State Health Reform Assistance Network
Charting the Road to Coverage
Per Capita Caps in Medicaid: Emerging Issues for States

June 5, 2017
Manatt Health
Key Considerations for Capped Funding

**Base Funding**
- What’s in, what’s out?
- Base year?
- Adequacy of base year funding?

**Supplemental Payments & Waiver**
- How treated in setting the base?
- Subject to the cap?

**Trend Rates**
- National or state trend rate?
- Which trend rate?
- Other adjusters?

**Savings Arrangement with Fed. Gov’t.**
- State option to share in federal savings?
- State option to “bank” savings for future?”

**State Spending Requirements**
- State spending requirements changed?
- Change in how states can raise match?

**Flexibility**
- Could new flexibilities be achieved through regulation or waiver?
- Are they worth the trade-off in reduced funding?
AHCA: Medicaid Funding Caps

*Aggregate cap* on Medicaid funding is built up from *per capita caps* for five different eligibility groups.

- **Aged**: Base Year Spending \( \times \) Trend Rate* \( \times \) Actual Enrollment
- **Blind & Disabled**: Base Year Spending \( \times \) Trend Rate* \( \times \) Actual Enrollment
- **Children**: Base Year Spending \( \times \) Trend Rate \( \times \) Actual Enrollment
- **Expansion Adults**: Base Year Spending \( \times \) Trend Rate \( \times \) Actual Enrollment
- **Other Adults**: Base Year Spending \( \times \) Trend Rate \( \times \) Actual Enrollment

\[ \text{Aggregate Spending Cap} = \text{Aged} + \text{Blind/Disabled} + \text{Children} + \text{Expansion Adults} + \text{Other Adults} \]

*If a state spends above its aggregate cap, the excess federal dollars are deducted from the following year’s cap; but, if a state spends below its cap, the unspent federal dollars are not rolled over into the following year’s cap.*

*To calculate states’ starting caps in 2020, 2016 spending is trended by M-CPI; starting in 2020, M-CPI+1 is used to trend and calculate the aged and disabled spending caps, while M-CPI continues to apply to children, expansion adults, and other adults.*
DSH is treated differently than UPL and waiver payments

- **DSH**
  - Excluded from the cap

- **UPL Payments**
  - Taken into account when calculating cap level based on 2016 spending
  - Subject to the cap

- **1115 Waiver Payments**
  - Includes Uncompensated Care Pools, Delivery System Reform Incentive Programs (DSRIP) and Designated State Health Programs (DSHP) funding pools
  - Taken into account when calculating cap level based on 2016 spending
  - Subject to the cap

- UPL and 1115 waiver payments are excluded from FY 2019 spending, but then added based on ratio of FY 2016 supplemental payments to FY 2016 total spending to calculate cap.

- This does not result in a directly proportionate increase in the cap.

- States with greater reliance on supplemental payments in FY 2016 will see a greater disparity.
Base Year Locks in Historic Spending Decisions

Medicaid Spending Per Full Benefit Enrollee by Eligibility Group and State, FY 2011

<table>
<thead>
<tr>
<th>State</th>
<th>Total Amount</th>
<th>Total Rank</th>
<th>Children Amount</th>
<th>Children Rank</th>
<th>Adults Amount</th>
<th>Adults Rank</th>
<th>Disabled Amount</th>
<th>Disabled Rank</th>
<th>Aged Amount</th>
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<td>$19,488</td>
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<td>$21,269</td>
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<tr>
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<td>$20,242</td>
<td>15</td>
<td>$21,163</td>
<td>18</td>
</tr>
</tbody>
</table>

- States are locked into base year spending levels with limited or no ability to increase provider rates, plan premiums or respond to public health crises or new technologies or cures with the benefit of federal matching dollars
- Per enrollee spending reflects base year enrollee mix within each eligibility category; future enrollee mix may include greater percentage of high-need, high-cost individuals

Factors to Consider in Evaluating Selected Base Year

A state's spending is baked into the calculation of its cap, giving an out-sized importance to base year spending*

- Temporary reduction in provider or plan payments
- Deferral of claim payments to future fiscal year
- Increase or decrease in UPL payments
- Timing of 1115 waiver payments
- Current enrollee risk profile
- Implementation of payment and delivery reform
  - Medicaid managed care implementation
  - HCBS rebalancing
- MMIS or other data and reporting problems

Details of how base year spending would be calculated are not available, raising questions of how prior period or future adjustments would be treated

*Current bill permits modification of base year for data errors subject to 2% cap
<table>
<thead>
<tr>
<th><strong>2016 Base Year</strong></th>
<th><strong>“Lucky” State</strong></th>
<th><strong>“Unlucky” State</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• State receives DSRIP or other waiver payments</td>
<td>• Some provider payments deferred to 2017 (e.g., due to budget shortfall, MMIS failure)</td>
</tr>
<tr>
<td></td>
<td>• Medicaid managed care premiums prove high*</td>
<td>• Long-standing approach to managed care</td>
</tr>
<tr>
<td></td>
<td>• State deferred some 2015 claims to 2016, thereby “inflating” 2016 spending</td>
<td>• Adopted legislation increasing minimum wage effective in 2017</td>
</tr>
<tr>
<td></td>
<td>• State added costly optional benefits such as personal care or health homes</td>
<td>• CMS recoups federal Medicaid dollars</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• DSRIP waiver approved at end of year; dollars will start flowing in 2017</td>
</tr>
</tbody>
</table>

