Evaluating the Fiscal Impact of a Medicaid Block Grant for Missouri

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When faced with tough budget choices to balance the budget, lawmakers across states frequently look to Medicaid as a source of savings. One concept that has been discussed as a strategy to contain Medicaid costs is changing the financing structure of Medicaid from an individual entitlement program to a block grant. The recently formed Missouri Senate Special Committee on Social Service Program Savings is currently assessing block grants for Missouri's Medicaid services. The following identifies the basic components of blocks grants, as well as the potential positive and negative fiscal outcomes for Missouri.

Changing the financing structure of Medicaid to a block grant has potential fiscal benefits

- 👍 Restricting federal money to a fixed amount determined by a formula could save the federal government money over time

- 👍 A block grant may provide the state with more flexibility regarding program design, benefits, cost-sharing and eligibility

Changing the financing structure of Medicaid to a block grant has potential serious fiscal implications for the state

- 👎 If Medicaid costs are greater than the defined federal allotment, the state would be responsible for all costs that exceed that cap

- 👎 There is no provision to increase the federal portion of a block grant during an economic downturn, natural disaster, or epidemic. Nor are there provisions to respond to changing demographics, such as Missouri's aging population. The state would bear the entirety of increased costs

Unknown factors could exacerbate costs for the state

- 👎 It is unlikely that the federal government will agree to total flexibility in determining eligibility, benefits and cost-sharing. If there are federal requirements for these, the potential to reduce costs through a block grant is unclear

Block grant basics

In a Medicaid block grant, a state is given a set amount of federal funding for Medicaid benefits. This amount is determined by a formula, rather than on actual costs of services provided. Federal funding does not increase if the number of eligible individuals increases, if new and more costly technologies or pharmaceuticals are available, or in the event of a recession or natural disaster. When a federal block grant is exhausted, the state must pay for the service entirely with its own resources. It may also try to reduce its costs by capping enrollment, establishing a waiting list, limiting benefits, charging higher co-payments, or reducing reimbursement to providers.

When considering whether changing Medicaid to a block grant is a prudent choice to balance the budget, it is important to understand the basic current structure of Medicaid[1].

1) **Medicaid is an individual entitlement program**. If an individual meets the eligibility criteria, he/she is assured of being covered by Medicaid insurance. There are no waiting lists or enrollment caps in the current Medicaid program.
2) **The costs of the health care provided through Medicaid insurance are shared by the state and federal government.** Of each dollar spent on services provided through Medicaid, 61 cents will come from the federal government, and 39 cents from Missouri beginning in October 2012.[2]
3) **Both the state and federal governments have a voice in deciding which services are provided through Medicaid.** The federal government mandates that Medicaid provide some basic services. States are allowed to choose whether to offer additional. An example of a federally mandated benefit is the EPSDT (Early, Periodic, Diagnostic and Treatment Services) package of benefits for children. Other examples of mandated care for adults include physician, hospital, and nursing home care. Other services are optional, such as the treatment for children with autism that Missouri requires private insurance to provide, and dental care for adults. Each state decides whether it will provide optional services.
4) **The federal government sets some minimum eligibility requirements. States must provide Medicaid to individuals with incomes under those levels. States decide if they will insure individuals whose incomes are above the floors.** For example, states must insure parents or caregivers whose income is beneath the 1996 Aid to Families with Dependent Children eligibility level. In Missouri, this is $292/month for a typical family of 3, about 19 percent of the Federal Poverty Level (FPL). Missouri could provide Medicaid to parents in families at higher income levels, but chooses not to. Missouri is required to provide Medicaid for seniors and individuals with a disability whose income is under 74 percent of FPL. Missouri chooses to insure individuals in those groups with incomes up to 85 percent of FPL.
5) **The federal government sets limits on the co-pays that can be required from those insured by Medicaid.**

Advantages of the current entitlement structure

When looking at Medicaid through a fiscal policy lens, one of the advantages of the current structure is that it is counter-cyclical, allowing federal funding to automatically rise to meet greater needs during a recession. In an economic downturn, demand for services often rises as more people fall under the income eligibility guidelines. At the very same time, state resources – such as revenue from income and sales taxes - usually decline. During the recent recession, many individuals lost their jobs, and with it, health insurance for themselves and their families. Because Medicaid is structured as an entitlement program, it covered newly uninsured children whose parents were unemployed.

