Traditional or expansion) there will likely be a fiscal impact on the State of Michigan to maintain services. Any potential fiscal impact on Michigan depends on the type and magnitude of the reform efforts.

In addition to per capita caps and block grants, other reforms could include Medicaid work requirements for able-bodied adults, modifying the FMAP formula, a reduction in the scope of Medicaid state-directed payments (mainly a change in the use of provider taxes for Medicaid health plans), or an overall limitation on Medicaid provider taxes. It is uncertain what, if any, reform efforts Congress ultimately will enact, so this paper attempts to guide the reader through a hypothetical example of block grants and per capita caps on the State of Michigan's Medicaid program.

The Senate Fiscal Agency will stay abreast of potential changes to Medicaid and any fiscal impact on the State of Michigan.

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[iv] *Id.*
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[xi] Senate Amendment 1030 to House Resolution 1628 115th Congress
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[xiii] KFF Health News, Total Medicaid Expansion Spending FY 2023. Retrieved 1-15-2025.

**Appendix I**

The majority of the Federal grant-in-aid concepts presented in this Appendix are sourced from two Congressional Research Service Reports titled "Block Grants: Perspectives and Controversies Report" and "Federal Grants to State and Local Governments: A Historical Perspective on Contemporary Issues".

There are three main types of Federal grant-in-aid program:

a. Categorical grants.
b. Block grants.
c. General revenue sharing.

1. **Categorical grants**: awarded through a competitive application process, used only for a specifically identified purpose, limited to defined activities, and meet greater administrative and reporting conditions than other grant types.

    1. Four subtypes of categorical grants:

        a. Project categorical grant: Discretionary grants that are awarded based on a competitive application process grant with applications submitted to Federal agency or department for review and approval.
            i. Example: Abandoned Mine Land Reclamation Program
                1. There is a total of $10 million nationwide in grant funding available. States must apply based on criteria specified by Federal government. Awards are based on the strength of the application and need for the project.

        b. Formula-project categorical grant: Grants are allocated via formula to states and states determine how much funding applicants within each state will receive.
            i. Example: Weatherization Assistance Program
                1. $100 million total national award with a state receiving 5% of the award by statutory formula. State A receives $5 million and then distributes grant on competitive application process.

        c. Formula categorical grant: Eligible recipients receive funding based on formula determination.
            i. Example: Rural and Low-Income School Program
                1. $50 million is available nationwide. States qualify based on formula parameters. State B receives 2.5% of grant based on population and other factors. No further application is necessary for State B to receive $1.25 million grant award.

        d. Open-ended reimbursement categorical grant: Amount of funding is dependent on program costs and program participants.
            i. Example: Medicaid (both Traditional and Medicaid Expansion)
                1. For each eligible enrolled Medicaid patient, if there is a cost paid for an eligible service the Federal government will provide 65% of the cost and State C will provide the remaining 35%.

2. **Block grants:** Specified amounts of funding to a state or local government to assist with a broad objective, such as reducing poverty. Block grants are typically authorized by the Federal government with fewer administrative conditions and more flexible uses by the recipient as a tradeoff for lower growth in the overall funding level.

i. Example: TANF program
    1. State D receives $40 million in TANF funding to achieve a broad purpose specified by statute. State D is authorized to use those funds to achieve a broad aim.

3. **General revenue sharing:** Grants made to states based on revenue collection and population size. Funds could be used for any purpose not expressly prohibited by Federal or state law. One feature mentioned in past efforts is that states can spend their share of revenue for any purpose that their own laws would permit them to spend it had they raised the revenue themselves.
    i. Example: General Revenue Sharing
        1. $500 million in total nationwide revenue is available for sharing. State E receives an award of 7.25% based on a formula that includes State E's population and total personal income. State E receives $36.25 million to spend on any item that it is legally allowed to spend its own revenue on.

