

Establishing a Per Capita Cap in Medicaid: Implications for California

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Prepared by Manatt Health for:



California Health Care Foundation

HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

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Purpose of This Project

With Congress proposing fundamental changes to the financing structure of Medicaid through creation of a per capita cap, CHCF asked Manatt Health to examine the implications for California and the 13.5 million beneficiaries served by Medi-Cal.

The purpose of this analysis is to:

- Describe the cap proposal under consideration in Congress
- Using the Senate's June 22 Better Care Reconciliation Act (BCRA), provide estimates of the fiscal impact on California of a per capita cap, and illustrate the impact of changes in the trend factor
- Describe the operational issues and challenges created by a per capita cap
- Review the choices available to California if a per capita cap is established

This analysis does not examine the impact of other BCRA provisions, including changes to federal match for the state's expansion population.

Key Takeaways

A per capita cap would put significant fiscal pressure on Medi-Cal, California's Medicaid program, and on the state budget, as it would eliminate the federal government's commitment to share all Medicaid costs with the state.

- California can expect to lose \$37.6 billion in federal funds between FY* 2020 and 2027 under the per capita cap as proposed by the Senate (BCRA June 22 version).

The actual impact will depend on the trend rates for the cap; if they turn out to be even slightly lower than expected, cuts will compound quickly.

- If medical consumer price index (CPI) is just half a percentage point below projections, and actual Medicaid spending does not similarly drop, cuts during FY 2020-2027 increase by 39% to \$52.4 billion.[†]
- If medical CPI is markedly higher (or spending pressures markedly lower) than expected for a given year, California may receive some short-term relief, but it cannot use the "good" year to ease the impact of cuts in future years.

A cap locks California into its relatively low Medi-Cal spending levels and puts the state at risk for unexpected health care costs.

A cap would pose major operational issues for California, including the need to make Medi-Cal and budget decisions in advance of knowing the amount of federal funds available to it.

California will face difficult choices if a cap is imposed; it will need to raise taxes, cut other programs, significantly reduce Medi-Cal expenditures — or some combination of all.

*References to FY throughout this document are federal fiscal years unless noted otherwise.

†Because Medical CPI may not accurately account for all services covered by Medicaid, actual spending may not be similarly reduced.

- **Role of Medicaid in California**
- **Background on Per Capita Caps**
- **Estimated Impact**
- **Uncertainty and Risk**
- **Operational Considerations**
- **State Options and Implications**

