

State Health Reform Assistance Network

Charting the Road to Coverage

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Robert Wood Johnson
Foundation

Per Capita Caps in Medicaid: Emerging Issues for States

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Manatt Health

Key Considerations for Capped Funding

Base Funding

- What's in, what's out?
- Base year?
- Adequacy of base year funding?

Trend Rates

- National or state trend rate?
- Which trend rate?
- Other adjusters?

State Spending Requirements

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

Supplemental Payments & Waiver

- How treated in setting the base?
- Subject to the cap?

Savings Arrangement with Fed. Gov't.

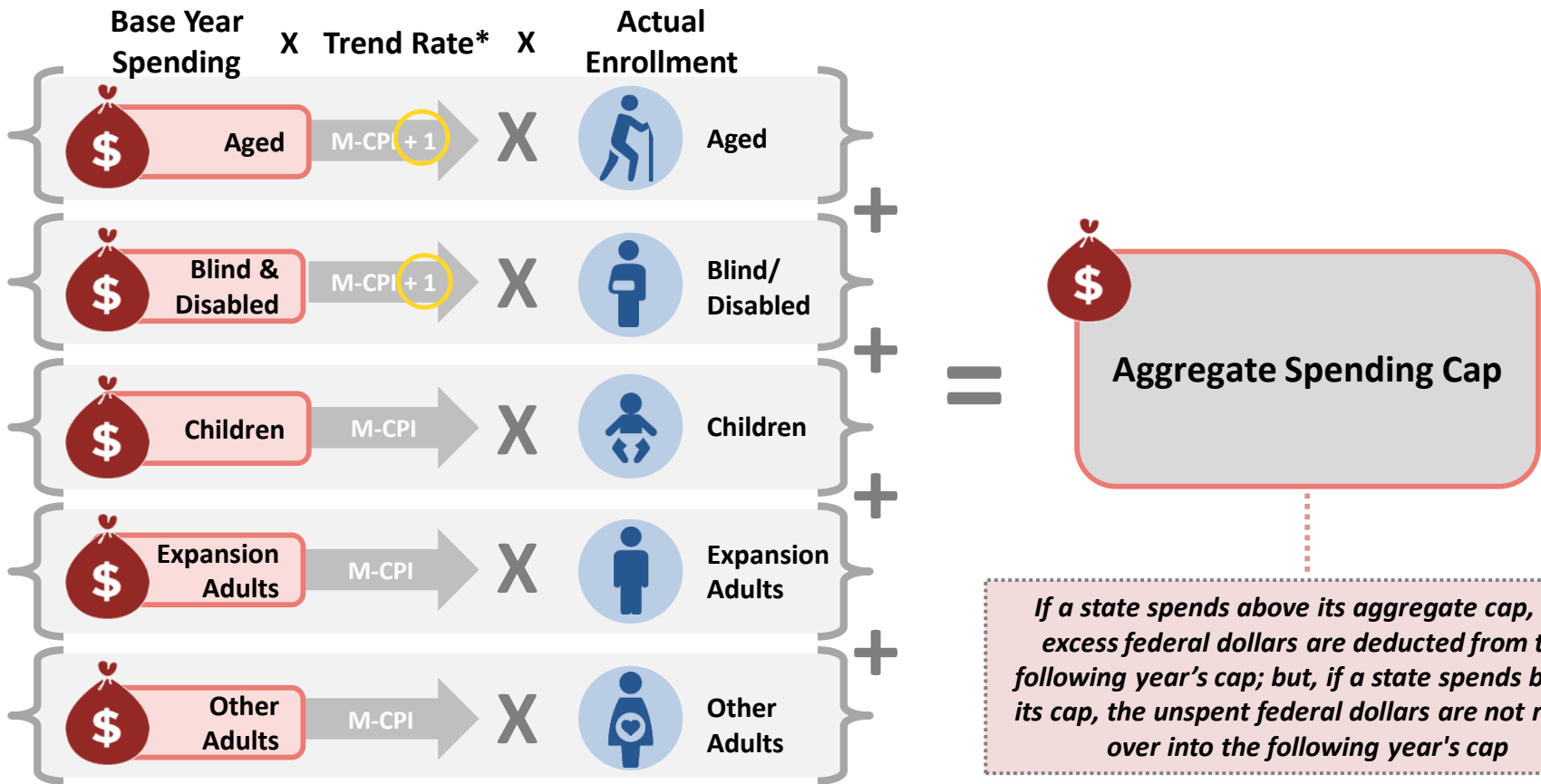
- State option to share in federal savings?
- State option to "bank" savings for future?"

