The Impact of Medicaid Capped Funding on Children

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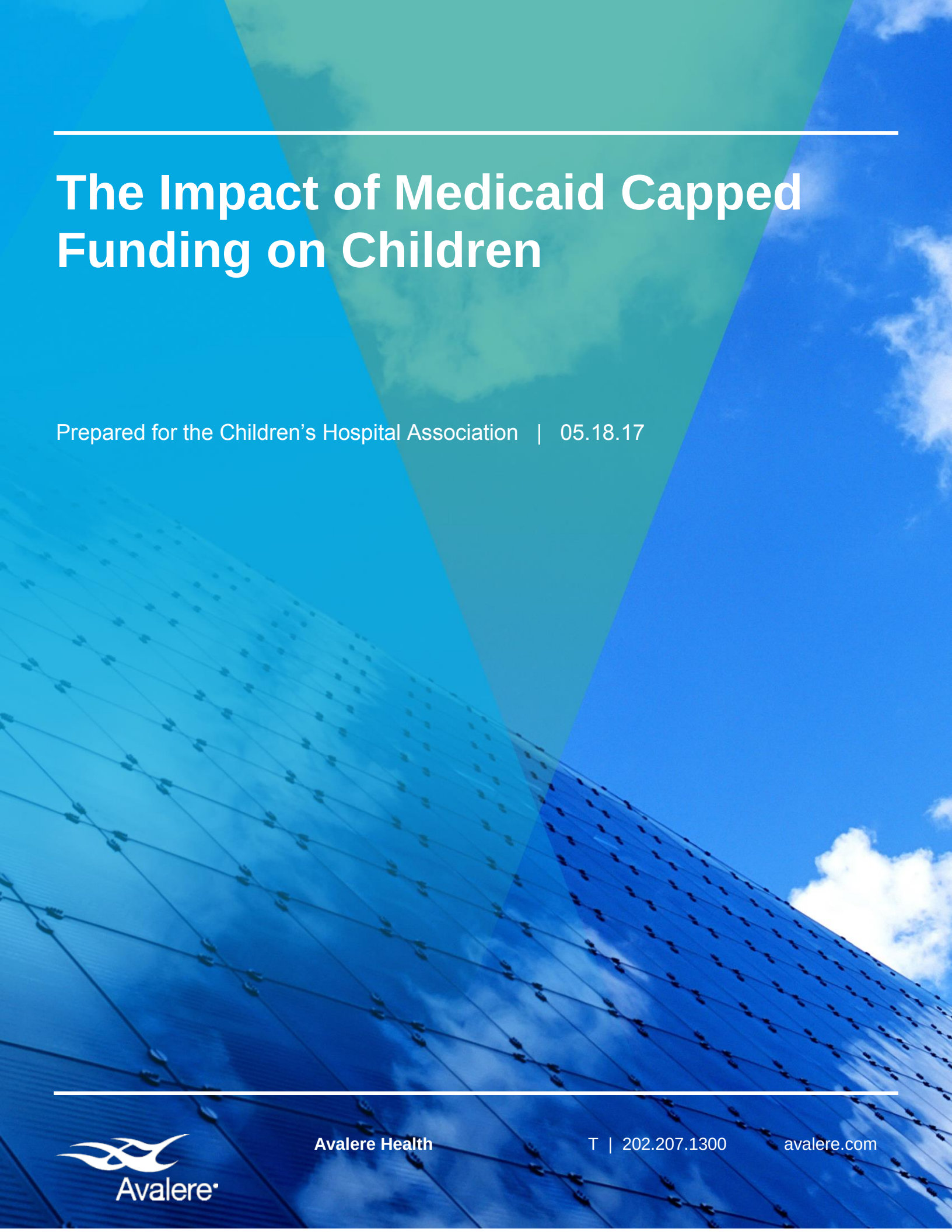

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Background

The American Health Care Act (AHCA), which passed the House on May 4, 2017, is the GOP's most recent step to repeal and replace the Affordable Care Act (ACA). While the AHCA will now be debated in the Senate, it and other policy proposals have included Medicaid capped funding, signaling that Medicaid funding will likely remain a key issue in healthcare reform. This is in contrast to the current policy in which open-ended federal funds are contributed as a fixed share of each state's spending.

