The Jewish Federations® of North America
Washington Office

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IMPLICATIONS OF MEDICAID FINANCING REFORM

Please reach out to your senators and representatives and tell them that transforming Medicaid into a block grant or capping the program's federal share of funding would jeopardize access to needed services for millions of vulnerable Americans.

Background

Medicaid is the joint federal-state program that pays for **health care and long-term care services to over 80 million people. Medicaid provides coverage to economically disadvantaged populations including low-income children and their families, older adults, and individuals with disabilities.**

Recent prominent plans to reform Medicaid, including the American Health Care Act (AHCA), have proposed fundamentally restructuring the program's financing. These proposals include limiting the federal funding share of Medicaid to a fixed federal payment in the form of a block grant or a per capita cap. Block grants provide a set amount of federal Medicaid funding for states, are not adjusted for the number of enrollees, and may or may not be adjusted for inflation over time. Per capita caps provide states a set amount of federal Medicaid funding adjusted by the number of enrollees, thus allowing states to receive more funding within a given year if their Medicaid populations grow, but could be set at an insufficient level per enrollee. Either of these proposals can result in draconian cuts to the Medicaid program that ultimately would lead to the denial of health and long-term care to millions of vulnerable Americans. The Congressional Budget Office (CBO) estimated that the AHCA would cut the Medicaid program by $834 billion over ten years due to changes in eligibility for the expansion population and by allowing these types of caps to the federal share of Medicaid.

Consequences to Medicaid Recipients & Their Families

- Due to the financial impacts of a block grant or per capita cap, Medicaid programs may have to reduce coverage for individuals who qualify for Medicaid through optional eligibility pathways. As a result, previously covered populations would be turned away from vital services and individuals who now qualify for Medicaid could end up uninsured.

- Many services that Medicaid currently pays for could be cut as well. For example, a sharp decrease in federal Medicaid spending could lead to cuts in home and community-based services and long-term care, undermining years of progress in caring for high-need individuals in less expensive and less restrictive settings. The loss of these services would make individuals more dependent on the unpaid support of already strained family caregivers, and would lead to increases in unnecessary and more expensive institutionalizations.

Consequences to State Economies

- Under a block grant or per capita cap, Medicaid programs would receive reduced federal funding and Medicaid's status as an entitlement for beneficiaries would be called into question. Either method would eliminate the current guarantee of federal matching funding to states for all who are eligible and for all services states are providing. Costs and liabilities would shift to the states,

which would force states either to make up the difference with their own funds or cut their Medicaid programs.

- Medicaid often pays providers inadequate rates for services. A block grant or per capita cap would further reduce Medicaid provider payments, as inflationary adjustments for Medicaid would be far below the national level of health care inflation.

- The impact of reduced federal funding for Medicaid would be even greater when either enrollment or per beneficiary health care costs rise faster than expected. Medicaid is counter-cyclical. During economic downturns, Medicaid enrollment rises as people lose their jobs and as access to employer-sponsored health insurance decreases. Under a block grant, the federal funding would not change to account for this increase in enrollment. Even a per capita cap, which does adjust for enrollment increases, would not fluctuate with unexpected increases in health care costs resulting from an epidemic, such as Zika, or high cost prescription drugs, such as Sovaldi.

- Major cuts in federal Medicaid funding due to a block grant or per capita cap would result in significant job losses among health care and social service workers. Medicaid currently plays a critical role in supporting the nation's health care sector, and helps to strengthen state and local economies. Health care providers, such as hospitals, physicians, nursing homes, and home care service providers, not only care for the people in their communities, but also are employers, taxpayers and consumers themselves. The network of providers in the Jewish Federations of North America alone includes 15 leading academic medical centers/health systems, 100 nursing homes, 125 Jewish family & children's agencies, and nearly a dozen group homes. Job losses in the health care industry due to cuts in Medicaid will mean that these members of the workforce will no longer be taxpayers, nor will they continue to be covered under their employers' health insurance plans. As jobs are lost, former employees will reach out for governmental support, including Medicaid and other safety net services, thus increasing the strain on these important public programs.

