

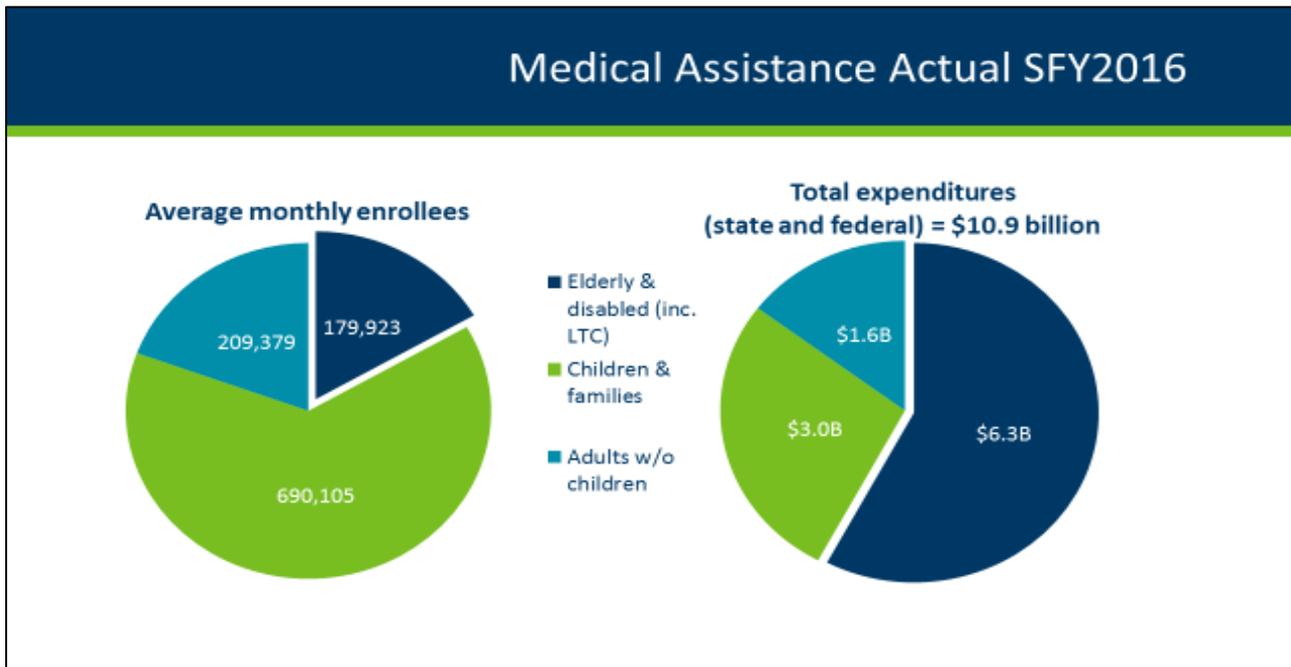
Block Grants or Per Capita Caps & Minnesota’s Medicaid Program

Block grants or per capita caps would be a substantial departure in how Medicaid is financed by federal government.

Since 1965, Medicaid has been a state-and-federal partnership that provides assistance to people whose income and resources are insufficient to cover the cost of their health care. The federal government shares the cost with states through a matching-rate structure. The federal government covers at least half of the costs, or more in states with poorer economies. Block grants and per capita caps represent an alternative way of financing Medicaid, designed to reduce federal spending. States would be provided with a base year of funding that would grow at a fixed rate, such as the consumer price index, gross domestic product (GDP) growth rate, or some other federally determined rate. This would allow for some marginal growth in federal spending to adjust for inflation, but not at a rate that would cover projected growth for health care coverage. States would be responsible for paying the costs that exceed the grant or cap amount. A block grant would base the initial grant year on a state’s current or historical federal funding levels for Medicaid. Per capita caps, on the other hand, would establish the initial cap on a per enrollee basis. Unlike block grants, per capita cap payments to states would reflect enrollment changes, allowing federal funding to increase or decrease, accordingly. However, payments would not account for changes in cost of care or changes in the health status or risk of a population.

