State Health Reform Assistance Network
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for Tennessee

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

- **Tennessee has low per capita Medicaid spending levels relative to other states, putting it at risk of being "locked in" to a low capped payment.** Since nearly all capped funding proposals start with a state's historic spending, Tennessee may be locked into low capped federal payments.
    - Tennessee spent an average of $5,607 per enrollee in federal fiscal year 2011 (15th lowest among states), well below the national average of $6,502.
    - Tennessee has relatively low spending for the aged and disabled – ranking 8th lowest on per capita spending per disabled enrollee ($14,680 compared to national average of $18,518, and the highest spending state at $33,808), and ranking 15th lowest on spending per aged enrollee ($15,745 compared to national average of $17,522, and the highest spending state at $32,199).
- **Under a capped funding model, Tennessee 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.
- **Tennessee relies on DSH 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 Tennessee to monitor.
    - DSH and waiver payments made up 9% of all Tennessee Medicaid benefit spending in 2015.
- **Between 2000-2011, Tennessee's Medicaid per capita spending on aged and disabled enrollees grew faster than nearly any other state and much more rapidly than the national trend rates typically advanced in capped funding proposals.** If Tennessee's historical spending rates are indicative of its future spending rates, over time federal Medicaid funding under a capped funding proposal may be short of Tennessee's needs.
    - Tennessee's average annual per enrollee spending growth for aged and disabled enrollees outpaced most states from 2000 – 2011: 13.3% for the aged (highest in the nation) and 6.8% for the disabled (4th in nation).
    - Tennessee's Medicaid spending growth on these groups significantly outstripped both per capita GDP (2.9%), CPI (2.5%), and medical CPI (4%) during that period.
    - Tennessee already has relatively high use of managed care, and has adopted many delivery system and payment reforms through managed care since 2011. In contrast to other states, it is not clear how much further Tennessee could reduce per capita spending without reducing benefits or provider payment rates.
- **Tennessee has a high uninsured population – leaving Tennessee with a bigger "hole" to address if and when the State is looking to cover additional residents.** Capped funding proposals to date do not take into account the size of each state's remaining uninsured population.
    - As of 2015, the uninsured rate in Tennessee was 10.2% - 18th highest in the nation.

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- While the current Medicaid structure preserves Tennessee's option to expand its Medicaid coverage, a capped model may eliminate or reduce federal financial support for any such expansion.

- **Tennessee'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 Tennessee budget and other State priorities, such as education.
    - Federal Medicaid funding ($6 billion in 2015) makes up more than half of all federal funding in Tennessee's budget – the 8th highest share among non-expansion states. By comparison, the next largest source of federal funds—for primary and secondary education—is just under 10% of the federal funds received by the State.

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