Role of Medicaid in California

California: Medicaid Enrollment

Medicaid covers **1 in 3** Californians

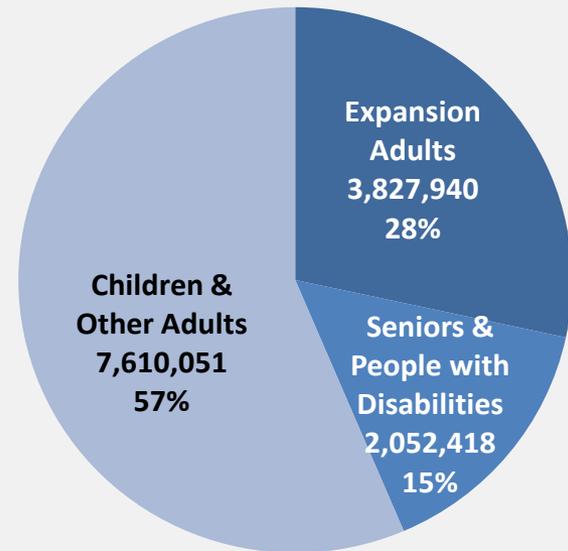
Total Medicaid Enrollment,
January 2017



Share of California Medicaid Enrollees in
Working Households,* 2015



Medicaid Enrollment by Eligibility
Category, January 2017



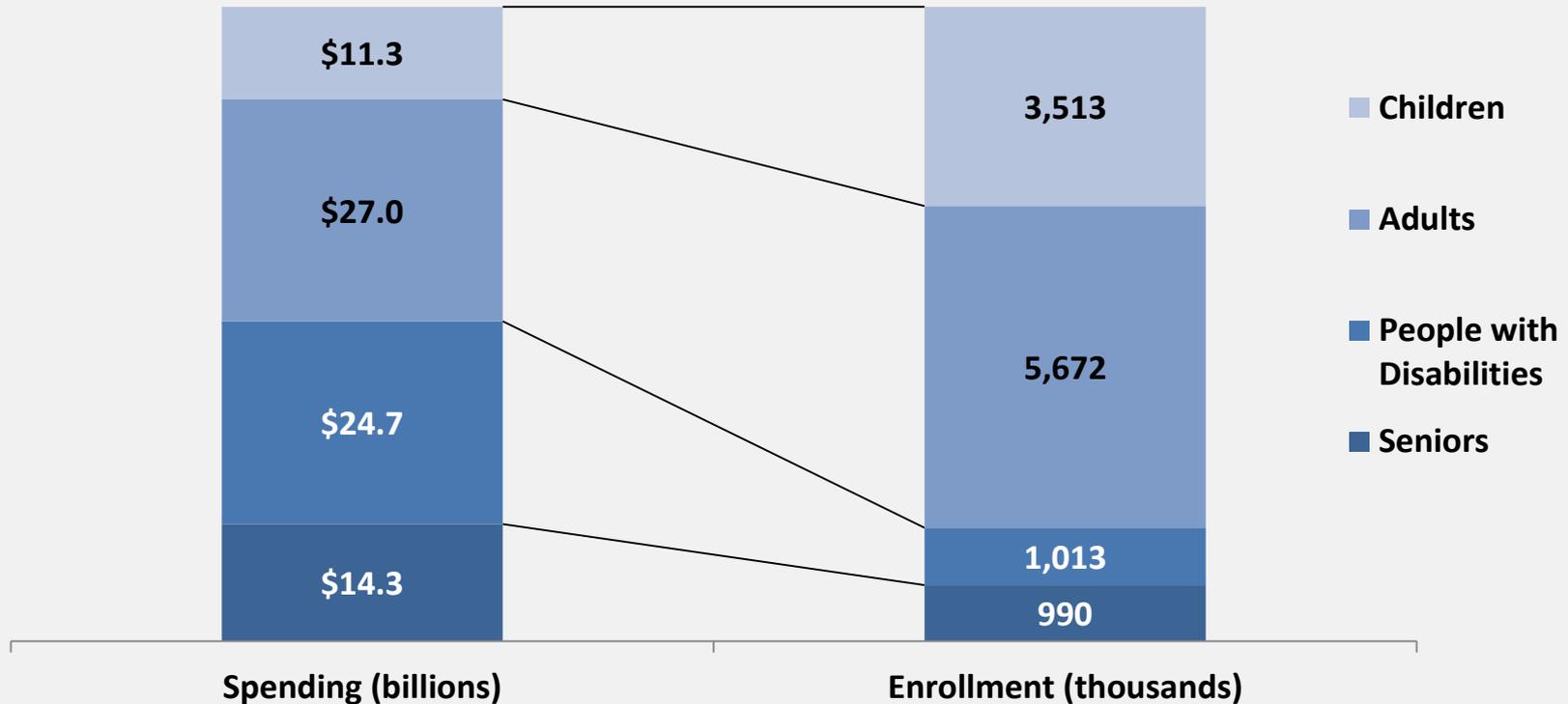
Total Medicaid Enrollment:
13,490,409

* Among nonelderly Medicaid enrollees. Includes households with at least one nonelderly full-time or part-time worker.
Note: Medicaid child group includes 1.3 million CHIP-funded children.
Sources: http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_January_2017_ADA.pdf;
<http://kff.org/medicaid/state-indicator/distribution-by-employment-status-4/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

Expenditures by Eligibility Group

Most Medi-Cal enrollees are children and nondisabled adults, but most program spending is on seniors and adults with disabilities.

Estimated California Medicaid Spending and Enrollment by Eligibility Group,* FY 2016



Source: Manatt Medicaid Financing Model.
Note: Excludes Medicaid children financed with CHIP funding.

Medicaid's Financing Structure Today

Currently the federal government covers a share of all Medicaid expenditures, but this guarantee would be eliminated by a per capita cap.

- **Federal dollars guaranteed as match to California spending.**
- **Matching rates vary by population and service.**
 - For many beneficiary groups and services, matching rate in FY 2017 = 50%
 - Matching rate for expansion adults = 95% in 2017; 90% in 2020 and beyond
 - Indian Health Service and tribal facility services matching rate = 100%
- **The federal government and California share in the risk if there are higher than expected health care costs — for example:**
 - Higher than expected enrollment
 - Public health epidemics (e.g., the substance use epidemic)
 - Breakthrough treatments or medications
 - New initiatives related to delivery system reform or access
 - Economic downturn

Per Capita Cap

Congress is considering enacting a per capita cap funding structure for Medicaid.

This represents a fundamental change in Medicaid financing.

- Eliminates the federal government's guarantee that it will fully share fiscal responsibility with states for the cost of Medicaid.
- Instead, states would be allocated a set amount per beneficiary. These amounts would be added together to establish an overall limit on expenditures that the federal government will match.
- Applies to nearly all beneficiaries and services.

There is no financial benefit to states — they face downside-only risk under a per capita cap.

- States face federal cuts if their spending exceeds the cap, but receive no additional federal funds if they keeping spending below the cap.
- Further, states cannot use any room that they have under the cap from a “good” year to offset federal cuts in a future year.