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



*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

Treatment of Supplemental Payments

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

State	Total		Children		Adults		Disabled		Aged	
	Amount	Rank	Amount	Rank	Amount	Rank	Amount	Rank	Amount	Rank
Total	\$6,502		\$2,492		\$4,141		\$18,518		\$17,522	
Alabama	\$4,976	47	\$2,156	34	\$3,899	34	\$10,142	51	\$18,473	24
Alaska	\$9,481	4	\$4,682	2	\$6,471	3	\$28,790	3	\$24,288	12
Arizona	\$7,167	15	\$3,052	10	\$6,460	4	\$22,040	10	\$16,145	34
Arkansas	\$6,258	27	\$2,458	28	\$3,198	43	\$14,023	45	\$20,484	19
California	\$6,108	28	\$2,475	25	\$2,855	48	\$20,080	16	\$12,019	47
Colorado	\$5,730	35	\$2,241	32	\$3,469	41	\$19,643	19	\$18,478	23
Connecticut	\$8,122	8	\$3,158	9	\$4,538	18	\$31,004	2	\$30,560	3
Delaware	\$6,661	20	\$2,942	13	\$5,430	8	\$22,972	9	\$27,666	5
District of Columbia	\$9,083	5	\$2,820	16	\$4,446	21	\$28,604	5	\$27,336	7
Florida	\$4,893	48	\$1,707	50	\$2,993	47	\$15,005	43	\$14,253	42
Georgia	\$4,245	50	\$2,023	43	\$4,215	27	\$10,639	50	\$14,142	43
Hawaii	\$5,506	40	\$2,062	41	\$3,765	36	\$17,035	30	\$18,439	25
Idaho	\$5,968	29	\$2,023	43	\$4,878	12	\$21,781	12	\$15,558	37
Illinois	\$4,682	49	\$2,123	35	\$3,184	45	\$16,689	33	\$11,431	49
Indiana	\$5,600	38	\$1,858	49	\$3,198	43	\$19,488	20	\$21,269	17
Iowa	\$5,908	32	\$2,116	36	\$2,056	51	\$20,242	15	\$21,163	18

- 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

Some States Will Be “Lucky,” Others Less So



“Lucky” State



“Unlucky” State

2016
Base
Year

- State receives DSRIP or other waiver payments
- Medicaid managed care premiums prove high*
- State deferred some 2015 claims to 2016, thereby “inflating” 2016 spending
- State added costly optional benefits such as personal care or health homes

- Some provider payments deferred to 2017 (e.g., due to budget shortfall, MMIS failure)
- Long-standing approach to managed care
- Adopted legislation increasing minimum wage effective in 2017
- CMS recoups federal Medicaid dollars
- DSRIP waiver approved at end of year; dollars will start flowing in 2017

Trend Rate Considerations

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

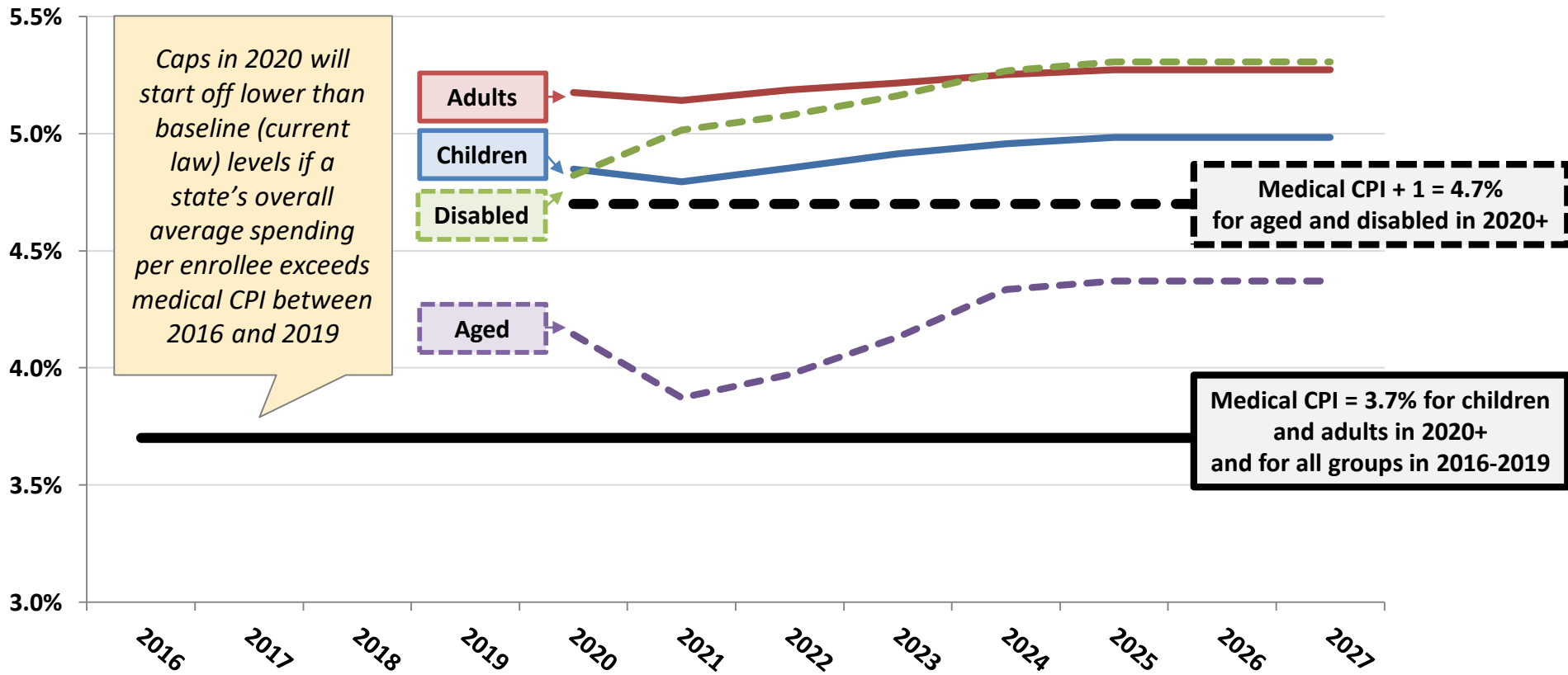
Does not allow geographic variation in price changes

