State Health Reform Assistance Network
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for West Virginia

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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 West Virginia-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact West Virginia 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 $732 million in federal funding to West Virginia in 2015, and has sharply increased coverage.** If Medicaid restructuring eliminates or reduces funding for the Medicaid expansion, it would pose a significant threat to coverage in West Virginia and to the State's budget.
    - Nearly 180,000 individuals are covered through the Medicaid expansion adult group in West Virginia, 35% of the State's Medicaid population as of March 2016.
    - West Virginia's uninsured rate dropped by nearly 60% from 2013 to 2015 (from 13.4% to 5.4%), due in large part to the Medicaid expansion.
    - Beyond coverage, reducing or repealing federal support for expansion would have an outsized impact on West Virginia's budget. Federal funding for new adults (an estimated $732 million in 2015) accounts for 26% of all federal Medicaid funding for West Virginia.
- **West Virginia'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 West Virginia budget and other state priorities, such as education.
    - Federal Medicaid funding ($2.8 billion in 2015) makes up nearly 79% of all federal funding in West Virginia's budget—the largest share of any state in the country. By comparison, the next largest source of federal funds—for primary and secondary education—is 12% of the federal funds received by the State.
- **West Virginia has a high per capita Medicaid spending level relative to other states.** Although nearly all capped funding proposals start with a state's historic spending, under some proposals, West Virginia may be expected to move the state's per capita expenditures toward the median over time.
    - West Virginia ranked 18th among states in total per capita Medicaid spending per enrollee. In fiscal year 2011, average spending was $6,821 per enrollee, above the national average of $6,502.
    - The West Virginia has higher than average spending for children and the aged: $2,506 per child compared to a national average of $2,492 (23rd highest) and $23,243 for per elderly enrollee compared to $17,522 nationally (15th highest).
- **Between 2000-2011, West Virginia's Medicaid spending on a per capita basis grew more rapidly for all eligibility groups than the national trend rates typically advanced in capped funding proposals, and faster than most other states.** If West Virginia'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 West Virginia's needs.
    - West Virginia's average annual per enrollee spending growth was above average for children, the aged, and adults from 2000 - 2011: 6.4% for children (14th in nation), 6.5% for the aged (10th in nation), and 8.2% for adults (15th in nation).
    - West Virginia's Medicaid spending growth on these groups significantly outstripped per capita GDP (2.9%), CPI (2.5%), and medical CPI (4%) during that period.

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- **West Virginia 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 West Virginia to monitor.
    - DSH and UPL payments made up 7.5% of all West Virginia Medicaid benefit spending in 2015.
- **West Virginia 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 70% of West Virginia's Medicaid spending was on elderly and disabled enrollees even though they accounted for only 38% of the State's Medicaid enrollment.
    - The expansion of Medicaid to low-income adults in West Virginia presumably has shifted the distribution of spending across eligibility groups since 2011, but, there is little doubt that when updated data become available, they will indicate that spending on the elderly and disabled remains substantial.
    - The large share of spending attributable to seniors and people with disabilities in 2011 occurred even though West Virginia had one of the lowest per capita spending levels for people with disabilities in the country – ranking 6th lowest nationally – at $12,993 in 2011 (compared to the national average of $18,518, and the highest spending state at $33,808).

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