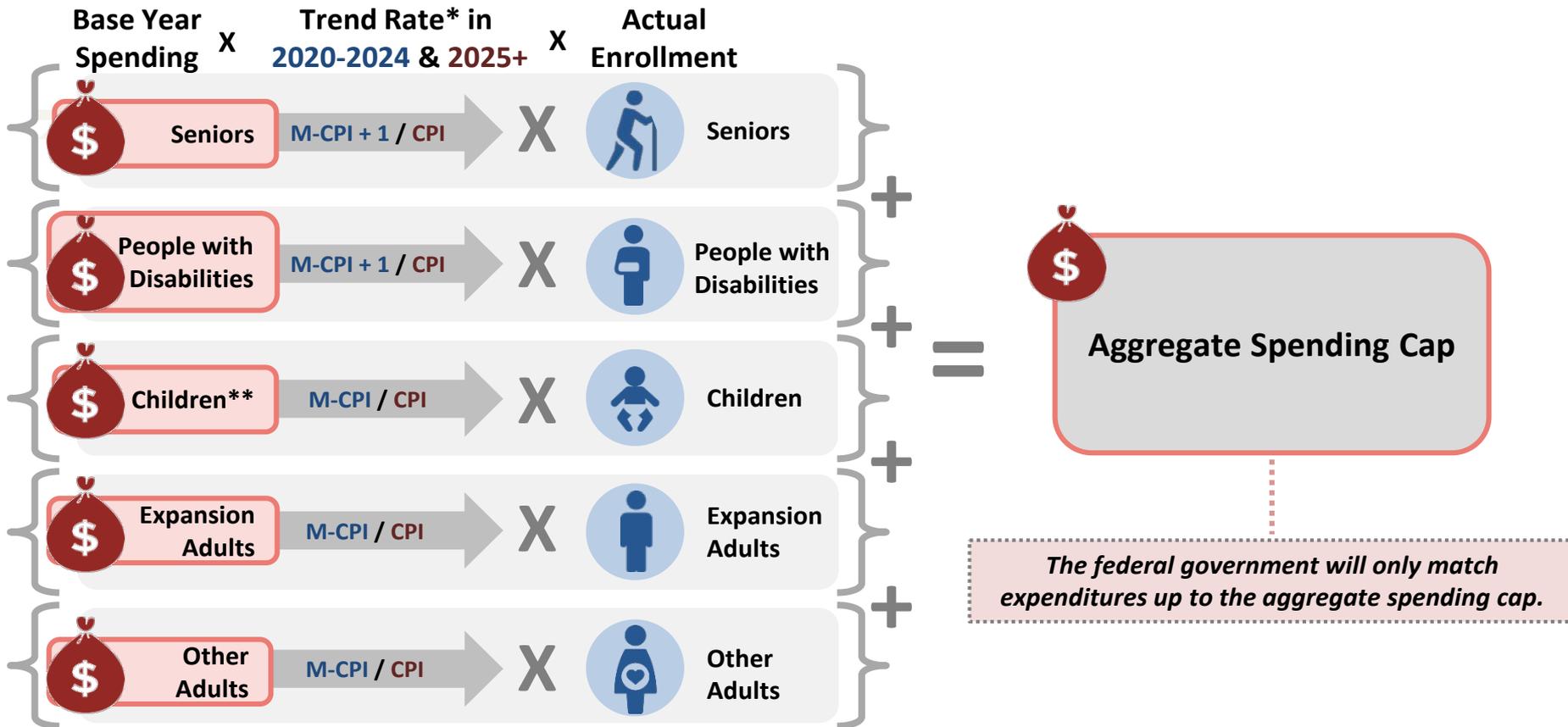
The Per Capita Cap in the Senate's June 22 Draft of BCRA

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- The Senate's Better Care Reconciliation Act (BCRA) would establish a cap starting in fiscal year 2020.
- The BCRA cap for each state's Medicaid spending is "built up" from per capita limits on five different eligibility groups.
 - Children, seniors, people with disabilities, expansion adults, and other adults.
 - Each group's limit is based on historic per capita spending increased by a national trend rate.
 - Through 2024: medical CPI for children and adults; medical CPI + 1 percentage point for seniors and people with disabilities
 - Starting in 2025: CPI for all groups
- If a state spends in excess of cap, the federal government will "claw back" any federal matching funds that it provided for these expenditures the next year.
- Under a "redistribution" provision, states with particularly high or particularly low spending in a given year will receive an adjustment in the following year to their caps.

Formula for the Per Capita Cap in BCRA

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



*To calculate states' starting caps in FY 2020, base year spending is trended by M-CPI; starting in 2020, M-CPI+1 is used to trend and calculate the spending caps for seniors and people with disabilities, while M-CPI continues to apply to children, expansion adults, and other adults; beginning in FY 2025, CPI is used for all eligibility groups.

**BCRA per capita cap carves out children enrolled based on a disability determination.

Example of a Per Capita Cap Calculation

- The aggregate cap will be built up from enrollment group-specific per capita caps.
- If actual spending in 2020 exceeds the aggregate cap, the state will be subject to a “clawback” in 2021.

Enrollment Group	2020 Per Capita Caps	2020 Enrollment	Group-Specific Aggregate Caps	
 Seniors	\$16,000	× 1,000,000	= \$16,000,000,000	} Estimated 2020 Aggregate Cap \$93.5 billion
 People with Disabilities	\$28,000	× 1,000,000	= \$28,000,000,000	
 Children	\$3,500	× 5,500,000	= \$19,250,000,000	
 Expansion Adults	\$5,500	× 3,500,000	= \$19,250,000,000	
 Other Adults	\$5,500	× 2,000,000	= \$11,000,000,000	

Note: Figures are intended only to provide an illustrative example of how the per capita cap is calculated and do not reflect actual estimates of California spending and enrollment.

The “High/Low” Provision in BCRA

The provision is designed to give more resources to low-spending states and less to high-spending states, but may not work as intended.