Final M-CPI for a given federal fiscal year not known until a month or more after the fiscal year ends

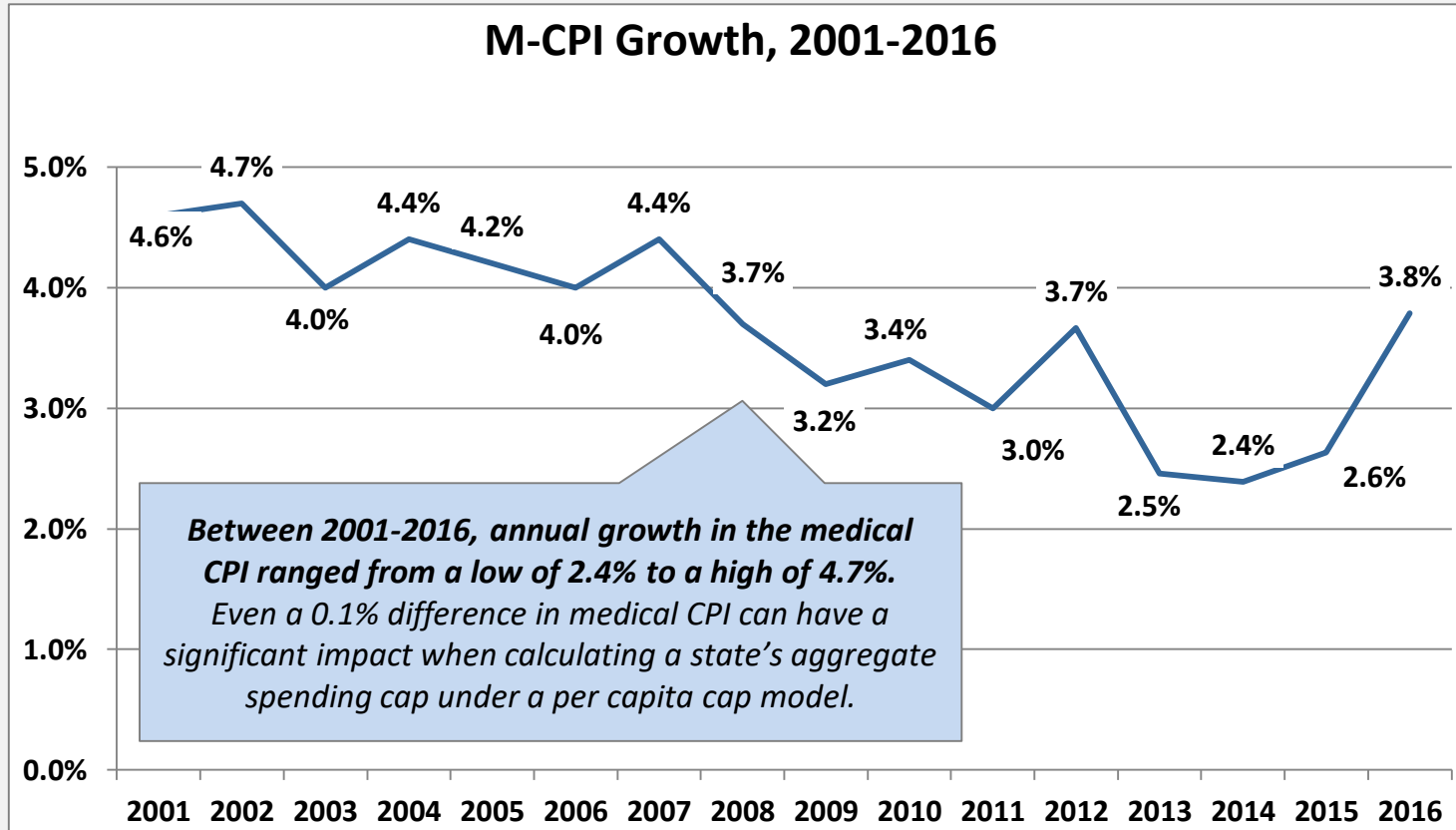
Projected Spending Growth Relative to AHCA Caps

