State Health Reform Assistance Network
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for the District of Columbia

April 5, 2017

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 District of Columbia-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact the District of Columbia 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 nearly $350 million in federal funding to the District of Columbia and sharply increased coverage.** If Medicaid restructuring eliminates or reduces funding for the Medicaid expansion, it would pose a significant threat to coverage in the District of Columbia and to the District's budget.
    - Nearly 62,000 individuals are covered through the Medicaid expansion adult group in the District of Columbia, 27% of the District's Medicaid population as of March 2016.
    - The District of Columbia's uninsured rate dropped by 43% from 2013 to 2015 (from 6.3% to 3.6%)—the second lowest uninsured rate in the country, due in large part to the Medicaid expansion.
    - Beyond coverage, reducing or repealing federal support for expansion would have an outsized impact on the District of Columbia's budget. Federal funding for new adults accounted for 19% of the $1.8 billion in federal Medicaid funding for the District of Columbia in 2015.
- **The District of Columbia has among the highest per capita Medicaid spending levels relative to other states.** Although nearly all capped funding proposals start with a state's historic spending, under some proposals, the District of Columbia may be expected to move the state's per capita expenditures toward the median over time.
    - The District of Columbia ranked 5th in the nation in total per capita Medicaid spending per enrollee. In fiscal year 2011, average spending was $9,083 per enrollee, well above the national average of $6,502.
    - The District of Columbia has relatively high spending for the disabled and the aged: $28,604 per disabled individual compared to $18,518 nationally (5th highest) and $27,336 per elderly enrollee compared to $17,522 nationally (7th highest). The District also has above average spending for children and adults: $2,820 compared to $2,492 nationally (16th highest) and $4,446 compared to $4,141 nationally (21st highest).
- **Between 2000-2011, the District of Columbia's Medicaid spending on a per capita basis grew much more rapidly than the national trend rates typically advanced in capped funding proposals, and faster than most states.** If the District of Columbia'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 the District of Columbia's needs.
    - The District of Columbia's average annual per enrollee spending growth was above average across most eligibility groups from 2000 - 2011: 6.5% for the disabled (6th in nation), 6.6% for the aged (9th in nation), and 7.2% for adults (25th in nation).
    - The District of Columbia's Medicaid spending growth on these groups significantly outstripped per capita GDP (2.9%), CPI (2.5%), and medical CPI (4%) during that period.
- **The District of Columbia 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 the District of Columbia to monitor.
    - DSH and UPL payments made up 2.2% of all of District of Columbia Medicaid benefit spending in 2015.

This product was prepared with support from the Robert Wood Johnson Foundation through its State Health Reform Assistance Network program.

- **District of Columbia Medicaid spending is disproportionately for seniors and people with disabilities.** As a result, capped funding is likely to disproportionately impact these populations.
    - In FY 2011, more than two-thirds (68%) of the District of Columbia's Medicaid spending was for elderly and disabled enrollees even though they accounted for only 24% of District of Columbia's Medicaid enrollment.
    - The expansion of Medicaid to low-income adults in the District of Columbia 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.

This product was prepared with support from the Robert Wood Johnson Foundation through its State Health Reform Assistance Network program.