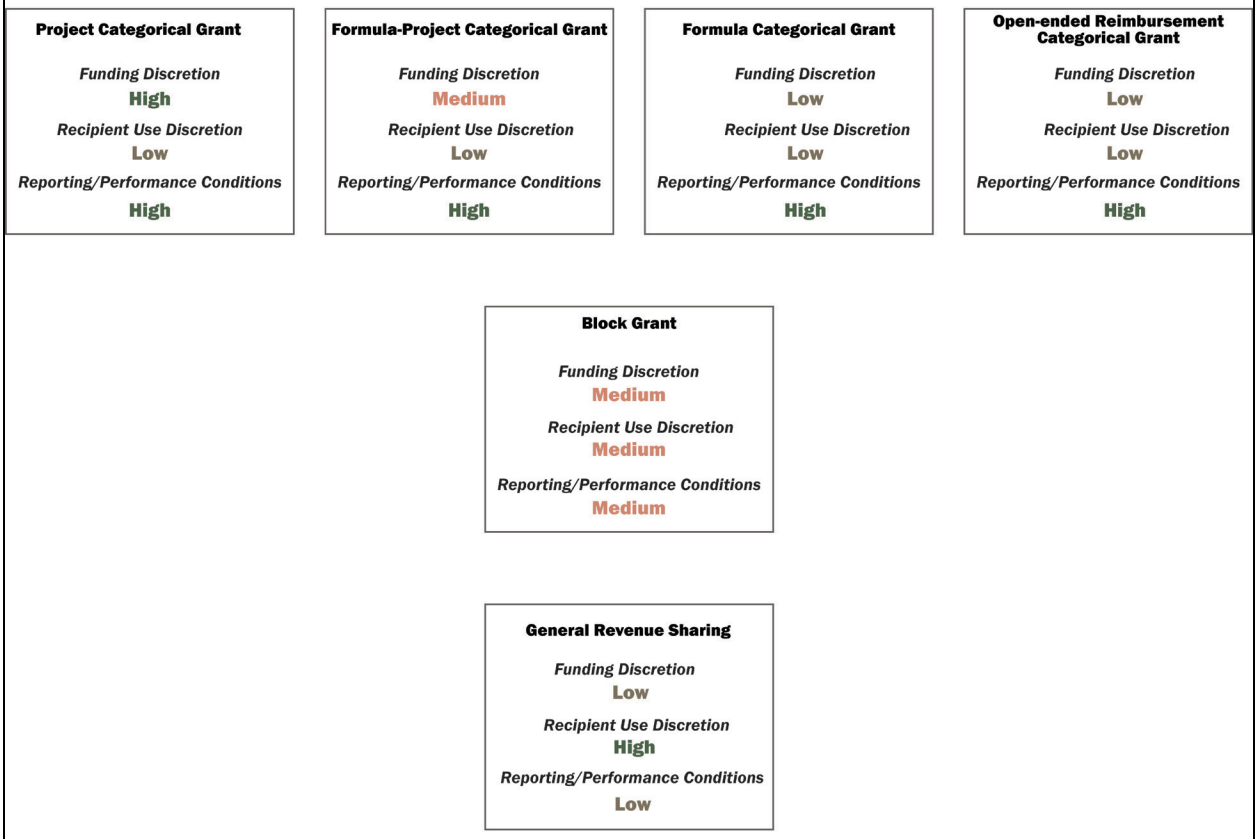
There are three main ways to distinguish a grant type:

1. The discretion of the Federal department or agency to determine which entity will receive the funding and in what amount.
2. The discretion that the grant recipient has in determining how to spend the grant.
3. The amount of reporting and conditions placed upon the grant recipient to complete the intent of the grant.

Each grant type has a tradeoff for both the Federal government and the recipient. The Federal government may want to ensure that disbursed funding is used for the purpose specified by Congress. This requires that the Federal government create or use staff to track the grants and require the recipients to provide reporting on the spending. In other cases, the Federal government may prefer that funding is directed to a state for a general purpose. Then the state can spend with more choice in how they meet that general purpose. With more freedom, the Federal government has less control in how the funding is spent.

Figure 1 below is adapted from a Congressional Research Service published table to show the continuum of attributes of Federal grant types.

# Figure 1: Spectrum of Federal Grant Type Features




Reproduced from Congressional Research Service Federal Grants to State and Local Governments: A Historical Perspective on Contemporary Issues; Table I. Classification of Grant Types by Three Defining Characteristics

## Appendix II

Table A: Projected Per Capita Allotments by Eligibility Group based on Actual Costs between FY 2014-15 through FY 2016-17

**Medicaid Per Capita Allotments**

**Projected Per Capita Allotments by Traditional Medicaid Eligibility Group FY 2014-15 through FY 2023-24**

CPI-MInflation Factor

| Total Funds Eligibility Group | Actual FY2014-15 | Actual FY2015-16 | Actual FY2016-17 | Baseline Average | Projected FY2017-18 | Projected FY2018-19 | Projected FY2019-20 | Projected FY2020-21 | Projected FY2021-22 | Projected FY2022-23 | Projected FY2023-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult | $6,838 | $5,855 | $4,710 | $5,801 | $6,037 | $6,144 | $6,268 | $6,554 | $6,671 | $6,816 | $7,086 |
| Aged | $19,464 | $21,971 | $22,251 | $21,228 | $22,093 | $22,486 | $22,939 | $23,987 | $24,414 | $24,944 | $25,931 |
| Children | $2,680 | $2,731 | $2,466 | $2,626 | $2,732 | $2,781 | $2,837 | $2,967 | $3,020 | $3,085 | $3,207 |
| Persons with disabilities | $16,549 | $15,927 | $17,455 | $16,644 | $17,322 | $17,630 | $17,985 | $18,807 | $19,142 | $19,557 | $20,331 |