Capped Medicaid funding is designed to set a target for federal spending on Medicaid and contains core components such as baseline funding levels, growth factors, and populations and services covered by the cap. Depending on the parameters of the capped funding formula, certain populations may be disproportionately affected through direct cuts to federal Medicaid spending or through state responses to manage costs of the population.

Nationally, children represent the largest group covered by Medicaid, which provides vital services such as screening and diagnostic services for this group, but also coverage for life-saving treatments. Decreased federal Medicaid spending on children under a cap could incentivize states to decrease services and enrollment. Further, while federal law currently mandates which benefits are covered by Medicaid, the AHCA proposed changes to these requirements and the Trump Administration has promised states more flexibility in administration of their Medicaid programs.

Children in Medicaid could be disproportionately affected by cuts to funding and benefits leading to instability in coverage and access, which can cause higher rates of unmet healthcare needs and worse health outcomes compared to children that have continuous coverage.[1] As policy makers debate Medicaid reform proposals, the potential impacts on children's health and development will need to be considered.

Capped Funding and Impact on Federal Funding for Children

Avalere projected the impact of federal Medicaid cap proposals on overall and state-by-state federal spending for children enrolled in Medicaid. Avalere only included the "traditional children" basis-of-eligibility group in its analysis and did not include children who were eligible for Medicaid due to disability due to the lack of comprehensive and up-to-date data on federal spending for disabled children at the state level.

[1] Orzol, Sean, et al. Program Churning and Transfers Between Medicaid and CHIP. Academic Pediatrics, 2015, Volume 15, Issue 3, S56 - S63.

National-Level Impact

The AHCA would implement a Medicaid per capita cap model starting in 2020 with the option for a state to select a block grant in 2020. Under the AHCA, per capita cap baseline funding would be based on 2016 federal Medicaid spending for each of five beneficiary groups: adults, children, aged, disabled, and newly-eligible adults. As originally introduced in the AHCA, the growth factor for a per capita cap would be set at the Consumer Price Index for medical inflation (CPI-M), or 3.7 percent, for all five eligibility groups over the next 10 years. The version that passed the House included a Manager's Amendment that increased the growth factor to CPI-M plus 1 percent (4.7 percent) for aged and disabled while maintaining CPI-M for adults, children, and newly-eligible adults. The AHCA also phases down enhanced FMAP for Medicaid expansion by 2020.

Under an AHCA-like per capita cap model, federal funding for traditional children would be reduced by a cumulative $43 billion over 10 years with reductions in spending becoming more dramatic each year.[2] In 2026, it is estimated that federal funding reductions for traditional children under this model would be reduced by 10 percent on average. Importantly, spending growth for children is projected to be 4.8 percent on average over the next 10 years, which is higher than CPI-M.[3] While the AHCA designated specific growth factors for per capita caps, policy makers may select other growth factors that could be higher or lower than the expected Medicaid spending growth for children. The selection of growth factor is critical to ensuring that adequate funding is provided through a per capita cap.

Change in Federal Medicaid Spending for Traditional Children under AHCA as Passed, 2020-2026

Year	2020	2021	2022	2023	2024	2025	2026	Total
Change in Federal Medicaid Spending	-$3B	-$3B	-$5B	-$6B	-$7B	-$9B	-$10B	-$43B

The AHCA gives states the option to select block grant funding for a 10 year period beginning in 2020 for children and non-elderly, non-disabled, non-expansion adults. Block grant allotments would be set to grow at a more modest growth factor of the Consumer Price Index, CPI-U, compared to the per capita cap. For expansion adults, aged, and blind and disabled beneficiaries, states would continue to receive funding through per capita caps, as described above. Following this 10-year period, states would move to a per capita cap model of funding for all eligibility groups.

