State Health Reform Assistance Network
Charting the Road to Coverage
A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for Georgia

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

- **Georgia has among the lowest per capita Medicaid spending levels in the U.S., putting it at risk of being "locked in" to a relatively low capped payment.** Since nearly all capped funding proposals start with a state's historic spending, Georgia may be locked into low capped federal payments.
    - Georgia spent an average of $4,245 per enrollee in federal fiscal year 2011 (2nd lowest among states), well below the national average of $6,502.
    - Georgia has relatively low spending for the disabled, elderly and children – $10,639 per disabled enrollee compared to $18,518 nationally (2nd lowest), $14,142 per aged enrollee compared to $17,522 nationally (8th lowest), and $2,023 per child enrollee compared to $2,492 nationally (9th lowest).
- **Under a capped funding model, Georgia 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.
    - Georgia has relatively low eligibility levels for adults in the country (34% 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.
- **Between 2000-2011, Georgia's Medicaid spending on a per capita basis grew more slowly than many other states but still more rapidly than or on par with the national trend rates typically advanced in capped funding proposals.** If Georgia decides that it needs to adjust its spending, for example, to ensure access to care, it is unlikely to have additional federal funding to rely on under capped funding.
    - Georgia's average annual per enrollee spending growth from 2000 – 2011 was: 4.9% for the aged (19th in the nation), 2.7% for the disabled (43rd in the nation), 4.5% for children (33rd in the nation), and 6.9% for adults (29th in the nation).
    - Georgia's Medicaid spending growth on most of these groups kept pace with or outstripped per capita GDP (2.9%), CPI (2.5%), and medical CPI (4%) during that period.
- **Georgia 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 Georgia to monitor.
    - DSH and UPL payments made up 8.3% of all Georgia Medicaid benefit spending in 2015.
- **Georgia is a fast growing state, especially for the very aged (85+), which puts it at particularly high risk under capped funding.** A capped funding formula that does not take enrollment into account would leave the State at higher risk than others states. Even if enrollment growth is accommodated by a per capita cap model, it would be at risk for the higher costs attributable to an aging population.
    - Georgia is the 11th fastest growing state in the country. While the country is expected to see its population grow by 8.4% by 2025, Georgia is looking at a 11.8% growth rate, or an additional 1.2 million people.

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- By 2025, Georgia is expected to see its oldest senior (age 85+) population – a group with high Medicaid costs – grow by 30%, among the fastest growth rates in the country (ranking 6th).
- Projected growth in the elderly population will be a particular challenge in Georgia in light of its extremely low per capita spending base for the elderly (8th lowest in the nation).

- **Georgia has among the highest uninsured rates in the nation – leaving Georgia 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 Georgia was 13.8% - the 4th highest in the nation.
  - While the current Medicaid structure preserves Georgia's option to expand its Medicaid coverage, a capped model may eliminate or reduce federal financial support for any such expansion.
- **Georgia'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 Georgia budget and other state priorities, such as education.
  - Federal Medicaid funding ($6.6 billion in 2015) makes up nearly half (49%) of all federal funding in Georgia's budget – above the median among non-expansion states. By comparison, the next largest source of federal funds—for primary and secondary education—is just over 17% of the State's federal funds received by the State.

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