- BCRA adjusts a state’s cap if its spending is significantly above or below the national mean.
 - States **above** by 25% or more (“high spending”) may see a downward adjustment of 0.5% to 2% in their subsequent year’s cap; states **below** by 25% or more (“low spending”) may see an increase of 0.5% to 2%.
 - In FY 2020 and FY 2021, the adjustment is based on whether a state’s average per capita spending across all eligibility groups is “high” or “low.”
 - In FY 2022 and beyond, states are judged separately for spending on each of the five eligibility groups; they can receive a downward adjustment for one eligibility group and an upward adjustment for another.
- The provision *cannot* result in a net cost to the federal government. Increases in the caps of low-spending states must be “paid for” by high-spending states.
- States will not know in advance of a fiscal year whether they qualify for an adjustment; they must wait until all states have finalized their expenditure and enrollment data for the preceding year.
- As discussed in the section on implications for California, the redistribution provision may not work as intended. California will not know in advance whether it qualifies for an adjustment in a given year, and whether it does will depend as much on other states’ spending choices as its own.

Since it is unclear how the redistribution provision will be implemented and whether it will affect California, it is not taken into account in the cap estimates unless otherwise noted.

Estimated Impact of Changes

Designed to assess state-by-state impact of Medicaid financing changes

- Per capita cap
- Block grant
- Reductions in federal funding for expansion

Uses publicly available data to establish baseline for each state, for example:

- CMS-64 data on total Medicaid expenditures and expansion adult and total enrollment
- MSIS/MAX data on expenditures by eligibility group
- State-specific population growth projections from the Census Bureau
- Centers for Medicare & Medicaid Services (CMS) and Congressional Budget Office (CBO) national growth projections by eligibility group
- CMS and CBO projections of medical CPI and overall CPI