| Federal Funds Eligibility Group | Actual FY2014-15 | Actual FY2015-16 | Actual FY2016-17 | Baseline Average | Projected FY2017-18 | Projected FY2018-19 | Projected FY2019-20 | Projected FY2020-21 | Projected FY2021-22 | Projected FY2022-23 | Projected FY2023-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult | $4,481 | $3,841 | $3,068 | $3,797 | $3,911 | $3,960 | $4,015 | $4,200 | $4,368 | $4,411 | $4,601 |
| Aged | $12,756 | $14,413 | $14,496 | $13,889 | $14,312 | $14,492 | $14,694 | $15,371 | $15,986 | $16,141 | $16,840 |
| Children | $1,756 | $1,792 | $1,606 | $1,718 | $1,770 | $1,792 | $1,817 | $1,901 | $1,977 | $1,996 | $2,083 |
| Persons with disabilities | $10,846 | $10,448 | $11,372 | $10,889 | $11,221 | $11,363 | $11,521 | $12,051 | $12,534 | $12,655 | $13,203 |

| State Funds Eligibility Group | Actual FY2014-15 | Actual FY2015-16 | Actual FY2016-17 | Baseline Average | Projected FY2017-18 | Projected FY2018-19 | Projected FY2019-20 | Projected FY2020-21 | Projected FY2021-22 | Projected FY2022-23 | Projected FY2023-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult | $2,356 | $2,014 | $1,641 | $2,004 | $2,126 | $2,184 | $2,253 | $2,354 | $2,303 | $2,405 | $2,484 |
| Aged | $6,707 | $7,558 | $7,754 | $7,340 | $7,781 | $7,994 | $8,244 | $8,616 | $8,428 | $8,803 | $9,092 |
| Children | $924 | $939 | $859 | $907 | $962 | $989 | $1,020 | $1,066 | $1,042 | $1,089 | $1,124 |
| Persons with disabilities | $5,703 | $5,479 | $6,083 | $5,755 | $6,101 | $6,267 | $6,464 | $6,755 | $6,608 | $6,902 | $7,128 |

Source: Medicaid and CHIP Payment and Access Commission, MACStats Archive Reports June 2013 through December 2024 and Centers for Medicare and Medicaid Services CMS-64 Medicaid Budget & Expenditure System (MBES) Expenditure Reports FY 2014 through FY 2023; State of Michigan SIGMA System Actual Expenditures

Table B: Actual Expenditures by Eligibility Group FY 2017-18 through FY 2023-24

**Medicaid Per Capita Allotments**

**Actual Expenditures by Traditional Medicaid Eligibility Group FY 2014-15 through FY 2023-24**

| Total Funds Eligibility Group | Actual FY2017-18 | Actual FY2018-19 | Actual | Actual FY2020-21 | Actual FY2021-22 | Actual FY2022-23 | Actual FY2023-24 |
|---|---|---|---|---|---|---|---|
| Adult | $4,414 | $5,652 | $5,324 | $5,544 | $5,294 | $5,738 | $5,250 |
| Aged | $22,807 | $22,427 | $22,603 | $21,457 | $20,894 | $21,434 | $23,685 |
| Children | $2,423 | $2,629 | $2,414 | $2,438 | $2,290 | $2,302 | $2,657 |
| Persons with disabilities | $15,716 | $18,941 | $18,741 | $19,051 | $18,488 | $19,520 | $18,906 |

| Federal Funds Eligibility Group | Actual FY2017-18 | Actual FY2018-19 | Actual FY2019-20 | Actual | Actual FY2021-22 | Actual FY2022-23 | Actual FY2023-24 |
|---|---|---|---|---|---|---|---|
| Adult | $2,859 | $3,642 | $3,410 | $3,552 | $3,466 | $3,713 | $3,410 |
| Aged | $14,774 | $14,454 | $14,479 | $13,750 | $13,682 | $13,870 | $15,381 |
| Children | $1,570 | $1,695 | $1,546 | $1,562 | $1,499 | $1,489 | $1,725 |
| Persons with disabilities | $10,181 | $12,207 | $12,005 | $12,208 | $12,106 | $12,631 | $12,278 |

| State Funds Eligibility Group | Actual FY2017-18 | Actual FY2018-19 | Actual FY2019-20 | Actual | Actual FY2021-22 | Actual FY2022-23 | Actual FY2023-24 |
|---|---|---|---|---|---|---|---|
| Adult | $1,555 | $2,009 | $1,913 | $1,991 | $1,827 | $2,025 | $1,841 |
| Aged | $8,033 | $7,973 | $8,123 | $7,707 | $7,213 | $7,564 | $8,304 |
| Children | $853 | $935 | $868 | $876 | $790 | $812 | $931 |
| Persons with disabilities | $5,535 | $6,733 | $6,735 | $6,843 | $6,382 | $6,889 | $6,628 |

