State Health Reform Assistance Network
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for Arkansas

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On March 24, 2017, the House of Representatives determined not to move ahead with the American Health Care Act (AHCA), its proposal to repeal and replace the Affordable Care Act (ACA). The AHCA included provisions that would have capped federal Medicaid funds through per capita caps and block grants, and reduced or eliminated federal funding for the expansion of Medicaid to low-income adults. While the AHCA failed to advance, these Medicaid proposals are likely to remain a priority for Congressional leadership. To assist states in evaluating how they might fare under a capped funding model, Manatt Health analyzed state-specific data for all 50 states and the District of Columbia. The Arkansas-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact Arkansas under capped funding proposals. The data are drawn from a tool kit prepared by Manatt Health for the Robert Wood Johnson Foundation's State Health Reform Assistance Network. [1]

Medicaid capped funding proposals are designed to provide the federal government with greater budget certainty and to reduce federal spending, and thereby reduce federal Medicaid funding for states, especially in the out years. In several recent proposals, including the AHCA, the size of the cap for each state is set based on its historical spending in Medicaid, trended forward by an annual, national "trend rate," rather than a state-specific trend. As a result, under a capped financing formula, federal Medicaid funding to states would no longer respond automatically to increases in state-specific health care expenditure growth, break-through therapies, public health crises, or, depending on the design of the cap, increases in enrollment due to growing populations, changing demographics, economic downturns or other factors. States might have additional flexibility to reduce eligibility, benefits or provider payment rates, but ultimately they bear the risk of costs exceeding the cap.

Data Considerations

This memo relies on the most recent publicly available data, and in some instances, it references 2011 data. While a state might have more recent data on its own program spending, 2011 is the most recent year for which per enrollee spending and historical growth rates are publicly available by eligibility group for all states. The lack of more recent 50-state data is challenging, but the comparison across states is helpful. In any event, faced with the lack of more recent 50-state data, Congress will likely need to rely on older and aggregated data in setting capped funding levels.

[1] http://statenetwork.org/resource/data-points-to-consider-when-assessing-proposals-to-cap-federal-medicaid-funding-a-toolkit-for-states/

Key Data Findings

- **Expansion brought $1.4 billion in federal funding to Arkansas in 2015 and sharply increased coverage.** If Medicaid restructuring eliminates or reduces funding for the Medicaid expansion, it would pose a significant threat to coverage in Arkansas and to the State's budget.
    - Almost 304,000 individuals are covered through the Medicaid expansion adult group in Arkansas, 40% of the State's Medicaid population as of March 2016.
    - Arkansas's uninsured rate dropped by 41% from 2013 to 2015 (from 16% to 9.4%), due in large part to the Medicaid expansion.
    - Beyond coverage, reducing or repealing federal support for expansion would have an outsized impact on Arkansas's budget. Federal funding for new adults accounts for 33% of all federal Medicaid funding for Arkansas.
    - Even if it could absorb the fiscal hit of a reduction in federal support for expansion, Arkansas is one of at least nine states that is required by state law to reduce or eliminate Medicaid eligibility and/or benefits for the expansion population if the Medicaid matching rate is reduced.
- **Arkansas has below average per capita Medicaid spending levels as compared to other states, and particularly low spending for individuals with disabilities, putting it at high risk of being "locked in" to a low capped payment.** Since nearly all capped funding proposals start with a state's historic spending, Arkansas is at risk of being locked into low capped federal payments for this high cost group.
    - Arkansas spent an average of $6,258 per enrollee in federal fiscal year 2011 (27th among states), just below the national average of $6,502.
    - Arkansas has relatively low spending across most eligibility groups – $14,023 per disabled enrollee compared to $18,518 nationally (7th lowest) and $3,198 per adult enrollee compared to $4,141 nationally (9th lowest).
- **Between 2000-2011, Arkansas's Medicaid spending on a per capita basis grew more rapidly than the national trend rates typically advanced in capped funding proposals, and faster than many other states.** If Arkansas's historical spending rates are indicative of its future spending rates, over time federal Medicaid funding under a capped funding proposal would be short of Arkansas's needs.
    - Arkansas's average annual per enrollee spending growth was above average in all eligibility groups from 2000 - 2011: 8.3% for the aged (4th in nation), 5.4% for disabled (13th in nation), 6.3% for children (15th in nation), and 12.1% for adults (2nd in nation).
    - Arkansas's Medicaid spending growth on these groups significantly outstripped per capita GDP (2.9%), CPI (2.5%), and medical CPI (4%) during that period.
- **Arkansas relies on DSH and UPL payments; depending on how they are treated in a capped funding approach, these federal funds may be at risk.** This is a critical issue for Arkansas to monitor.
    - DSH and UPL payments made up just under 8% of all Arkansas Medicaid benefit spending in 2015.
- **Arkansas Medicaid spending is disproportionately for seniors and people with disabilities.** As a result, capped funding is likely to disproportionately impact these populations.

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- In FY 2011, over two-thirds (71%) of Arkansas's Medicaid spending was for elderly and disabled enrollees even though they accounted for approximately one-third (31%) of the State's Medicaid enrollment.
- The expansion of Medicaid to low-income adults in Arkansas undoubtedly has shifted the distribution of spending across eligibility groups, but there is little doubt that when updated data become available, they will indicate that spending on the elderly and disabled remains substantial.

- **Arkansas's State budget relies heavily on federal Medicaid funding.** Medicaid represents the single largest source of federal funding for the State. A loss of federal Medicaid funding could shift costs to the State, posing a threat to the Arkansas budget and other State priorities, such as education.
  - Federal Medicaid funding ($4.3 billion in 2015) makes up 64% of all federal funding in Arkansas's budget—a higher than the average share among expansion states. By comparison, the next largest source of federal funds—for primary and secondary education—is 7.5% of the federal funds received by the State.

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