State Health Reform Assistance Network
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for Kansas

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 Kansas-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact Kansas 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

- **Under a capped funding model, Kansas could be disadvantaged relative to states that receive federal funding for the ACA Medicaid expansion.** Expansion states and states with higher eligibility levels could see higher funding allowances than non-expansion states with respect to any block grant proposal.
    - The 31 expansion states received nearly $73 billion in additional federal funding in 2016.
    - Kansas has low eligibility levels for adults relative to other states (33% FPL for parents, 0% FPL for childless adults), which contributes to the risk of a relatively small allotment under any model using a block grant.
- **Kansas has below average per capita Medicaid spending levels relative to other states in the U.S., putting it at risk of being "locked in" to a relatively low capped payment.** Since nearly all capped funding proposals start with a state's historic spending, Kansas may be locked into low capped federal payments.
    - Kansas spent an average of $6,267 per enrollee in federal fiscal year 2011 (26th among states), slightly below the national average of $6,502.
    - Kansas has relatively low spending for the disabled, children, and adults – $17,153 per disabled individual compared to a national average of $18,518 (23rd lowest), $2,186 per child compared to a national average of $2,492 (19th lowest), and $3,726 per adult compared to a national average of $4,141 (15th lowest).
    - Kansas already has relatively high use of managed care. In contrast to other states, it is not clear how much further Kansas could reduce per capita spending without reducing benefits or provider payment rates.
- **Between 2000-2011, Kansas's Medicaid spending on a per capita basis grew more slowly than many other states but, for three out of four eligibility groups, still more rapidly than or on par with the national trend rates typically advanced in capped funding proposals.** If Kansas decides that it needs to adjust its spending, for example, to ensure access to care, it is unlikely to have additional federal funding to rely on under capped funding.
    - Kansas's average annual per enrollee spending growth from 2000-2011 was: 1.4% for the disabled (2nd lowest in the nation), 3.1% for the aged (15th lowest in the nation), 5.4% for children (24th lowest in the nation), and 5.3% for adults (14th lowest in the nation).
    - Kansas's Medicaid spending growth for the aged, children and adults outstripped per capita GDP (2.9%) and CPI (2.5%) during that period. Kansas's Medicaid spending growth for children and adults also outstripped medical CPI (4%) during that period.
- **Kansas relies on DSH, UPL and waiver 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 Kansas to monitor.
    - DSH, UPL and waiver payments made up 5.5% of all Kansas Medicaid benefit spending in 2015.
- **Kansas 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, 70% of Kansas's Medicaid spending was for elderly and disabled enrollees even though they accounted for 30% of the State's Medicaid enrollment.

- **Kansas'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 Kansas budget and other State priorities, such as education.
  - Federal Medicaid funding ($1.7 billion in 2015) makes up nearly half (46%) of all federal funding in Kansas's budget – a below average share among non-expansion states but still the largest single source of federal funding for the State. By comparison, the next largest source of federal funds—for higher education—is just under 15% of the federal funds received by the State.

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