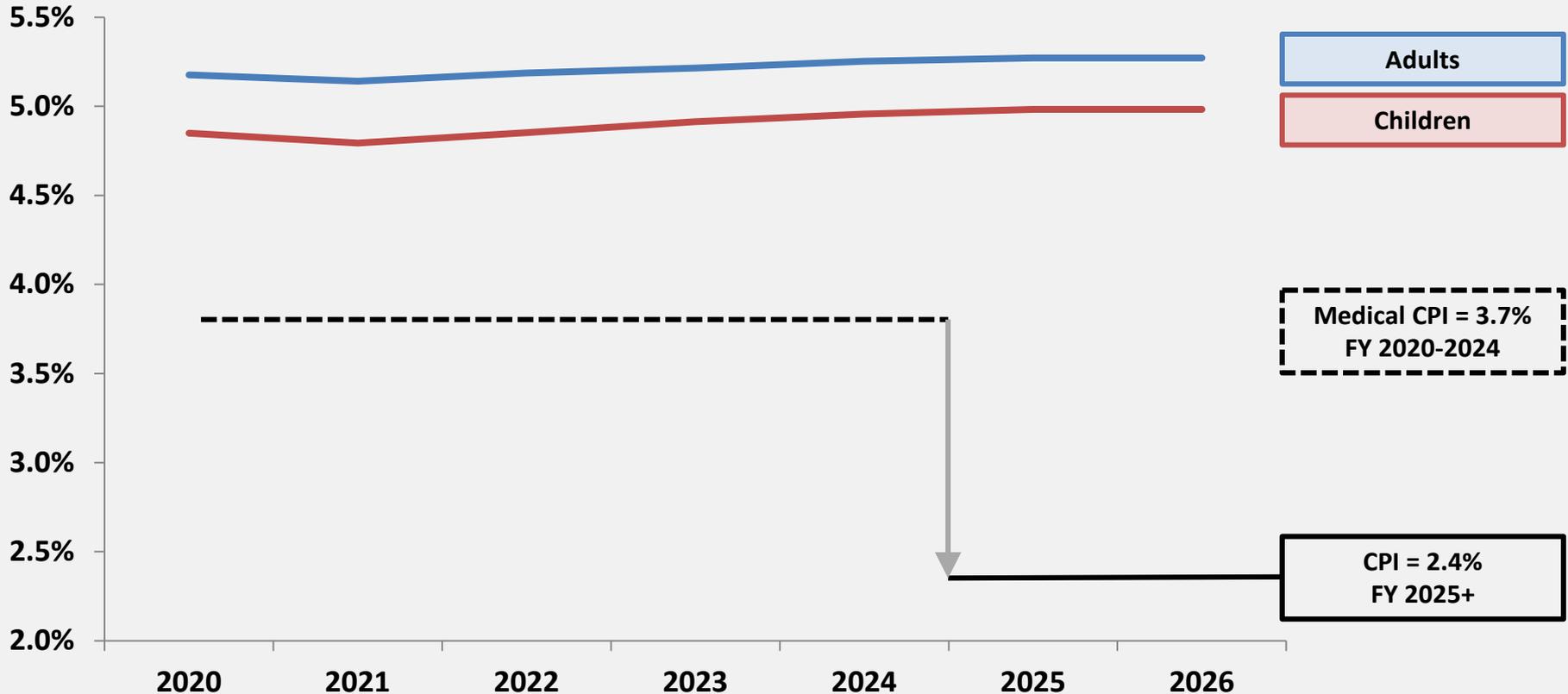
Allows for sensitivity analysis

- Alternative inputs
- Diversion from projections
- State behavioral response

- **California will maintain expansion coverage** by using state funds to replace lost federal dollars; this affects per capita cap estimates because more beneficiaries will be subject to the cap.
- **Baseline (current law) spending per enrollee** will increase at the rates projected by the CMS Office of the Actuary national projections.
- **Medical CPI** will grow at 3.7% a year and overall CPI at 2.4% in accordance with CBO projections.
- **California cannot be assured it will benefit from the “high/low” provision** and estimates do not take this provision into account unless otherwise noted.
- **Estimates were developed from publicly available data**, which may differ from the state’s internal data; the state may also make different assumptions around per enrollee spending growth and medical CPI or overall CPI growth when developing its own estimates.

Spending for Children and Adults Growing Faster Than the Allowable Trend Rate in BCRA

Estimated Annual Per Enrollee Spending Growth, FY 2020-2026

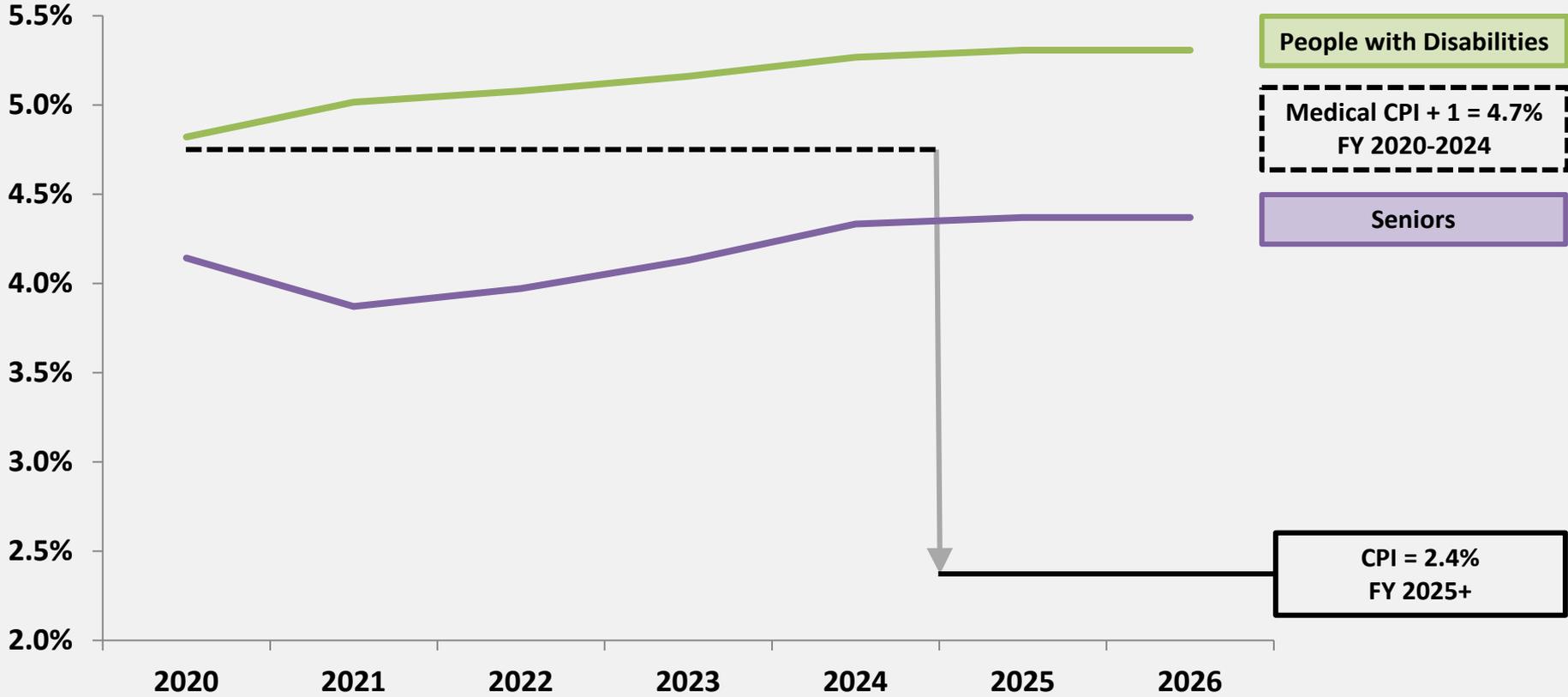


Source : Manatt Medicaid Financing Model. | Note: Per enrollee growth rates projected by CMS Office of the Actuary; M-CPI projected by CBO. Spending growth for the seniors and people with disabilities groups is capped at medical CPI + 1 in FY 2020-2024; the 2019 baseline amount from which 2020 caps are calculated is trended forward from 2016 by M-CPI.