Under a scenario in which all states and DC chose the block grant option, states would see a cumulative reduction in federal funding for traditional children of $78 billion over 10 years. In 2026, it is estimated that federal funding reductions for traditional children under a block grant would be reduced by 19 percent on average. States would benefit from choosing the block grant option only if they expect to slow, or reduce, their enrollment for

[2]10-year CBO-style score from 2017-2026, but policy does not take effect until 2020. This analysis adjusts the estimated percent change in federal Medicaid spending to the CBO March 2016 Baseline.
[3]CBO March 2016 Baseline.

children and non-expansion adults. Otherwise, the block grant option is less generous than per capita caps, since it constrains both per person spending and overall enrollment growth.

Further, spending reductions for children will be even more dramatic when accounting for children enrolled through the disabled basis-of-eligibility group. On average, 1.6 million children between 0-18 years of age are enrolled in Medicaid each month due to disability and would also be impacted by federal funding reductions under the AHCA's per capita cap model.[4]

State-Level Impact

Under a per capita cap, all 50 states and DC will see a reduction in their baseline funding of 10 percent in federal Medicaid spending for traditional children in 2026 compared to what is expected to be spent under current law. Cumulative reductions in federal funding for traditional children from 2020 to 2026 would range from $59 million in North Dakota to $5.1 billion in Texas. Cuts are likely to become more dramatic over time as medical spending for children continues to grow faster than CPI-M over time.

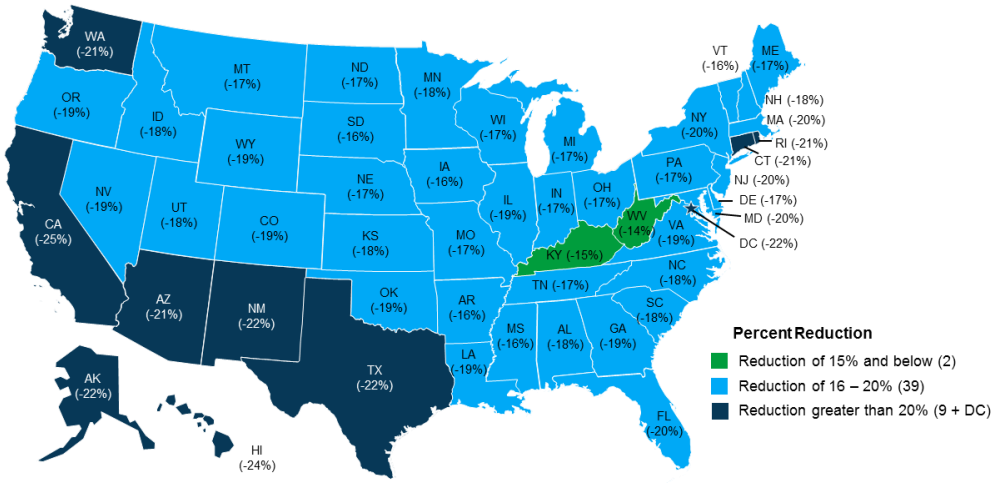
State	Dollar Change (Millions)	State	Dollar Change (Millions)
Alabama	-$578	Montana	-$113
Alaska	-$180	Nebraska	-$135
Arizona	-$1,487	Nevada	-$223
Arkansas	-$529	New Hampshire	-$127
California	-$4,700	New Jersey	-$665
Colorado	-$571	New Mexico	-$608
Connecticut	-$476	New York	-$2,640
Delaware	-$143	North Carolina	-$1,223
District of Columbia	-$205	North Dakota	-$59
Florida	-$2,299	Ohio	-$1,614
Georgia	-$1,041	Oklahoma	-$551
Hawaii	-$153	Oregon	-$433
Idaho	-$238	Pennsylvania	-$1,540
Illinois	-$1,715	Rhode Island	-$101
Indiana	-$647	South Carolina	-$665
Iowa	-$283	South Dakota	-$74
Kansas	-$352	Tennessee	-$1,911
Kentucky	-$713	Texas	-$5,083
Louisiana	-$1,057	Utah	-$473
Maine	-$283	Vermont	-$101
Maryland	-$613	Virginia	-$626

[4] Kaiser. 2017. Medicaid Enrollment of Children Qualifying Through a Disability Pathway.