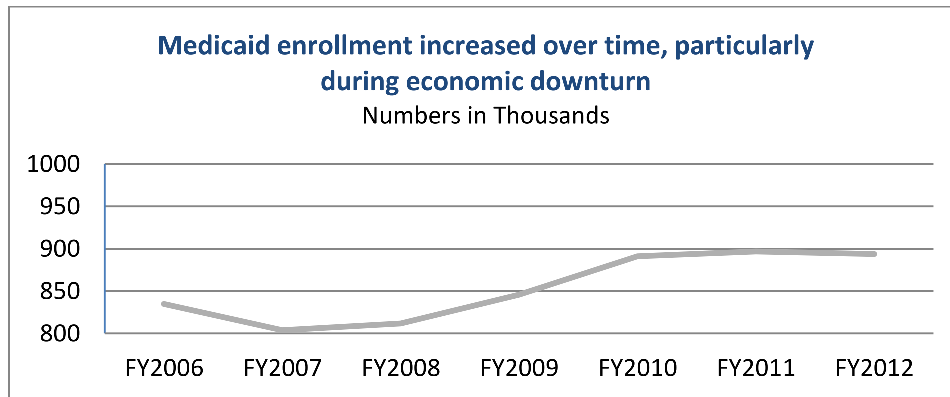
Federal funds also helped Missouri and other states balance their budget without making deep cuts in services. Realizing that states were facing tremendous budget challenges to adequately fund education and health care during the recent recession, the federal government matched state Medicaid funds at a higher-than-normal rate. This flexibility allowing increased federal funds not only assured needed health care for children, seniors and individuals with a disability, but pumped millions of dollars into the state and local economies, and prevented job loss in the health sector.

The following graph shows the recent trend in enrollment for Medicaid[3].

[1] In Missouri, the Medicaid program is called MO HealthNet.

[2] This federal match, called the FMAP, varies by state. It ranges from 50 percent to 78 percent. Missouri had a higher match rate (63 percent) than about two-thirds of the states in FY2012 (ends September 30, 2012). http://aspe.hhs.gov/health/fmap.htm.

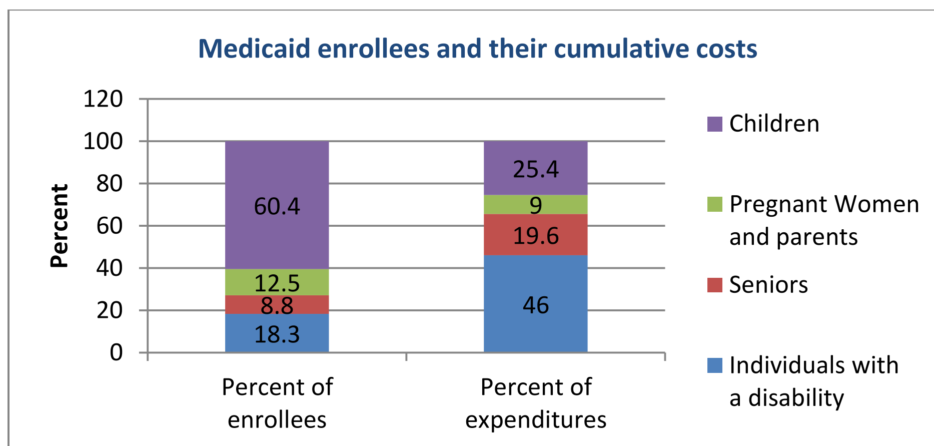
[3] Department of Social Services 2010 annual report , p. 35