Spending for People with Disabilities Group Outpacing Allowable Trend Rate, Seniors to Exceed Trend Rate in 2025

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Estimated Annual Per Enrollee Spending Growth, FY 2020-2026



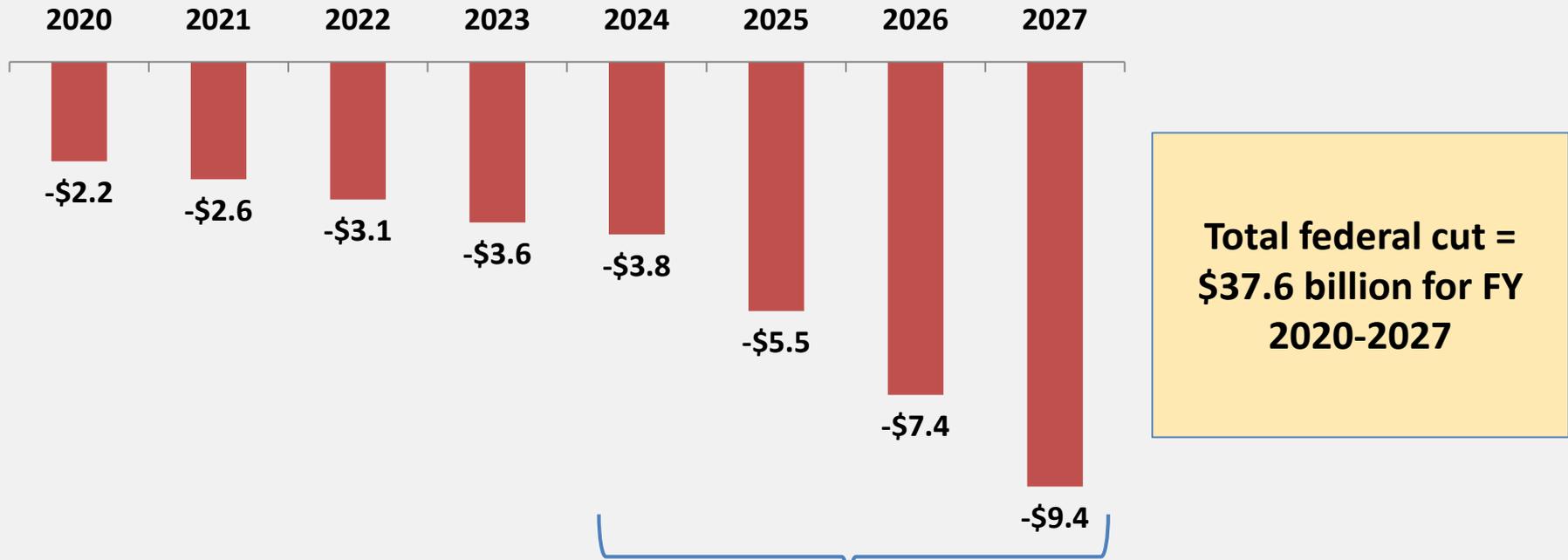
Source : Manatt Medicaid Financing Model. | Note: Per enrollee growth rates projected by CMS Office of the Actuary; M-CPI projected by CBO. Spending growth for the seniors and people with disabilities groups is capped at medical CPI + 1 in FY 2020-2024; the 2019 baseline amount from which 2020 caps are calculated is trended forward from 2016 by M-CPI.



Estimated Impact of Per Capita Cap on California

California would have to substantially increase state general fund spending to offset the per capita cap cuts in order to maintain current program spending levels.

Reduction in Federal Funding Due to Per Capita Cap, FY 2020-2027 (billions)

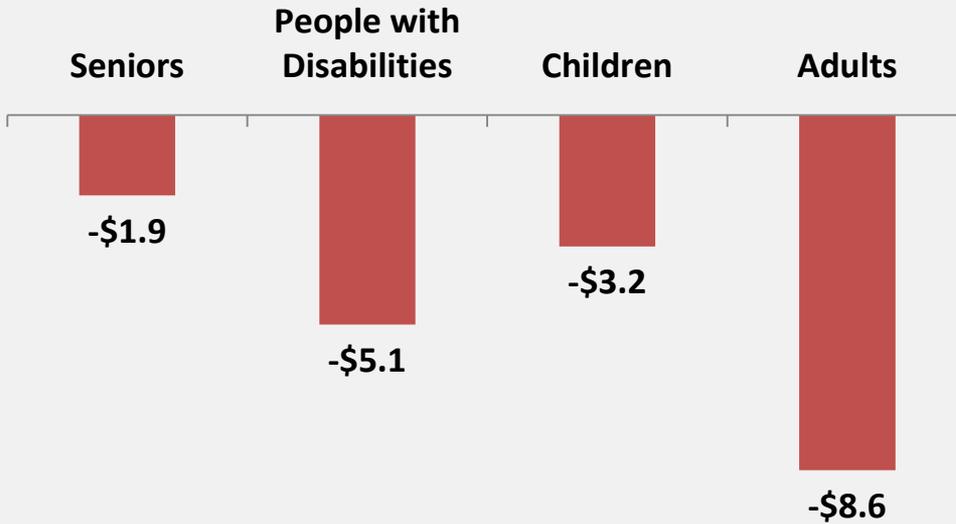


Federal cuts more than double between 2024 and 2027 due to switch to CPI as the per capita cap trend rate in 2025.