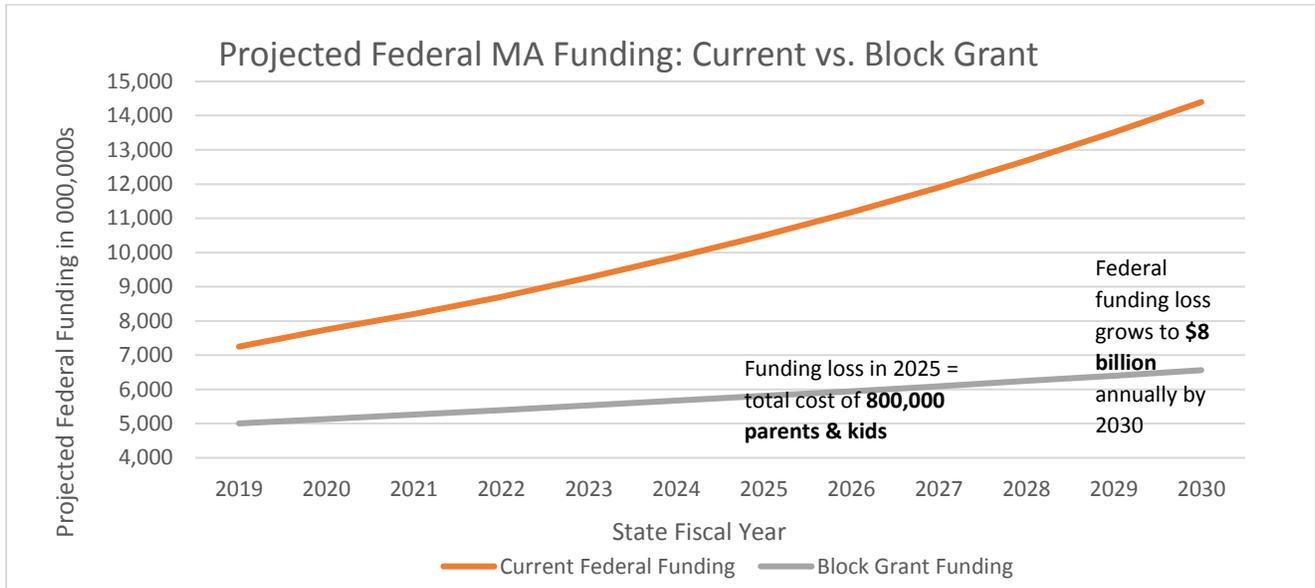
A block grant or per capita cap would significantly impact Minnesota’s Medicaid Program.

A block grant or per capita cap would significantly impact the state’s ability to maintain its current Medicaid program, Medical Assistance (MA), which serves one of every five Minnesotans. The loss in federal resources would limit the state’s ability to respond to changing health needs, unexpected population growth, unforeseen economic or public health disasters, or increases in cost of care including changes in local health care markets and drug prices. This is critical given the rapidly growing population of seniors, which is expected to sustain pressure on the budget. Projected expenditure growth through 2021 for seniors and people with disabilities is about 7 percent, compared to 4 percent for adults and children. As illustrated below, seniors, along with individuals with disabilities, make up more than half of the costs of MA.