*Not clear how CMS would handle this*
Medical CPI (M-CPI) measures the price for a representative “basket” of medical goods and services

- M-CPI is generally higher than other potential trend factors, but it does not keep pace with expected growth in Medicaid expenditures per person for most eligibility groups
- Does not measure price changes specifically for the Medicaid population
  - Services are included (or given more weight) in the M-CPI market basket based on the degree of out-of-pocket consumer spending for the item
  - Generally excludes long-term care and specialized mental health services
- Significantly varies from year-to-year
  - Range of 2.4% to 4.7% since 2001
  - One-sided approach to the per capita cap means that “low” years may not be fully offset by “high” years
- Does not allow geographic variation in price changes
- Final M-CPI for a given federal fiscal year not known until a month or more after the fiscal year ends
Projected Spending Growth Relative to AHCA Caps

Per enrollee spending is projected to grow more quickly than the trend rates established in the AHCA for all eligibility groups except aged.

**Estimated Annual Per Enrollee Spending Growth, 2017-2027**

- **Caps in 2020 will start off lower than baseline (current law) levels if a state’s overall average spending per enrollee exceeds medical CPI between 2016 and 2019.**

- **Medical CPI + 1 = 4.7% for aged and disabled in 2020+**

- **Medical CPI = 3.7% for children and adults in 2020+ and for all groups in 2016-2019**

Source: Manatt Medicaid financing model.
Note: Per enrollee growth rates projected by CMS Office of the Actuary; medical CPI projected by CBO. Spending growth for the aged and disabled groups is capped at medical CPI plus one percentage point starting in 2020; the 2019 baseline amount from which 2020 caps are calculated is trended forward from 2016 by medical CPI.
Between 2001-2016, annual growth in the medical CPI ranged from a low of 2.4% to a high of 4.7%. Even a 0.1% difference in medical CPI can have a significant impact when calculating a state’s aggregate spending cap under a per capita cap model.

Monthly M-CPI Provides Indication, But No Guarantee, of Final Annual M-CPI

M-CPI Rolling 12-Month Average Growth

While M-CPI Grew by 3.8% between 2015 and 2016
Nationally, M-CPI Growth Varied Greatly by Region

*San Francisco and San Diego regions use variation between 2012-2013 as 2015-2016 data was not available
Impact of Per Capita Cap Highly Sensitive to M-CPI

If medical CPI is 3.7%...

If medical CPI is 3.2%...

Contribution to the impact of the cap, 2026 (millions)
Total spending prior to per capita cap cuts, 2026 = $7.9 billion

State must cut $477.4 million to stay below cap

State must cut $826.5 million to stay below cap

Source: Manatt Medicaid financing model
Note: Assumes CMS baseline spending per enrollee growth rates. Includes federal and state spending for example state.
Contribution to Impact of Per Capita Cap Varies by Group, but Distribution of Cuts May Differ

Contribution to Impact of Cap, by Eligibility Group

<table>
<thead>
<tr>
<th>Group</th>
<th>Contribution to Impact of Cap, 2026 (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged</td>
<td>$166.0</td>
</tr>
<tr>
<td>Disabled</td>
<td>$1,764.7</td>
</tr>
<tr>
<td>Children</td>
<td>$1,193.3</td>
</tr>
<tr>
<td>Adults</td>
<td>$400.0</td>
</tr>
</tbody>
</table>

State must cut spending by $477.4 million to stay below cap, or it faces clawback.

Baseline spending, 2026 = $7.9 billion

Source: Manatt Medicaid financing model
Note: Assumes CMS baseline spending per enrollee growth rates and M-CPI averaging 3.7%. Includes federal and state spending for example state.
Many states will set their Medicaid budgets more than 1 year ahead of knowing their federal funding for Medicaid, putting states at significant financial risk.
Additional Considerations

States will face significant pressure to “manage to the cap”

- **Incents underspending to assure state stays under cap and avoids future clawback**
  - Create “buffer” by pegging spending below anticipated cap?
  - Treat each eligibility group as facing an eligibility-group specific cap?
  - Establish a reserve fund to ensure state stays under cap?

- **Creates incentive to maximize enrollment of relatively low-cost individuals within any given eligibility group**
  - May be advantageous to manage or limit new enrollment of relatively high cost individuals within any given eligibility group (e.g., through tighter cap on HCBS waiver)

- **Requires new state resources to support capacity to track enrollment and spending across eligibility groups and manage to the cap**
Are Federal Per Capita Caps Just MMC for States?

State Pays PMPM Premium to MCO

States

Medicaid MCOs

Federal Government

U.S. Pays Per Enrollee Per Year “Premium” to States

States

State Health Reform Assistance Network
Charting the Road to Coverage
Establishing Per Cap Amount for MCOs

Develop base rate off historic utilization and price data
Apply appropriate trend adjustments
Apply appropriate non-benefit costs
Adjust to reflect changing landscape and program features
Consider historical and projected MLR
Apply risk adjustment methodology, if used

Source: 42 CFR 438.2, .4-.7; Effective: Rating periods for contracts starting on or after 7/1/17
Establishing Per Cap Amount for States

Set base rate off historic spending broken down by eligibility group (i.e., children, adults, elderly, disabled)

Apply national trend rate
Thank You

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