For further information, please contact:

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The Jewish Federations of North America represents 148 Jewish Federations and 300 Network communities, which raise and distribute more than $3 billion annually for social welfare, social services and educational needs. The Federation movement, collectively among the top 10 charities on the continent, protects and enhances the well-being of Jews worldwide through the values of tikkun olam (repairing the world), tzedakah (charity and social justice) and Torah (Jewish learning).

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RECOMMENDED WAYS TO REFORM MEDICAID & REALIZE COST SAVINGS

- **Rebalancing:** The concept of rebalancing refers to shifting Medicaid spending and resources from primarily financing long-term services and supports in institutional settings to community-based environments. Although skilled nursing facilities will remain vital providers, rebalancing Medicaid reimbursement for community-based long-term services and supports is both cost-effective and enhances quality of life for many Medicaid enrollees. The Balancing Incentive Program and the Money Follows the Person Program are both designed to help states shift Medicaid spending on long-term services and supports from institutional settings to the community. Through these programs, states have successfully expanded these services and transferred individuals from institutional settings to their communities. Expanding rebalancing within the Medicaid program so that Medicaid funding can be made available for community-based long-term services and supports without a waiver is both cost-effective and assures enhanced quality of life.

- **Promoting Telemedicine:** Although expanding the use of telemedicine and health information technology through long-term care and behavioral health delivery systems will require an initial investment in technology, it offers the promise of greater efficiency, better and coordinated care, and significant cost savings.

- **Improving the Coordination between Medicare and Medicaid**: Medicaid and Medicare together provide health coverage for approximately 10 million low-income seniors and people with disabilities who are dually eligible for both programs. However, Medicaid and Medicare generally operate as separate programs. Beneficiaries have to navigate multiple sets of requirements, benefits, and plans. Different coverage and payment policies can create incentives to shift costs back and forth between the states and the federal government, leading to underutilization of services in some cases and overutilization in others. This lack of coordination between the programs may also result in fragmented care, which can lead to high costs and poor outcomes. The Dual-Eligible Special Needs Plans and the Financial Alignment Demonstration Initiative are two programs working to coordinate the financing structures and rationalize the administration between the two programs to improve care and reduce costs. These two programs should be explored further for their ability to improve care while also reducing costs.

- **Increasing Value-Based Purchasing Initiatives:** Value-based purchasing models, such as Accountable Care Organizations increasingly are being adopted in both Medicare and Medicaid. These models move away from the traditional fee-for-service system and towards payment based on quality and cost savings. Implementing these models more widely for high-cost, high-need populations in need of long-term services and supports could be a method to reduce costs while improving care for beneficiaries and should be analyzed further.

- **Reducing Hospitalizations for Nursing Facility Residents:** In 2011, the CMS Medicare-Medicaid Coordination Office implemented an initiative to reduce avoidable hospitalizations of dually eligible beneficiaries living in nursing facilities. Long-term care facilities participating in the initiative have reported declines in all-cause hospitalizations and potentially avoidable hospitalizations, as well as reductions in Medicare expenditures. The second phase of this

initiative is underway and will test whether a new payment model for long-term care facilities can improve quality of care by reducing avoidable hospitalizations lower combined Medicare and Medicaid spending. As the new results become available, if successful, this new payment model could be expanded.

- **Promoting Prevention:** Implementing preventive measures, such as chronic disease management, health education, and other services targeting high-risk groups, also may be able to lower Medicaid costs in the long term. Wellness programs, such as diabetic education, prenatal care, depression screening, and nutritional counseling, will improve the health of patients and save scarce funds.

- **Expanding the Hospice Benefit:** Expanding hospice education and care in Medicaid, a strategy which has already realized cost savings in Medicare, can reduce unnecessary treatment costs while enhancing the quality of life for patients and their families.

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