Contribution to Impact of Per Capita Cap Varies by Group, but Resulting Cuts Could Be Applied to Any Group

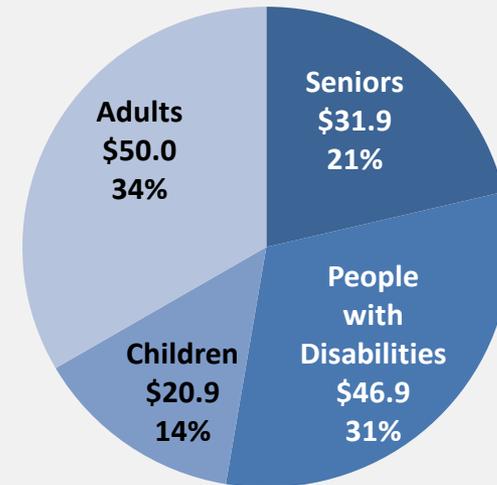
- Estimated FY 2027 spending of \$150 billion would leave California \$18.9 billion over its projected cap.
- State would need to cut spending in FY 2027, or face a clawback the following year.

Estimated Contribution to Impact of the Cap, FY 2027 (billions)



Total: \$18.9 billion

Estimated Spending Prior to Per Capita Cap Cuts, FY 2027 (billions)



Total: \$149.6 billion

Individuals exempt from the cap – e.g., children enrolled based on disability and users of IHS and tribal health facilities – could be affected by the cuts, such as payment rate reductions, necessary to stay below cap.

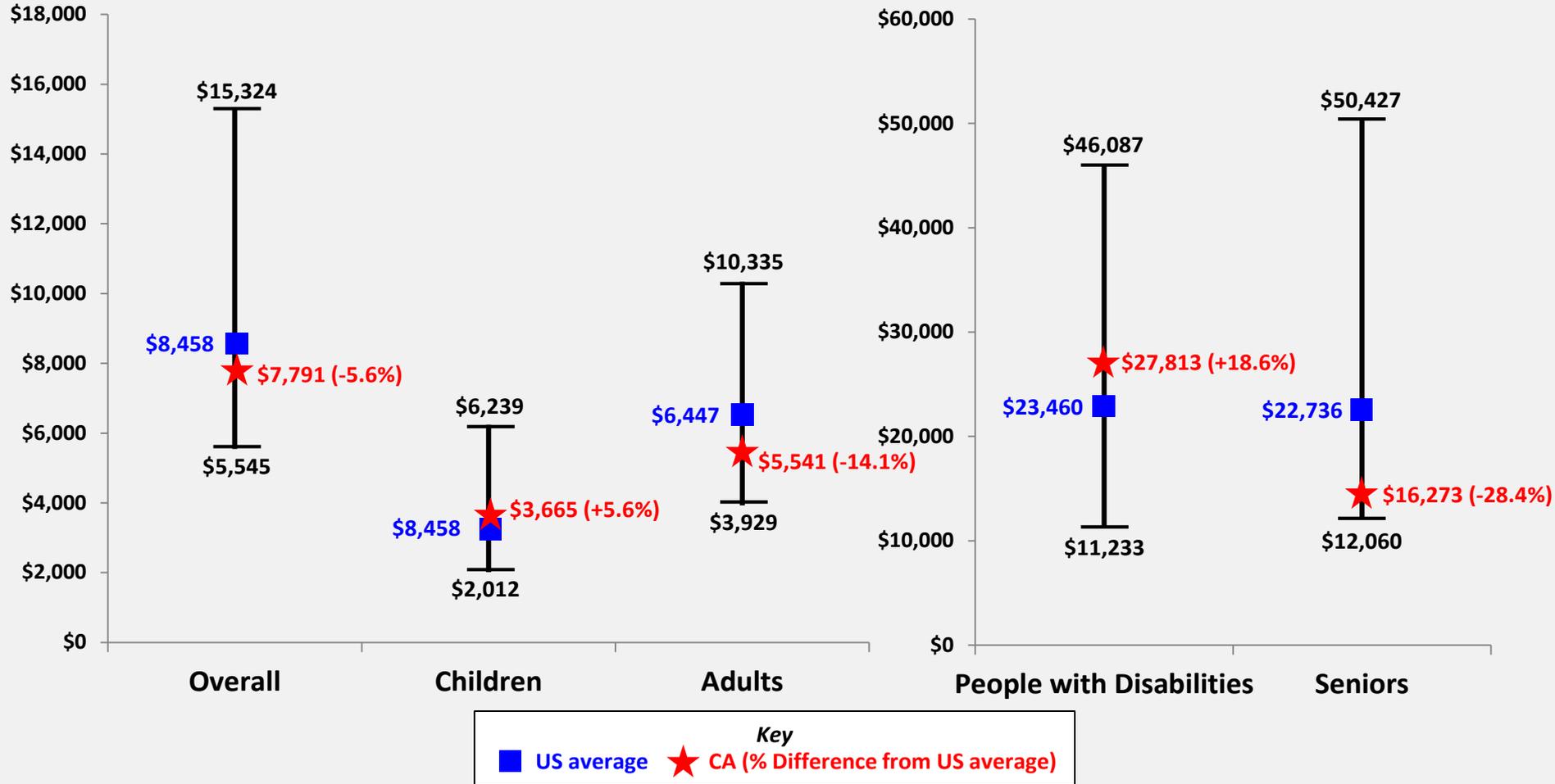
Source: Manatt Medicaid Financing Model.
Note: Includes federal and state funding. IHS is Indian Health Services.

