

Partnership for Medicaid Partnership for Medicaid

THREATS TO MEDICAID: IMPACT ON THE SAFETY NET

Medicaid – The Backbone of the Safety Net

One in five Americans, spanning all walks of life, receives health insurance through the Medicaid program. It serves as the safety net for the elderly in nursing homes, working families, children, pregnant women, and people with disabilities. With this many Americans relying on Medicaid, it is vital that the program retains and improves its ability to ensure beneficiaries actually have a place to go for care – since coverage does not equate to access. To accomplish this goal, states must address administrative barriers and provide adequate payments to providers to ensure Medicaid beneficiaries have the same access to care as the rest of society and that providers are able to recoup enough of the costs associated with caring for these beneficiaries to stay in business.

Changes to Medicaid Eligibility Rules

The Medicaid program guarantees coverage for different categories of vulnerable populations, and while states have tremendous flexibility in deciding which populations to cover, the federal government has always specified certain populations that states must cover. This important protection ensures people who would otherwise lack access to coverage are able to get it and reflects a substantial federal financial commitment.

Proposals changing eligibility rules would seriously impede the ability of vulnerable, low-income Americans to access care before they become ill or their health status further deteriorates, which often leads to greater utilization of care in higher-cost settings, such as emergency departments, that may be avoided. Changes to Medicaid eligibility levels would threaten Medicaid's ability to cover the very populations it was intended to protect. We urge Congress and the administration to consider the impact any changes to Medicaid eligibility rules would have on the nature of the program and its providers and beneficiaries. We urge policymakers to support policies that preserve and strengthen the Medicaid program, such as raising the eligibility floor for adults and retaining the maintenance of effort provisions in the Affordable Care Act.

A Medicaid Block Grant or Global Spending Cap

The Partnership has long opposed Medicaid block grants. Block grants would arbitrarily cap the amount of federal funding available to state and local governments and are often proposed in exchange for increased state flexibility. But arbitrarily limiting federal Medicaid contributions would force state and local governments to either raise taxes or pass Medicaid costs along by either 1) cutting benefits to Medicaid enrollees, 2) reducing or limiting eligibility, or 3) reducing rates to providers.

- If benefits are limited, beneficiaries may be forced to go without necessary care. Similarly, health plans may be forced to prioritize benefits or patients to make up for a loss in revenue because of inadequate rate increases or even rate cuts, in which case optional services, such as adult dental, may be eliminated.
- If eligibility is limited, providers such as nursing homes, children's hospitals, safety net hospitals, and community health centers would likely see an increase in uninsured and underinsured in their patient load, thereby increasing their uncompensated care burden.
- If provider rates are reduced, many providers would be forced either out of business or to stop accepting Medicaid patients. As other providers stop seeing Medicaid patients, community health centers and hospitals that are open to all patients regardless of insurance status or ability to pay

will see a significant impact. Reduced provider rates also undermine the very business model of other providers that see a large volume of Medicaid patients, such as nursing homes, safety net hospitals, and children's hospitals.

A global spending cap would function similarly to a block grant, placing a finite limit on the amount of money the federal government can spend, thereby limiting the federal funding available for entitlement programs such as Medicaid and the Children's Health Insurance Program. While a global spending cap would not necessarily specify an up-front dollar limit for Medicaid spending (as a block grant would), the limit on available funding means that it would likely have the same impact as a block grant.

A Per Capita Cap

A per capita cap has been floated as a politically palatable alternative to a Medicaid block grant. A per capita cap sets one all-encompassing, upper payment limit that the federal government will pay per beneficiary. The Partnership has a number of concerns about how such a cap would be implemented, and has yet to see a workable proposal. A per capita cap is guaranteed to impact each state differently based on how the federal matching rate is set. In addition, a per capita cap may not be sufficient to cover the cost of care for some Medicaid-eligible individuals – such as seniors in nursing homes or disabled children in need of the many habilitative services that are part and parcel of the early and periodic screening, diagnostic, and treatment (EPSDT) benefit, which is truly the foundation of the Medicaid program. Given the highly disparate needs (and corresponding costs) among different Medicaid-eligible populations, a per capita cap would need to reflect the breadth of populations and services that are currently covered by Medicaid, account for risk adjustment, and build in an appropriate inflation factor to keep pace with the natural growth of the Medicaid program over time. If such a proposal were to include incentives for quality improvement, for example, details of the incentive structure and baseline measurement would matter greatly.

A Blended FMAP

States currently receive varied federal matching rates for different populations and services. Arguments can be made on both sides of the policy as to whether state and local governments should receive the same dollar amount per beneficiary. However, the Partnership has a policy concern with the proposed solution: To date, publicly available blended rate proposals (which would provide for a single matching rate to a state for all populations and services) would simply be an arbitrary cut to the current sum total federal match with no foundation or policy rationale for what that rate would be. The proposal does not actually reduce the cost of care or “bend the cost-curve,” so ultimately it would impact providers' ability to care for patients and force states to either absorb a large cost-shift or pass those costs along to providers or beneficiaries, just as a block grant would.

Provider Taxes

Provider taxes are tax revenues paid by providers and used by states to help finance their Medicaid program – 46 states and the District of Columbia use provider taxes in some form to help pay for the nonfederal share of their Medicaid program. Provider taxes enable states to maintain a stable, functioning Medicaid program, and limiting their use does not increase efficiency or performance – it simply shifts costs onto states. Without this revenue stream, states would be forced to find revenue from other sources or dramatically cut back their Medicaid program, which would shift the high costs of indigent care onto local governments, providers, and beneficiaries. Limiting states' ability to use provider taxes in accordance with the Centers for Medicare & Medicaid Services' current regulations will create a greater strain on states' already stretched budgets and negatively impact the care available to Medicaid beneficiaries.

*The **Partnership for Medicaid** is a nonpartisan, nationwide coalition of safety net providers, counties, labor and health plans. Over the years, the Partnership has been responsible for proposing successful Medicaid endeavors, such as emergency room diversion programs that have reduced cost while improving quality and health care delivery. The Partnership is committed to continuing in this role by offering solutions and identifying areas of concern. Contact Shawn Gremminger, First Co-Chair of the Partnership, with any questions: 202-585-0112.*