State Health Reform Assistance Network
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for Wyoming

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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 Wyoming-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact Wyoming 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, Wyoming 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.
    - Wyoming has among the lowest eligibility levels for adults relative to other states (55% 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.
- **Wyoming has about average per capita Medicaid spending overall relative to other states, but among the highest per capita Medicaid spending levels for some eligibility groups.** Although nearly all capped funding proposals start with a state's historic spending, under some proposals, Wyoming may be expected to move the state's per capita expenditures toward the median over time.
    - Wyoming ranked 25th among states in total per capita Medicaid spending per enrollee. In fiscal year 2011, average spending was $6,322 per enrollee, just slightly below the national average of $6,502.
    - Wyoming has relatively high spending for the disabled and the aged: $32,199 per elderly individual compared to $17,522 nationally (highest in the country) and $25,346 per disabled individual compared to a national average of $18,518 (7th highest).
- **Between 2000-2011, Wyoming's Medicaid spending on a per capita basis grew more rapidly than the national trend rates typically advanced in capped funding proposals, and faster than most other states.** If Wyoming's historical spending rates are indicative of its future spending rates, over time federal Medicaid funding under a capped funding proposal would be short of Wyoming's needs.
    - Wyoming's average annual per enrollee spending growth was above average in three of four eligibility groups from 2000 - 2011: 6.8% for aged (8th in the nation), 5.4% for disabled (12th in the nation), and 8.1% for adults (16th in the nation).
    - Wyoming's Medicaid spending growth on these groups significantly outstripped per capita GDP (2.9%), CPI (2.5%), and medical CPI (4%) during that period.
- **Wyoming 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 Wyoming to monitor.
    - DSH and UPL payments made up 8.9% of all Wyoming Medicaid benefit spending in 2015.
- **Wyoming 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 (70%) of Wyoming's Medicaid spending was for elderly and disabled enrollees even though they accounted for one-fifth (20%) of the State's Medicaid enrollment.

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