Fact Sheet: Nebraska

Changing Medicaid to a Block Grant or Per Capita Cap Could Hurt Nebraskans

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For more than 50 years, Medicaid has served as a critical safety net and lifeline for over 70 million Americans. This includes more than 17 million children and adults with disabilities and low-income seniors, many of whom need health care and long-term services and supports (LTSS)—including help with eating, bathing, dressing, or managing finances—to address their daily needs. Financed by both the federal and state governments, ***Medicaid guarantees health and LTSS coverage for all eligible individuals and families.***

Under the current system, federal funding increases in response to increases in enrollment, service costs, and use. Some policymakers have recommended that federal financing be limited, either by annually providing states with a fixed amount—a "block grant"—or by providing a set amount per beneficiary—a "per capita cap"—for their Medicaid programs. While block grants and per capita caps are related but different concepts, both could end Medicaid's guaranteed access to care. They could also shift costs over time to both states and to Medicaid enrollees, many of whom simply cannot afford to pay more for their health care or LTSS needs.

Current Status: What Medicaid Does for Nebraskans

Medicaid is a key source of health care and LTSS coverage.

Medicaid provides health care and LTSS to low-income children, families, and low-income seniors and individuals of all ages with physical, mental health, intellectual, or developmental disabilities in Nebraska. Medicaid helps individuals who have low incomes, incur high costs, or have already spent through their resources paying out-of-pocket for health care and LTSS. LTSS can be delivered in institutional settings (such as nursing facilities) or through home and community-based services (HCBS).

- In fiscal year (FY) 2013, more than 262,000 Nebraskans (14 percent of the state's total population) received health coverage and LTSS through Medicaid.[1,2]
- About 9.5 percent (24,000) of Nebraska's Medicaid beneficiaries were low-income seniors and 16.2 percent (42,000) were children and adults under age 65 with disabilities.[3]

If Nebraska limits or reduces enrollment in Medicaid as a result of a block grant or a per capita cap policy, these individuals could lose the essential services they need.

Medicaid helps low-income Medicare beneficiaries.

Most low-income seniors and some people with disabilities under age 65 who receive Medicaid are also covered by Medicare. These individuals are known as dual eligibles. Medicaid covers a range

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of important services *not covered* by Medicare, including LTSS and in some cases dental, vision and prescription drugs not covered by Medicare Part D. Medicaid can also help cover Medicare cost-sharing expenses.

- In FY2013, about 45,900 low-income Medicare beneficiaries in Nebraska received Medicaid.[4]
- An estimated 40,400 were "full" dual eligibles and received full Medicaid benefits in addition to assistance with their Medicare costs.[5]
- About 5,400 of these individuals were "partial" dual eligible enrollees and received help with only their Medicare Part A and/or Part B costs.[6]

States and the federal government share the cost of financing Medicaid.

Federal payments represent a significant contribution, which allow states to meet the health and LTSS needs of vulnerable populations.

- In FY 2015, Nebraska received $1.1 billion in federal funding for its Medicaid program.[7]

Federal funding for Medicaid could drastically decline under a block grant or per capita cap. This could shift costs to Nebraska and force the state to raise taxes, restrict enrollment, reduce services, and/or cut provider payments.

How Block Grants or Per Capita Caps Would Affect Nebraskans

Block grants do not account for changes in Medicaid enrollment.

Block grants would provide states a fixed amount of federal funds that would not change based on enrollment. Under a block grant, states would likely have discretion to determine which populations and services they cover. States would be at risk for covering expenses that exceed block grant funds. This puts Nebraska at risk in the event of an economic downturn or other cause of higher-than-anticipated enrollment. For example, during the Great Recession (June 2008-June 2010),

- The unemployment rate in Nebraska reached 4.8 percent[8] and
- Medicaid enrollment increased in Nebraska by 11.8 percent (23,800 people).[9]

Per capita caps would likely not meet the needs of Nebraskans receiving Medicaid.

Medicaid provides health and LTSS to a broad range of populations, including low-income seniors and children and adults with disabilities. In addition, the care needs of Medicaid enrollees can also vary significantly. As a result, it would be difficult to set a per capita cap that would appropriately serve Nebraskans who rely on Medicaid to meet their health care and LTSS needs. Because per capita caps are based on historical spending on Medicaid, such caps would also likely lock in the current variation of federal dollars sent to the states indefinitely—even with health care costs consistently rising faster than inflation.

There are better ways to stretch Medicaid dollars that do not cut people off from the services they need.

Under federal Medicaid law, states receive federal funding for and are *required* to provide nursing facility care for all who are eligible. Meanwhile, states *may* offer HCBS, but are not required to do so and often limit the number of people who may receive services. HCBS, however, is traditionally more cost effective than institutional LTSS. This institutional bias is a costly component of Medicaid LTSS.

- In FY2012, approximately 24,643 Nebraskans received LTSS through Medicaid, including institutional care and HCBS.[10]
- About 47.5 percent (11,695) of Medicaid LTSS beneficiaries in Nebraska were low-income seniors, 38 percent (9,371) were adults with disabilities ages 21 through 64, and 9.4 percent (2,327) were children and youth with disabilities under age 21.[11]
- Nebraska spent an average of $18,146 per Medicaid enrollee receiving HCBS compared to $28,614 per Medicaid enrollee served in a nursing facility.[12]
- Because nursing facility care is so expensive, it comprised 51.5 percent of Medicaid LTSS expenditures in Nebraska.[13]

Restructuring Medicaid's current rules and allowing states flexibility to access funding for HCBS in the same way they can access nursing home funding

could help realize savings in Medicaid without cutting people off from the services they need. Beyond cost savings, AARP surveys show that about 90 percent of older adults want to remain in their homes and communities for as long as possible.

Finally, updating current law to both improve cost efficiencies and reflect where and how people want to receive services today could reduce cumbersome administrative burdens for states.

References

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