Source: Medicaid and CHIP Payment and Access Commission, MACStats Archive Reports June 2013 through December 2024 and Centers for Medicare and Medicaid Services CMS-64 Medicaid Budget & Expenditure System (MBES) Expenditure Reports FY 2014 through FY 2023; State of Michigan SIGMA System Actual Expenditures

Table C: Difference between Actual Expenditures and Projected Allotments by Eligibility Group FY 2017-18 through FY 2023-24

**Medicaid Per Capita Allotments**

**Difference between Actual and Projected by Traditional Medicaid Eligibility Group FY 2014-15 through FY 2023-24**

| Total Funds Eligibility Group | Actual FY2017-18 | Actual FY2018-19 | Actual | Actual FY2020-21 | Actual FY2021-22 | Actual FY2022-23 | Actual FY2023-24 |
|---|---|---|---|---|---|---|---|
| Adult | $1,623 | $493 | $944 | $1,011 | $1,377 | $1,078 | $1,835 |
| Aged | ($714) | $59 | $336 | $2,530 | $3,520 | $3,510 | $2,246 |
| Children | $309 | $152 | $423 | $529 | $730 | $784 | $551 |
| Persons with disabilities | $1,606 | ($1,311) | ($756) | ($244) | $654 | $37 | $1,425 |

| Federal Funds Eligibility Group | Projected FY2017-18 | Projected FY2018-19 | Projected FY2019-20 | Projected | Projected FY2021-22 | Projected FY2022-23 | Projected FY2023-24 |
|---|---|---|---|---|---|---|---|
| Adult | $1,051 | $318 | $605 | $648 | $902 | $698 | $1,192 |
| Aged | ($462) | $38 | $215 | $1,621 | $2,305 | $2,272 | $1,459 |
| Children | $200 | $98 | $271 | $339 | $478 | $507 | $358 |
| Persons with disabilities | $1,040 | ($845) | ($484) | ($156) | $428 | $24 | $925 |

| State Funds Eligibility Group | Projected FY2017-18 | Projected FY2018-19 | Projected FY2019-20 | Projected | Projected FY2021-22 | Projected FY2022-23 | Projected FY2023-24 |
|---|---|---|---|---|---|---|---|
| Adult | $572 | $175 | $339 | $363 | $475 | $381 | $644 |
| Aged | ($251) | $21 | $121 | $909 | $1,215 | $1,239 | $788 |
| Children | $109 | $54 | $152 | $190 | $252 | $277 | $193 |
| Persons with disabilities | $566 | ($466) | ($272) | ($88) | $226 | $13 | $500 |

Table D: Traditional Medicaid Enrollment by Eligibility Group FY 2014-15 through FY 2023-24

**Traditional Medicaid Enrollment**

| Eligibility Group | FY2014-15 | FY2015-16 | FY2016-17 | FY2017-18 | FY2018-19 | FY2019-20 | FY2020-21 | FY2021-22 | FY2022-23 | FY2023-24 |
|---|---|---|---|---|---|---|---|---|---|---|
| Adult | 311,672 | 309,369 | 351,610 | 336,502 | 315,962 | 330,412 | 364,773 | 402,983 | 418,432 | 427,498 |
| Aged | 150,000 | 145,205 | 148,845 | 154,898 | 159,242 | 165,577 | 175,028 | 186,358 | 195,526 | 174,712 |
| Children | 984,534 | 964,684 | 980,552 | 981,992 | 974,135 | 1,007,737 | 1,083,524 | 1,139,767 | 1,204,539 | 1,104,101 |
| Persons with disabilities | 375,000 | 368,299 | 319,719 | 324,249 | 329,492 | 333,496 | 334,701 | 334,974 | 337,671 | 288,087 |
| Total Non-Expansion Enrollment | 1,821,206 | 1,787,557 | 1,800,726 | 1,797,641 | 1,778,831 | 1,837,222 | 1,958,026 | 2,064,082 | 2,156,168 | 1,994,398 |