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

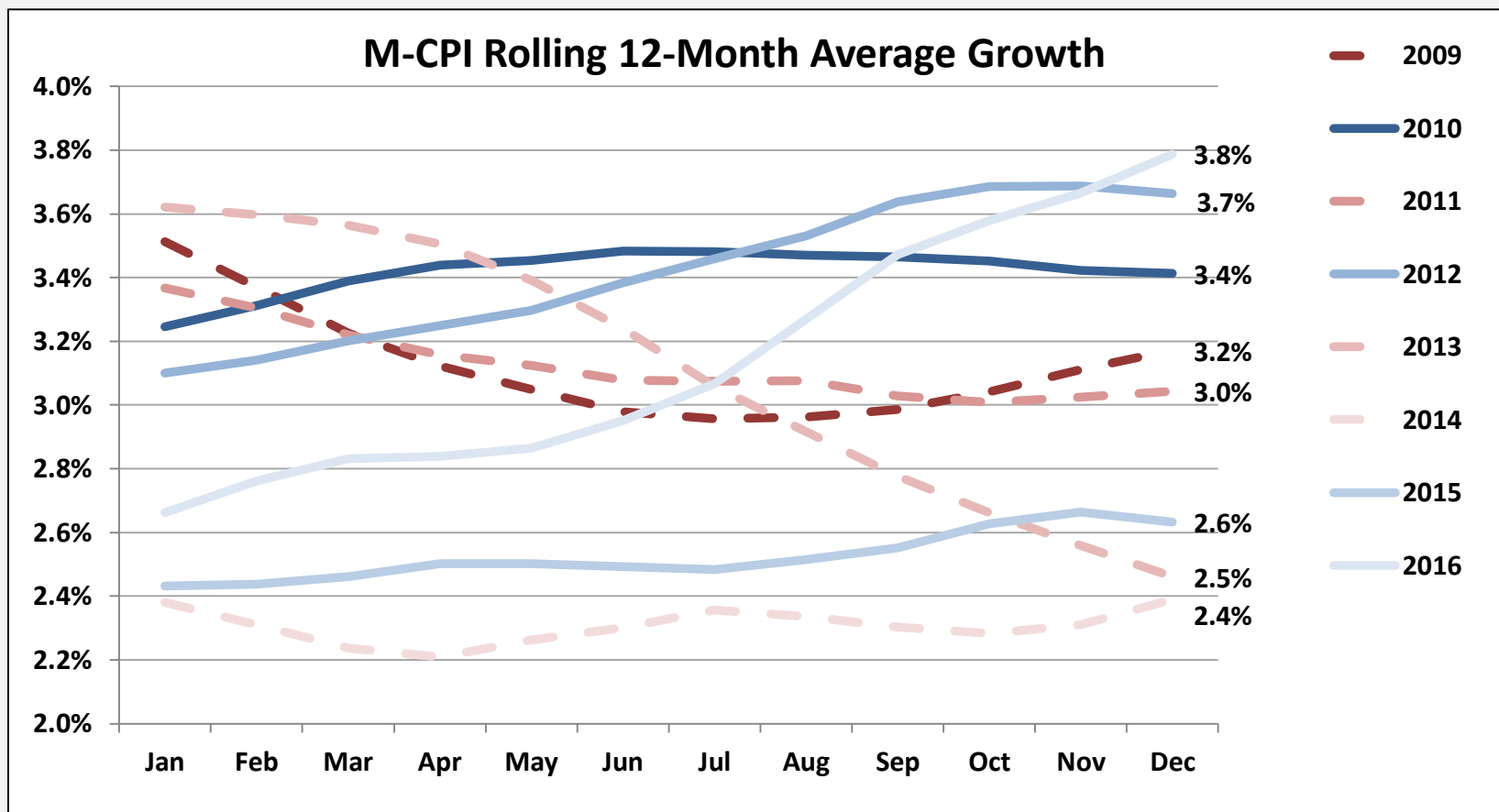
Estimated Annual Per Enrollee Spending Growth, 2017-2027