Potential Risks of a Medicaid block grant

Growing number of seniors presents challenge in curbing Medicaid costs

A Medicaid block grant may give Missouri flexibility to design new programs, as well as to cap enrollment, scale back eligibility, limit benefits, and charge higher co-pays. However, the difficulty of saving significant costs through program design is evident when looking at who is insured by Medicaid, who accounts for the costs of the program, and population trends.[4]



Almost two-thirds of the costs of Medicaid are incurred by individuals with a disability or seniors, but they comprise only about one fourth of the individuals who are insured by Medicaid. These populations tend to have more complex, expensive medical needs. Many depend on Medicaid for nursing home care or for services that enable them to stay in their home. The federal government already offers incentives to states to do a better job of supporting people in their home whenever possible. Missouri is implementing programs to do this, as well as to better coordinate the care of individuals with multiple health needs. So it appears that the state has already financially benefited from these types of program redesign.

The growing number of seniors also presents a challenge in cutting costs in Medicaid. Missouri's seniors (age 65 and older) make up an increasingly large portion of the population. In 2004, seniors made up 12.8 percent of Missouri's total population[5]. By 2010 this had increased to 14 percent[6]. AARP

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[4] Ibid

[5] http://www.missourieconomy.org/newsletter/olderpop.htm..

[6] http://2010.census.gov/2010census/popmap/ipmtext.php?fl=29.

estimates that by 2030, seniors will make up 20 percent of Missouri's total population[7].

As the senior population grows it is likely that the state will face increasing Medicaid costs. If Medicaid financing is structured as a block grant, the state will be responsible for all costs that exceed the block grant allotment.

The amount of flexibility allowed under a block grant is unknown

The concept of saving money through a block grant counts on being able to decrease overall costs by redesigning programs, benefits, increasing the cost-sharing of those insured by Medicaid, or decreasing reimbursement to providers.

The degree to which the federal government will allow program redesign is unknown. It is likely that Missouri will be given mandates about eligibility and services.

Missouri's eligibility is at, or slightly above, the mandated Medicaid eligibility for most populations. Almost 83 percent of those eligible for Medicaid are mandated to be covered by federal law.[8]

Children are the largest group insured by Medicaid at income levels that are above the federally mandated eligibility[9]. But the costs of their health care, for the most part, are low. It would be difficult to find cost savings without greatly reducing eligibility, increasing cost-sharing, or limiting benefits for the relatively small number of children with complex health needs.

It will also likely be difficult to find cost savings by limiting benefits. Almost two-thirds of the services provided covered by Medicaid are mandatory. The one-third that are "optional" services (and most likely to be part of flexibility under a block grant) are primarily composed of pharmacy benefits, mental health services and in-home services.

Conclusion

Pursuing a Medicaid block grant as a strategy to save money is a fiscally risky proposition. It a gamble that Missouri can save money by redesigning its Medicaid program, likely cutting some benefits, making eligibility more restrictive, charging individuals more for their care, and/or cutting reimbursement rates to providers.

Part of the risk includes not knowing the extent to which the federal government will mandate eligibility, benefits, cost sharing limits, and reimbursement rates for services provided.

Even if small cost savings can be achieved through program redesign, Missouri's aging population is likely to swell Medicaid enrollment over time. The needs of seniors are generally more complex, and meeting those needs costs more.

Once the federal block grant is spent, the state will be responsible for all of the additional Medicaid costs. Even after cutting eligibility and benefits, Missouri could still be on the hook for substantial Medicaid costs. The end result could well be a program that is less effective in meeting real health care needs, is a financial burden for those insured, and which costs the state more. Rather than getting more bang for its buck, Missouri could end up paying more for less.

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[7] http://assets.aarp.org/rgcenter/econ/social-security-facts-2011-missouri.pdf;

[8] DSS presentation to the Senate Special Committee on Social Service Program Savings, February 21, 2012

[9] Department of Social Services 2010 Annual Report, p. 35