

Medicaid Capped Funding: Findings and Implications for Ohio
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 Ohio-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact Ohio 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 \$3.6 billion in federal funding to Ohio and sharply increased coverage.** If Medicaid restructuring eliminates or reduces funding for the Medicaid expansion, it would pose a significant threat to coverage in Ohio and to the State's budget.
 - Some 677,000 individuals are covered through the Medicaid expansion adult group in Ohio, 23% of the State's Medicaid population as of March 2016.
 - Ohio's uninsured rate dropped by 41% from 2013 to 2015 (from 10.9% to 6.4%), due in large part to the Medicaid expansion.
 - Beyond coverage, reducing or repealing federal support for expansion would have an outsized impact on Ohio's budget. Federal funding for new adults (an estimated \$3.6 billion in 2015) accounts for 25% of all federal Medicaid funding for Ohio.
- **Ohio'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 Ohio budget and other State priorities, such as education.
 - Federal Medicaid funding (\$14.3 billion in 2015) makes up more than half (54%) of all federal funding in Ohio's budget—below the average share among expansion states but still the single largest source of federal funding for the State. By comparison, the next largest source of federal funds—for primary and secondary education—is 13% of the federal funds received by the State.
- **Ohio 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, Ohio may be expected to move the state's per capita expenditures toward the median over time.
 - Ohio ranked 17th among states in total per capita Medicaid spending per enrollee. In fiscal year 2011, average spending was \$7,057 per enrollee, well above the national average of \$6,502.
 - Ohio has relatively high spending for the disabled and the aged: \$27,494 per aged individual compared to a national average of \$17,522 (6th highest) and \$21,892 per disabled individual compared to a national average of \$18,518 (11th highest).
- **Between 2000-2011, Ohio's Medicaid spending on a per capita basis grew faster than most other states and much more rapidly than the national trend rates typically advanced in capped funding proposals.** If Ohio's historical spending rates are indicative of its future spending rates, over time federal Medicaid funding under a capped funding proposal would fall short of Ohio's needs.
 - Ohio's average annual per enrollee spending growth was above average from 2000 – 2011 for most eligibility groups: 6.5% for children (12th in nation), 8.7% for adults (13th in nation), and 5.1% for disabled (17th in nation).
 - Ohio's Medicaid spending growth on these groups significantly outstripped per capita GDP (2.9%), CPI (2.5%) and medical CPI (4%) during that period.
- **Ohio 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 Ohio to monitor.

- DSH and UPL payments made up 6% of all Ohio Medicaid benefit spending in 2015.
- **Ohio 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 (69%) of Ohio's Medicaid spending was for elderly and disabled enrollees even though they accounted for approximately a quarter (25%) of the State's Medicaid enrollment.
 - The expansion of Medicaid to low-income adults in Ohio 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.