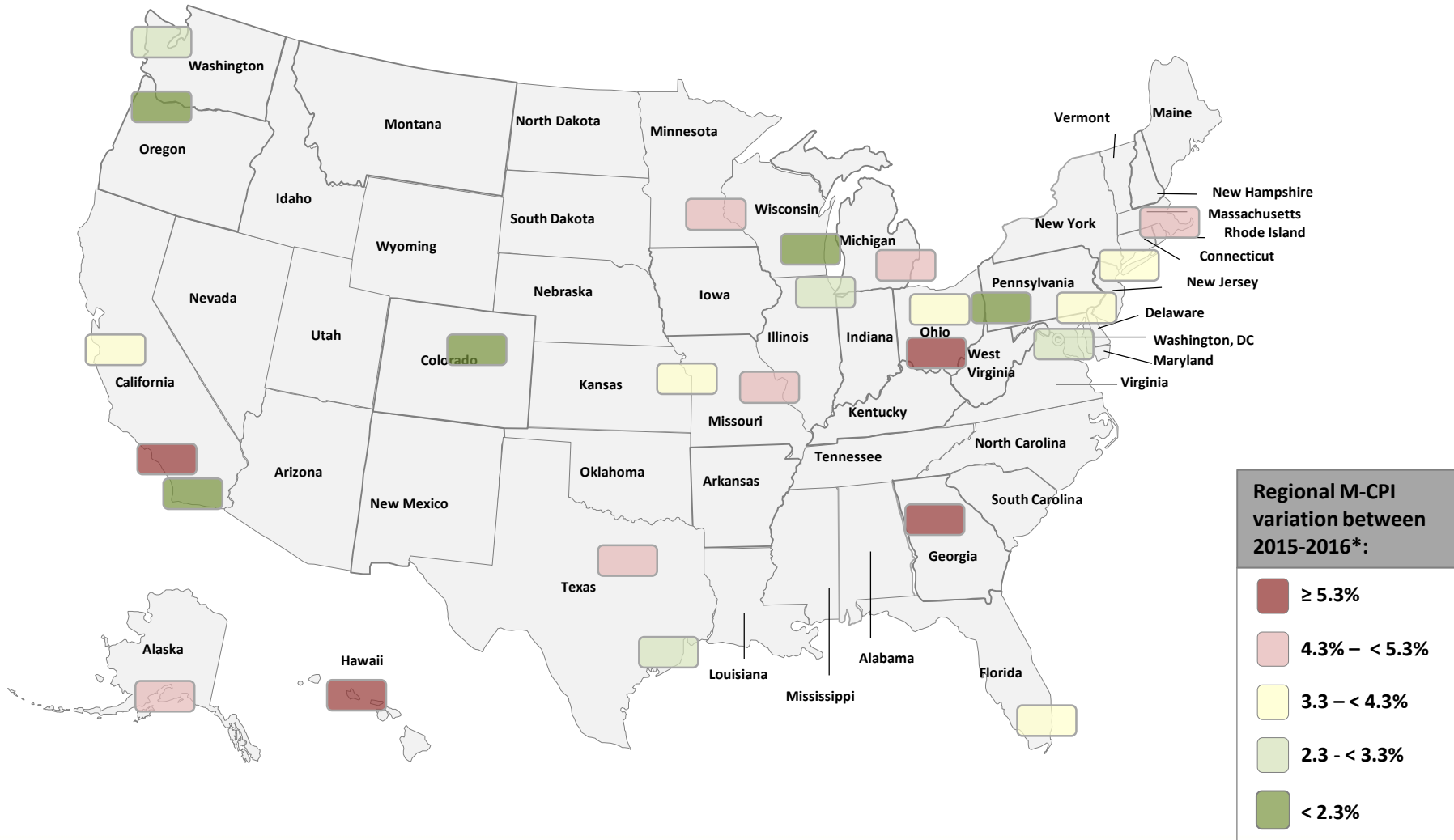
Annual Growth in Medical CPI Has Varied



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

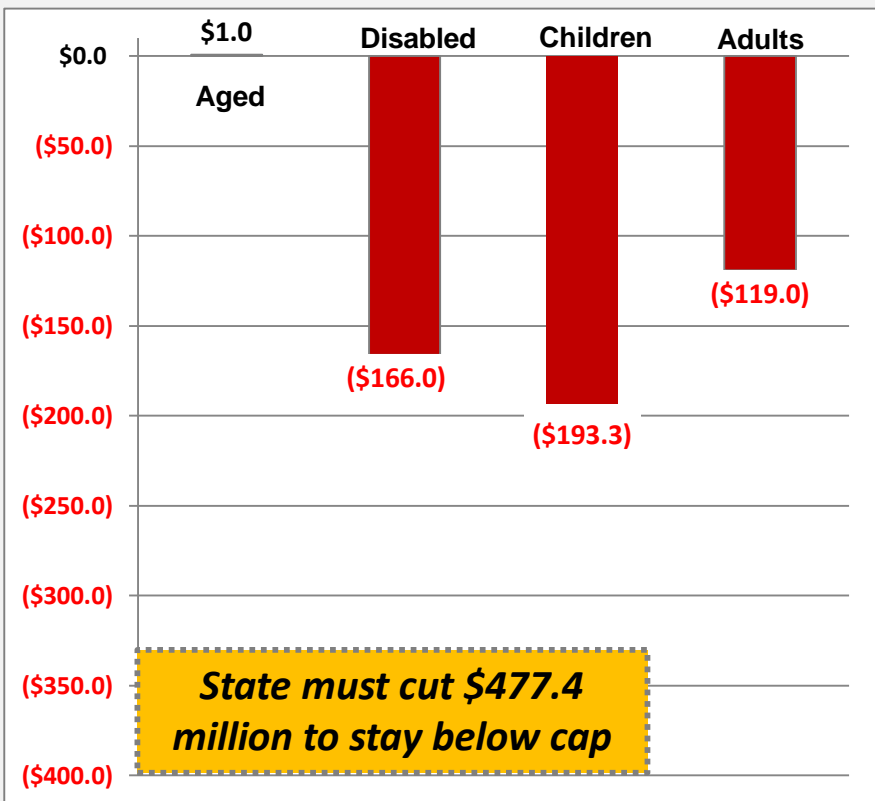


