State Health Reform Assistance Network
Charting the Road to Coverage

A Robert Wood Johnson Foundation program

Medicaid Capped Funding: Findings and Implications for 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 Virginia-specific data provided here offers insight into how base payment calculations and trend rates, as well as state policies and demographics, could impact 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

- **Under a capped funding model, Virginia 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.
    - Virginia has relatively low eligibility levels for adults (49% 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.
- **Virginia has a slightly lower than average total per capita Medicaid spending level, 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, Virginia may be locked into low capped federal payments.
    - Virginia spent an average of $6,477 per enrollee in federal fiscal year 2011, slightly below the national average of $6,502.
    - Virginia has relatively low spending for the aged – ranking 20th lowest on per capita spending per aged enrollee ($16,367 compared to national average of $17,522, and the highest spending state at $32,199).
- **Between 2000-2011, Virginia's Medicaid spending on a per capita basis grew much more rapidly than the national trend rates typically advanced in capped funding proposals, and faster than most other states.** If Virginia'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 Virginia's needs.
    - Virginia's average annual per enrollee spending growth was above average in most eligibility groups from 2000 – 2011: 8.9% for children (4th in nation), 9.7% for adults (10th in nation), and 5.3% for the disabled (15th in nation); its per capita spending growth rate for the elderly (3.5%) was just slightly below the national average (3.7%).
    - Virginia's Medicaid spending growth for children, adults, and the disabled significantly outstripped per capita GDP (2.9%), CPI (2.5%), and medical CPI (4%) during that period.
- **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 Virginia to monitor.
    - DSH and UPL payments made up 2.9% of all Virginia Medicaid benefit spending in 2015.
- **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, almost to two-thirds (64%) of Virginia's Medicaid spending was for elderly and disabled enrollees, even though they accounted for only 28% of the State's Medicaid enrollment.
- **Virginia is one of the fastest growing states in the country, 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 other states. Even if enrollment growth is

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accommodated by a per capita cap model, it would be at risk for the higher costs attributable to an aging population.

  - Virginia is the 12th fastest growing state in the country. While the country is expected to see its population grow by 8.4% by 2025, Virginia is looking at a 10.6% growth rate, or an additional 900,000 people.
  - By 2025, Virginia is expected to see its senior (age 65+) population – a group with high Medicaid costs – grow by 37%.
  - Projected growth in the elderly population will be a particular challenge in Virginia in light of its relatively low spending base for the elderly (20th lowest in the nation).

- **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 Virginia budget and other State priorities, such as education.
  - Federal Medicaid funding ($4.1 billion in 2015) makes up nearly 43% of all federal funding in Virginia's budget –a median share among non-expansion states. By comparison, the next largest source of federal funds—for transportation—is 14% of the federal funds received by the State.

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