Alternative Approaches to Federal Medicaid Financing

Medicaid and CHIP Payment and Access Commission

Martha Heberlein
Concerns about the level and rate of growth has prompted discussions of altering the Medicaid financing structure.

Growth reflects a number of factors:
- Federal and state policy decisions
- External factors such as population aging and changes in the economy

The nature of the cost growth has implications for alternative approaches:
- Amount of federal savings from alternatives
- Appropriate mechanisms to slow these trends
Per Capita Caps

• Instead of an open-ended federal match, a per capita cap would place per enrollee limits on federal payments to the states
• A fixed growth rate would be established to increase per person spending
• Unlike a block grant, federal spending would increase based on the number of enrollees
• States would be responsible for any spending above the fixed per capita payment
Design Considerations

• Determining which programmatic pieces to include
• Establishing spending limits
  – Base year
  – Growth factors
  – State-specific caps
  – Enrollee-specific caps
• Defining the level of state contribution
• Determining the level of state flexibility and accountability
Congressional Action

• American Health Care Act (AHCA, H.R. 1628)
  – Passed House of Representatives on May 4, 2017

• Better Care Reconciliation Act
  – Failed procedural vote in Senate on July 25, 2017

• Congressional Budget Office (CBO) estimates:
  – Coverage provisions (including changes to Medicaid expansion) were projected to save between $756-$840 billion in federal outlays for Medicaid over the 2017-2026 period

• Unclear what next steps will be
Financing Alternatives

• Both bills would have shifted federal Medicaid financing from an open-ended match to a per capita cap beginning in FY 2020

• States would have had the option to use a block grant for certain populations:
  – House bill – non-elderly, non-disabled, non-expansion adults only or these adults and children
  – Senate bill – non-elderly, non-disabled, non-expansion adults, or expansion enrollees, or both
Enrollee Groups

• Per capita caps set for defined eligibility groups:
  – aged
  – disabled
  – children
  – non-expansion adults
  – new adult group

• Senate bill excluded children who qualify on the basis of disability
Excluded Populations and Expenditures

• Excluded populations
  – Individuals covered by CHIP
  – Individuals who receive services under Indian Health Services or the Breast and Cervical Cancer Treatment program
  – Partial benefit enrollees

• Excluded expenditures
  – Disproportionate Share Hospital (DSH) payments
  – Medicare cost sharing
  – Vaccines for children
  – Administration
Base Years

• House bill:
  – FY 2016 trended to FY 2019
  – Adjustment to reflect state spending on non-DSH supplemental payments

• Senate bill:
  – State may choose a base period
  – Any eight consecutive quarters between the first quarter of 2014 and the third quarter of FY 2017
  – Same non-DSH supplemental payment adjustment
Growth Factors

• House bill:
  – FY 2016 to FY 2019: CPI-M
  – FY 2019 to FY 2020 and subsequent years
    • aged and disabled per capita spending: CPI-M + 1 percentage point
    • children, non-expansion adults, and new adults: CPI-M

• Senate bill:
  – Same growth factors as House bill through FY 2024
  – Beginning in FY 2025, growth factor is CPI-U
  – Includes an adjustment for states with spending 25 percent above or below the national average
## Growth Factors Compared to Projected Annual Growth in Spending

<table>
<thead>
<tr>
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<th>2020</th>
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<th>2023</th>
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<tbody>
<tr>
<td><strong>Aged and disabled</strong></td>
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<tr>
<td>AHCA growth factor (CPI-M +1)</td>
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<td>BCRA growth factor (CPI-M +1/CPI-U)</td>
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<tr>
<td>Projected spending - aged</td>
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<td>3.9</td>
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<td>4.3</td>
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<td>Projected spending - disabled</td>
<td>4.8</td>
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<td>5.1</td>
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<td><strong>Child, non-expansion adult, expansion adult</strong></td>
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<tr>
<td>Projected spending - child</td>
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<td>4.9</td>
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<tr>
<td>Projected spending - non-expansion adult</td>
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<td>5.2</td>
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<td>Projected spending - expansion adult</td>
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<td>5.5</td>
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September 13, 2017
Aggregate Federal Spending Limit

- The per capita cap amount for each enrollee group is multiplied by number of enrollees to calculate a total medical expenditure limit
- The federal share of any excess spending over the aggregate limit is offset the following year on a quarterly basis
Other Design Considerations

- Defining the level of state contribution
  - Under both bills, states continue to provide funds under existing matching system
- Determining the level of state flexibility and accountability
  - Little change to the level of state flexibility
  - More state options under the block grant alternative
Potential Effect of Restructuring Federal Financing

- Depends on the design and the level of funding
- States may raise revenues to fill gap or make changes to eligibility, benefits, provider payments
- Effect on enrollees and providers depends on state reaction
- Other programs that serve low-income individuals
Additional Resources

• Design Issues in Medicaid Per Capita Caps: An Update

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