While M-CPI Grew by 3.8% between 2015 and 2016 Nationally, M-CPI Growth Varied Greatly by Region

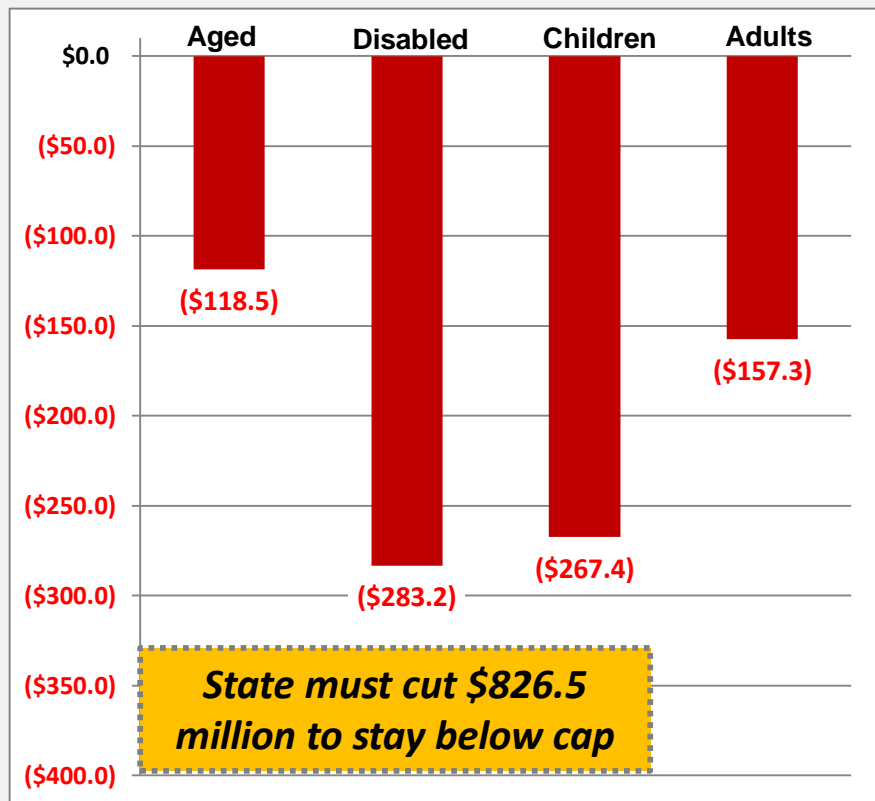


Impact of Per Capita Cap Highly Sensitive to M-CPI

If medical CPI is 3.7%...