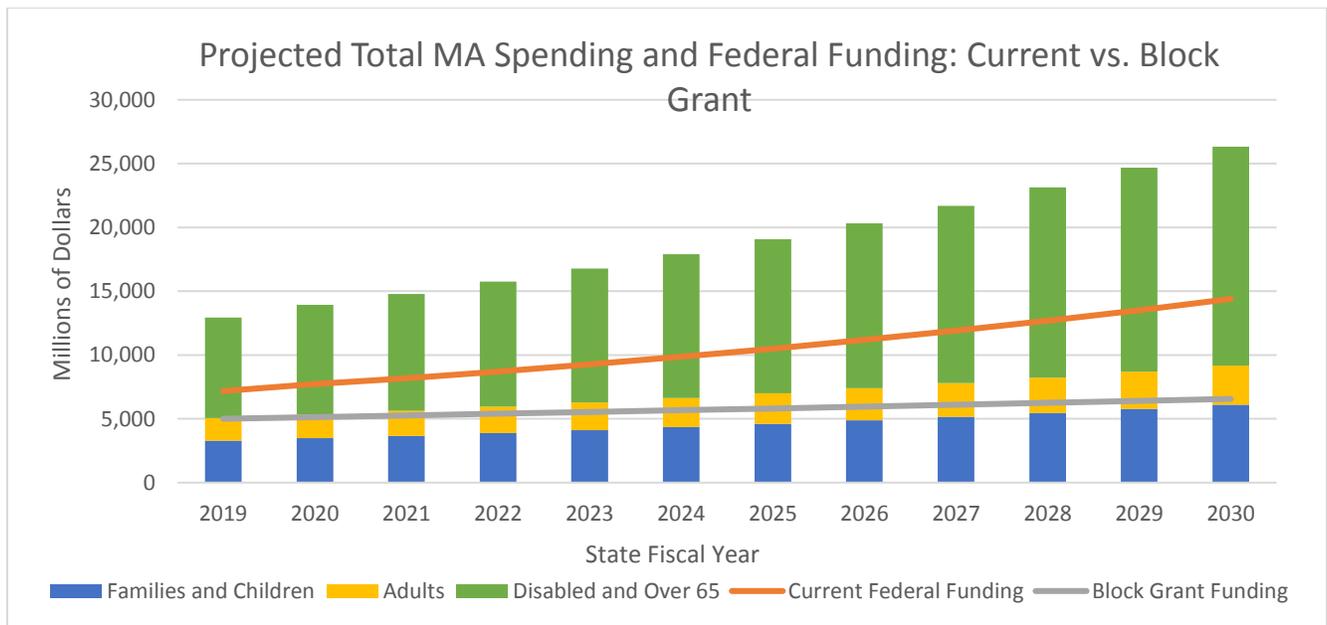


As shown below, based on an analysis provided by the Minnesota Department of Human Services, a block grant would result in a \$2.2 billion shortfall in the 2019 fiscal year alone that would accumulate to an \$8 billion gap through

FY2021, the state's current budget horizon.¹ This is based on a scenario where the Affordable Care Act is repealed and federal expenditures for the Medicaid adult expansion population are not included in the base year of a block grant.²



By FY2025, Minnesota would experience an annual budget shortfall of nearly \$5 billion, which is equivalent to the projected cost of MA coverage for all parents and children. The table below compares total projected MA spending, including state and federal, to two federal funding scenarios—the current financing structure and a block grant.



¹ The federal allotment assumes a growth trend rate that is based on the consumer price index, similar to the approach used for the Patient CARE Act of 2015 (authored by Sen. Burr, Sen. Hatch, and Rep. Upton). While U.S. House Speaker Ryan's current proposal appears silent on a trend rate for inflation, a previous proposal that he offered in 2011 to block grant Medicaid used CPI along with some adjustment for population growth. This analysis also assumes a historical MA cost trend plus expected growth in long-term care, which results in an annual cost trend of nearly 7 percent. If current trends remain, two thirds or roughly \$12 billion of total MA expenditures in FY2025 will be for recipients who are disabled or over 65.

² Even in a scenario where funding for the adult expansion population is included in the initial base year for a block grant, the state still experiences about \$1.3 billion annual shortfall in the 2019 fiscal year that would grow to \$5 billion gap through the state's current four-year budget horizon.

Given the projected loss in federal resources, block grants and per capita caps would likely lead to major changes or reductions in Minnesota’s Medicaid program.

To compensate for the substantial loss in federal dollars, Minnesota would need to increase state funding for Medicaid, or lower the cost of the program. The state would have a limited number of options for lowering the cost of this program given the number of innovations and reforms already leveraged by the state to produce savings.

Minnesota’s Options for Lowering Costs in Its Medicaid Program

Eliminating eligibility
Reducing benefits
Shifting costs to enrollees
Limiting access to care
Reducing provider-payment rates

While a block grant or per capita approach may allow states to change how and who they cover to lower costs, Minnesota likely could not achieve this level of reduction without impacting many consumer protections. These consumer protections would be difficult to maintain in an environment where the state would bear most of the financial burden, including:

- Providing access for all children on Medicaid to comprehensive and preventative screenings, tests, and services;
- Ensuring a statewide Medicaid program – available to everyone who is currently eligible –with comprehensive benefits;
- Providing due process, freedom to choose a provider, and consumer assistance to all enrollees;
- Maintaining evaluations and reporting of standards to ensure a quality program;
- Keeping basic eligibility and benefit requirements as required under federal law;
- Covering drugs when federal rebates are available;
- Allowing individuals to spenddown to become eligible for Medicaid;
- Keeping the MA for Employed Persons with Disabilities (MA-EPD) program available in Minnesota; and
- Ensuring managed care rates are reasonable and pay for the program.

Under the existing financing structure for Medicaid, federal matching funds help cover the costs of these requirements, including the cost of supporting the state’s county-based administrative infrastructure. Counties in Minnesota provide case management, eligibility work and other functions related to administering the MA program. **In fiscal year 2016, county governments in Minnesota received \$284.3 million in federal funding for Medicaid. A large-scale reduction in federal funds with a block grant or per capita cap would put a strain on these critical local resources and the state’s ability to sustain funding levels to support a county-based infrastructure.** This could force the state to choose between covering enrollees and paying for operational costs and staff.

Counties also pay a portion of the nonfederal share of certain MA services like chemical dependency, mental health, and longer nursing facility stays. Reductions to federal funding through a block grant could cause the state to shift more of the costs for these services to counties, if the state cannot accommodate the loss in federal funds with state dollars or reduce the overall costs of the program.