Massachusetts	-$714	Washington	-$708
Michigan	-$1,236	West Virginia	-$281
Minnesota	-$609	Wisconsin	-$348
Mississippi	-$578	Wyoming	-$68
Missouri	-$917	**Total**	**-$42,686**

Under the block grant option, states would see across the board cuts in federal Medicaid spending for children ranging from a 14 percent reduction in West Virginia to a 25 percent reduction in California.[5] Because block grants create financial incentives for states to reduce enrollment, states that select this option are likely to take measures to reduce their Medicaid enrollment growth. In other words, states may reduce enrollment proportionate to their federal funding reduction under this model in order to maintain current state funding levels or generate savings to be used in future years.

Percent Reduction in Federal Medicaid Spending for Children Under AHCA Block Grant, 2026



Potential Impacts on Children Enrolled in Medicaid

Faced with reductions in total federal spending for Medicaid and specifically for children, states will feel pressure to further manage costs or increase state funding for the program. While the Administration has pledged to provide more flexibility to states in administering their Medicaid programs, this does not necessarily mean that states can control costs. For instance, spending at the state level may be unpredictable, such as in the event of an epidemic or introduction of a costly yet effective treatment, which can increase the rate of state spending on Medicaid beyond projected growth. Further, under the phase down of enhanced FMAP for the Medicaid expansion population, states will be under additional financial pressure if they choose to maintain coverage of the expansion population. These pressures may lead states to evaluate where funding is allocated and identify ways to reduce spending by narrowing eligibility, reducing services, or lowering provider rates.

[5] State level analysis may vary if using different baseline funding and growth rates than the methodology used in this analysis.

While children represent a smaller share of expenditures compared to other groups, they account for the largest group of enrollees covered by Medicaid. Reductions in funding for children and subsequent state actions to manage costs of their Medicaid program could lead to coverage instability and access issues for children. For instance, under current law, states are required to provide Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefits to children and youth up to age 21, however the Manager's Amendment eliminated this requirement under the block grant option and limited services to "health care for children under 18 years of age". This would allow states to reduce the amount and type of services provided to children likely by targeting the most costly services. States may also implement utilization management as a means to manage spending, requiring prior authorization or step therapy for certain treatments and services. States could consider lowering Medicaid provider rates as well, which could lead to decreased provider participation and access issues for children needing care.

The effects on children are likely to be even more dramatic when considering those enrolled in Medicaid due to disability who have greater use of long-term care services and whose per enrollee costs are much higher than the traditional children group. In fiscal year 2011, per enrollee spending for children with disabilities was on average $16,802, compared to $2,463 for traditional children.[6]

The Children's Hospital Association provided funding for this analysis. Avalere maintained full editorial control.

Methodology

Avalere used its Medicaid forecasting and simulation model to estimate the national- and state-level effect of federal Medicaid cap policies, focusing specifically on funding for children in the Medicaid program. This analysis did not take into account spending on children whose basis-of-eligibility is disability.

Avalere's forecasting and simulation model uses a combination of CMS' Medicaid statistical information system (MSIS) and Medicaid budget and expenditure system (MBES) data to estimate recent and historical Medicaid spending and enrollment. To estimate future Medicaid spending and enrollment, it relies on the 2016 CMS Medicaid actuarial report for per enrollee spending growth and a combination of U.S. Census Bureau state population projections and each state's historical enrollment to estimate future state-specific enrollment by basis of eligibility group. Avalere uses congressional budget office (CBO) assumptions for future overall inflation (CPI-U) and medical inflation (CPI-M). Direct changes in federal Medicaid spending excludes the effect of any resulting changes in Medicaid enrollment. The simulation assumes Medicaid funding policies start in 2020 (using 2016 as the base year for federal spending levels) and that states do not alter enrollment or benefits. Avalere's forecast period for this analysis aligns with the most recent CBO budget window, 2017-2026.

[6] Kaiser. May 2017. State Variation in Medicaid Per Enrollee Spending for Seniors and People with Disabilities.

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