State Health Reform Assistance Network
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for South Dakota

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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 South Dakota-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact South Dakota 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, South Dakota 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.
    - South Dakota has among the lowest eligibility levels for adults in the country (57% FPL for parents, 0% FPL for childless adults) relative to other states, which contributes to the risk of a relatively small allotment under any model using a block grant.
- **South Dakota has low total per capita Medicaid spending levels relative to other states, 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, South Dakota may be locked into low capped federal payments.
    - South Dakota spent an average of $5,841 per enrollee in federal fiscal year 2011 (19th lowest among states), well below the national average of $6,502.
    - South Dakota has relatively low spending for its elderly population – $16,374 per aged enrollee compared to $17,522 nationally (22nd lowest in the nation); its per capita spending for children, adults and the disabled was slightly above average relative to other states (ranking 21st highest for the disabled and 24th highest for children and adults).
- **South Dakota's Medicaid spending per enrollee grew more slowly than many other states between 2000-2011 but kept pace with or exceeded the national trend rates typically advanced in capped funding proposals.** If South Dakota'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 South Dakota's needs.
    - South Dakota's average annual per enrollee spending growth from 2000 - 2011: 5.4% for children (25th lowest), 7.3% for adults (29th lowest), 4% for disabled (22nd lowest), and 3.2% for the aged (17th lowest).
    - South Dakota's Medicaid spending growth on these groups outstripped per capita GDP (2.9%) and CPI (2.5%) during that period. South Dakota's spending growth on children and adults also significantly outstripped medical CPI (4%) during that period.
- **South Dakota receives DSH and UPL payments; depending on how they are treated in a capped funding approach, these federal funds may be at risk.** This is an issue for South Dakota to monitor.
    - DSH and UPL payments made up almost 1% of all South Dakota Medicaid benefit spending in 2015.
- **South Dakota 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, close to two-thirds (60%) of South Dakota's Medicaid spending was for elderly and disabled enrollees even though they accounted for approximately a quarter (24%) of the State's Medicaid enrollment.

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- **South Dakota has among the highest uninsured rates in the nation – leaving South Dakota 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 South Dakota was 11% - the 13th highest in the nation.
    - While the current Medicaid structure preserves South Dakota's option to expand its Medicaid coverage, a capped model may eliminate or reduce federal financial support for any such expansion.
- **South Dakota'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 South Dakota budget and other State priorities, such as education.
    - Federal Medicaid funding (over $468 million in 2015) makes up more than one third (36%) of all federal funding in South Dakota's budget—below the average share among non-expansion states but still the single largest source of federal funding for the State. By comparison, the next largest source of federal funds—for transportation—is just over 24% of the federal funds received by the State.

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