State Health Reform Assistance Network
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for Massachusetts

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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 Massachusetts-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact Massachusetts 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 $1.5 billion in federal funding to Massachusetts in 2015, and helped maintain Massachusetts's uninsurance rate as the lowest in the U.S.** If Medicaid restructuring eliminates or reduces funding for the Medicaid expansion, it would pose a significant threat to coverage in Massachusetts and to the State's budget.
    - Nearly 395,000 individuals are covered through the Medicaid expansion adult group in Massachusetts, 21% of the State's Medicaid population as of March 2016.
    - Massachusetts' uninsured rate dropped by 26% from 2013 and 2015 (from 3.8% to 2.8%), due in large part to the Medicaid expansion.
    - Beyond coverage, reducing or repealing federal support for expansion would have an outsized impact on Massachusetts's budget. Federal funding for new adults accounts for 17% of all federal Medicaid funding for Massachusetts.
- **Massachusetts'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 Massachusetts budget and other state priorities, such as education.
    - Federal Medicaid funding ($9 billion in 2015) makes up nearly three-fourths (74%) of all federal funding in Massachusetts's budget—the second highest share among expansion states. By comparison, the next largest source of federal funds—for primary and secondary education—is just under 11% of the federal funds received by the State.
- **Massachusetts has high per capita Medicaid spending levels for most groups, relative to other states.** Although nearly all capped funding proposals start with a state's historic spending, under some proposals, Massachusetts may be expected to move the state's per capita expenditures toward the median over time.
    - Massachusetts ranked first among states in total per capita spending per enrollee. In fiscal year 2011, average spending was $11,091 per enrollee, well above the national average of $6,502.
    - Massachusetts has relatively high spending for children and the aged: $4,173 per child compared to a national average of $2,492 (5th highest), and $27,205 for the aged compared to a national average of $17,522 (8th highest). In contrast, Massachusetts has relatively low spending for the disabled: $16,927 compared to a national average of $18,518 (31st highest), at least in part related to the Commonwealth's more expansive disability eligibility levels and its substantial premium assistance program for people with disabilities.[2]
- **Between 2000-2011, Massachusetts's Medicaid spending on a per capita basis grew more rapidly than the national trend rates typically advanced in capped funding proposals.** If Massachusetts' historical spending rates are indicative of its future spending rates, over time federal Medicaid funding under a capped funding proposal would be short of Massachusetts' needs.

[2] Although the source for these estimates (Kaiser Commission on Medicaid and the Uninsured) reflects an analysis of both person-level and aggregate spending data reported by states to the Centers for Medicare & Medicaid Services (CMS), Massachusetts is known to exclude certain home and community-based services (HCBS) waiver spending from its person-level data submissions to CMS. The extent to which aggregate spending totals are used to correct or adjust for this exclusion is not documented in the source notes for Kaiser's analysis.

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- Massachusetts's average annual per enrollee spending growth was above average for most eligibility groups from 2000 - 2011: 7.8% for children (8th in the nation), 6.2% for the aged (13th in nation), and 7.3% for adults (24th in the nation).
- Massachusetts's Medicaid spending growth on these groups significantly outstripped per capita GDP (2.9%), CPI (2.5%), and medical CPI (4%) during that period.

- **Massachusetts 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 Massachusetts to monitor.
  - DSH, UPL, and waiver payments made up 3.1% of all Massachusetts Medicaid benefit spending in 2015.
- **Massachusetts 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, over two-thirds (69%) of Massachusetts's Medicaid spending was for elderly and disabled enrollees though they accounted for one-third (33%) of the State's Medicaid enrollment.
  - Massachusetts is also experiencing rapid growth in enrollment of disabled individuals. From 2000-2011, average annual enrollment growth for disabled individuals was 5% (11th highest). This may compound issues under capped funding that could arise due to Massachusetts' relatively low per enrollee historical spending for this group of enrollees. The expansion of Medicaid to low-income adults in Massachusetts 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. In addition, as the average age of elderly Medicaid enrollees increases (e.g., due to growth in the number of people age 85 or older), average costs may increase as well, placing upward pressure on funding caps that were set in a base year that reflected a less costly population.

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