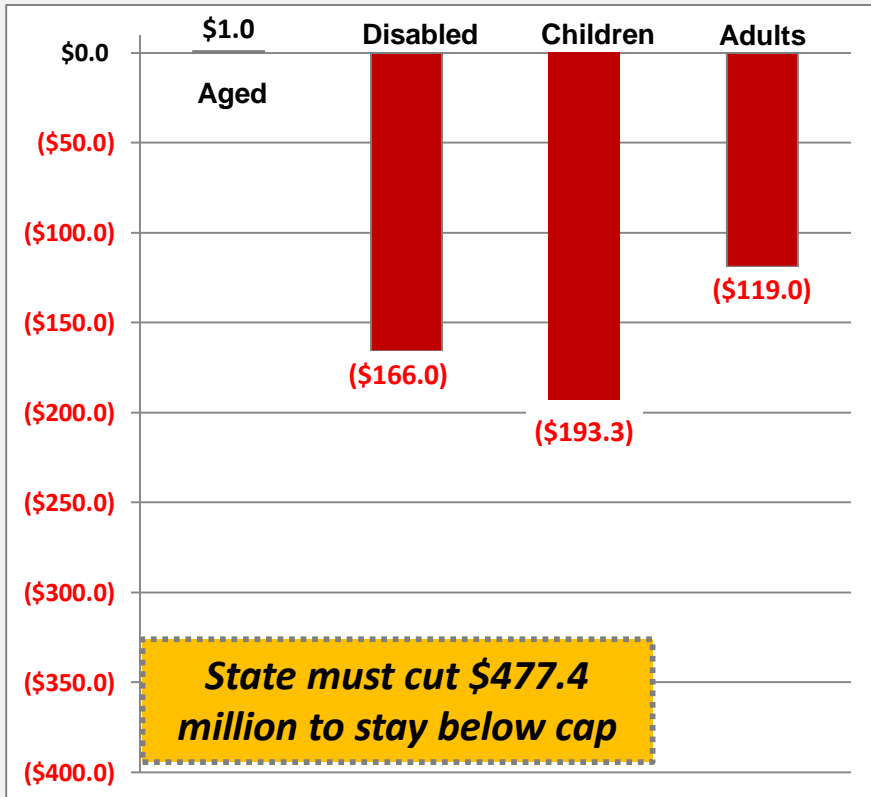
If medical CPI is 3.2%...



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

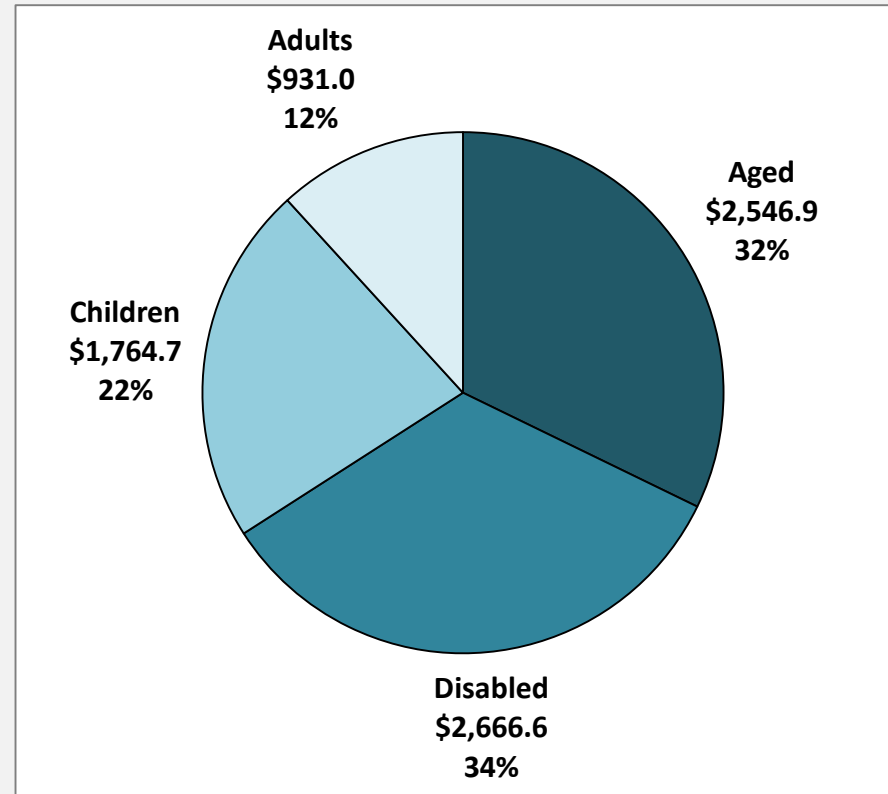
Contribution to Impact of Per Capita Cap Varies by Group, but Distribution of Cuts May Differ

Contribution to Impact of Cap, by Eligibility Group



Contribution to impact of cap, 2026 (millions)

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



Baseline spending, 2026 = \$7.9 billion

Retrospective Nature of Per Capita Cap Compounds Operational Challenges for States

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

Governor and legislature determine Medicaid budget for July 1, 2019 - June 30, 2020