A block grant or per capita cap would penalize Minnesota for its program efficiencies and cost saving reforms. Minnesota has made significant strides in reducing the cost of its Medicaid program through various purchasing and delivery reforms. It has also seen efficiencies through its efforts to streamline the program and change how we deliver long-term care so people can remain living in their homes through community-based health care. Minnesota has accomplished this all while ensuring a comprehensive coverage continuum. Over the last 5 years, the state has saved \$1 billion through such reforms. A block grant or per capita cap approach will cap federal resources to the state at a level that reflects federal spending on Minnesota’s Medicaid program after the federal government has benefited from the

savings the state has produced in the last several years. This would put Minnesota at a disadvantage for being an early innovator in cost-saving reforms, when compared to other states that have been less successful in controlling the cost of their Medicaid programs.

Block grants and per capita caps coupled with a repeal of the ACA would eliminate support for MinnesotaCare. MinnesotaCare is the state's basic health program (BHP), authorized under the Affordable Care Act (ACA). This program provides subsidized coverage options for people who are ineligible for Medicaid and have incomes up to 200 percent of poverty or \$23,760 in annual income. Minnesota elected to establish a BHP because many working, lower-income Minnesotans rely on MinnesotaCare for affordable care. Requiring individuals served by MinnesotaCare to purchase a qualified health plan in MNsure would have resulted in higher costs of care and a reduction in access to benefits.

Today, as a BHP, the state receives federal funding equal to 95 percent of the amount of the federal assistance that would have otherwise been provided to eligible individuals if they had enrolled in a qualified health plan in MNsure. Currently, enrollee premiums and federal funds cover almost all of the costs of this program. Because MinnesotaCare is no longer part of the Medicaid program, the level of federal funding available under the BHP for this population would not be included in a future Medicaid block grant base or per capita cap. Instead, coupled with a repeal of the ACA, a block grant or per capita cap would leave Minnesota with no federal resources available to support coverage for the more than 100,000 individuals on MinnesotaCare. **DHS estimates that the impact of a block grant combined with the loss of BHP funding from an ACA repeal would cut \$2.7 billion from the state budget in SFY2019 and would accumulate to a \$9.5 billion gap in the state's budget through FY2021, the state's current forecast horizon.**³

Numerous factors impact the cost of Minnesota's Medicaid program that are not within the state's control. State Medicaid programs are a critical part of the nation's safety net and along with other entitlements such as federal nutrition programs and unemployment insurance, the Medicaid program adjusts immediately in response to any increase in poverty from an economic downturn. Block grants have been used to finance other federal programs, such as the Temporary Assistance for Needy Families (TANF) program. However, unlike other benefit programs, the cost of providing coverage for health and long-term care is subject to a variety of factors, like changes in local health care needs and markets, public health crises, prescription drug pricing, and other factors that are not within the State Medicaid Agency's (or any other insurance payer's or employer's) control.

The cost of the Medicaid program is also impacted by changes to Medicare. For example, Medicaid helps pay for the Medicare premiums and cost-sharing expenses of low-income individuals who are also on part A and B or are dually eligible for both Medicare and Medicaid. Under a block grant or per capita cap scenario, when Medicare premiums increase, state Medicaid programs will also experience an increase in costs for serving dually-eligible individuals. While states have no control over the Medicare program, they will be the ones to carry the burden of these additional costs with no commensurate increase in federal funding.⁴

Affordable prescription drugs for Medicaid enrollees could be at risk under a block grant or per capita approach.

It has been unclear if a block grant or per capita cap would include the Medicaid drug rebate program. The rebate program is the primary mechanism that states have to prevent drug coverage from being too expensive. This rebate program ensures Medicaid prices remain relatively stable or go down over time. Elimination of this program, while maintaining the requirement that Medicaid programs cover all drugs, would significantly increase costs for prescription drugs and once again shift more costs of the Medicaid program to the state budget.

³ This estimate assumes that, with the implementation of both a repeal of the ACA and a block grant approach to Medicaid in SFY2019, no federal funding for the Medicaid adult expansion population would be included in the base allocation for states.

⁴ The possibility has also been raised that Medicare would no longer contain prescription drug coverage, part D. In that scenario, for individuals who are dually eligible, the Medicaid program would need to fill this coverage gap. This would mean that once again the financial burden of these additional Medicare-related costs would be shifted from the federal government to the states.

Block grants or per capita caps would slow Minnesota’s progress in innovative payment and delivery models.

There are other longer-term strategies in how the state purchases, pays for and delivers care for this population that could reduce the costs of MA. However, these alternatives would not be sufficient to cover the projected loss of federal resources from a block grant, especially since these reforms often require an upfront state investment. Furthermore, the increase in Medicaid enrollment and the new payment reforms for Medicare under the ACA, are both important contributing factors to the success of these types of efforts including Minnesota’s accountable care model, Integrated Health Partnerships. Repealing the ACA and replacing its Medicaid reforms with a block grant or per capita cap would stifle these efforts and discourage provider participation, thereby minimizing their potential to provide future savings.