End of federal fiscal year 2020

Fall-Spring
2018-2019

October 1,
2019

September 30,
2020

Late 2020

Start of federal fiscal year 2020

State retroactively learns final per capita limit based on M-CPI for federal fiscal year 2020 and final enrollment tallies

Additional Considerations

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

Incentives 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

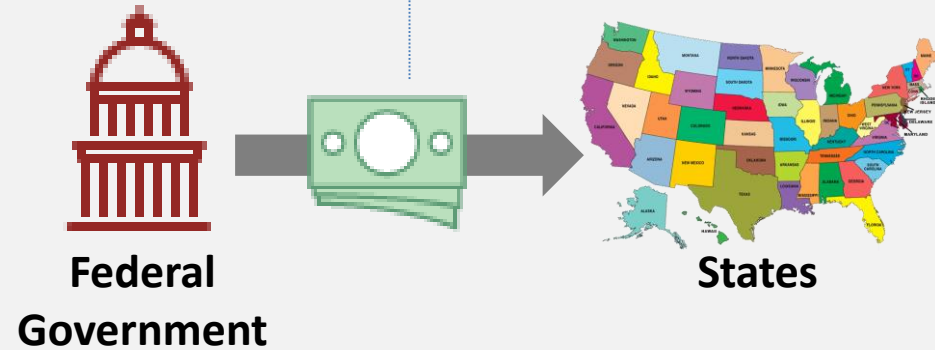
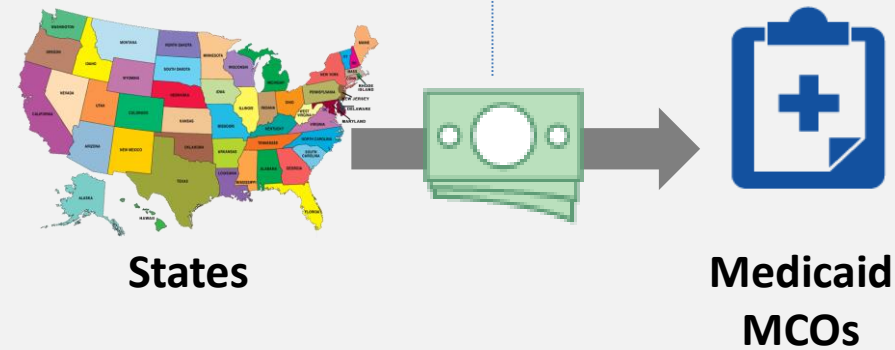
- May be advantageous to manage or limit new enrollment of relatively high cost individuals within any given eligibility group (e.g., through tighter cap on HCBS waiver)

Requires new state resources to support capacity to track enrollment and spending across eligibility groups and manage to the cap

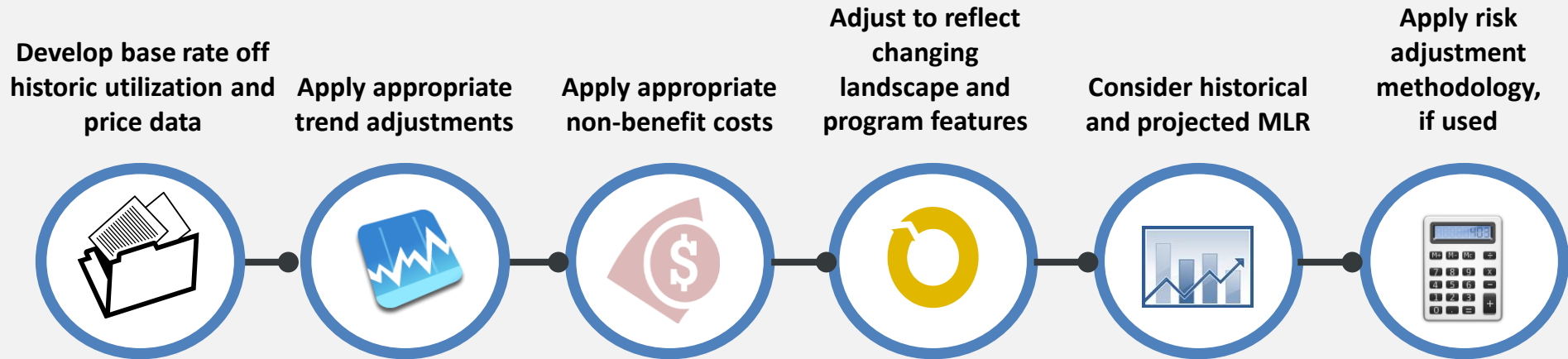
Are Federal Per Capita Caps Just MMC for States?

State Pays PMPM
Premium to MCO

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



Establishing Per Cap Amount for MCOs



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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