Implications for California of the Redistribution Provision 22

- In general, California is a low-spending state that would be “locked into” these relatively low spending levels because of the use of historic spending levels in cap calculations.
- The redistribution provision appears designed to help states such as California, but it may not work as intended.
- Based on current spending patterns, California would not qualify for an adjustment in fiscal years 2020 and 2021 because its average spending across all eligibility groups is 5.6% below the national mean, not at least 25% as required.
- In future years, California might qualify for an upward adjustment for seniors (28% below national mean), but it also could be at risk for a downward adjustment for people with disabilities (19% above the national mean).
- In practice, whether California “wins” or “loses” under the redistribution provision will depend on California expenditures relative to the national mean, which in turn will be driven to a large extent by future spending choices made in other states.
- California has no way of knowing whether it will ultimately benefit from the redistribution provision or not, and any benefit will soften, but not eliminate, the impact of cuts.

Range of Per Enrollee Spending Subject to Redistribution Provision

Projected Medicaid Spending Per Enrollee, FY 2019



Uncertainty and Risk Under Per Capita Cap

Estimates of the impact of a per capita cap are highly sensitive to key assumptions, including:

- Baseline spending growth
- Projections of medical CPI

California's financial exposure may be even greater if reality differs from key assumptions and projections.

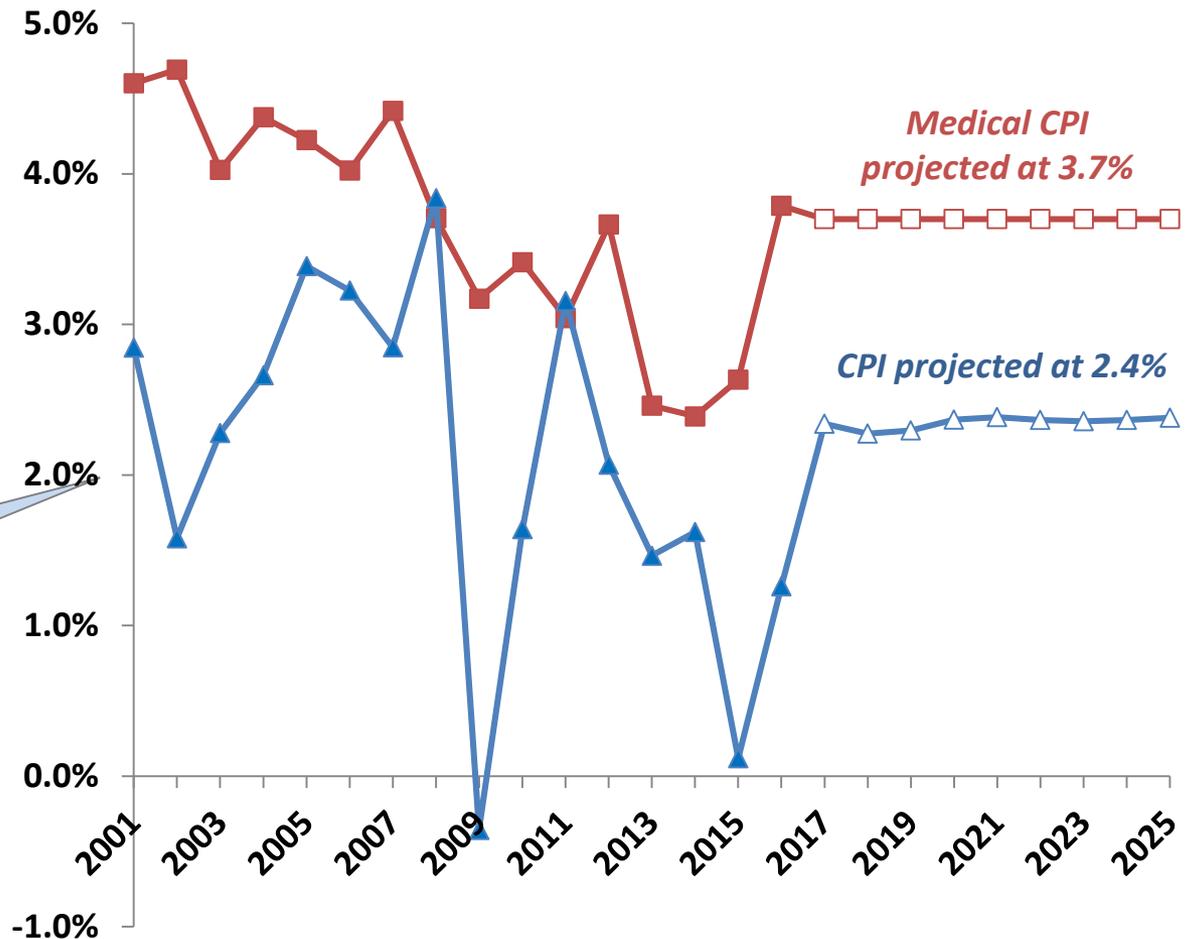
- Unanticipated spending pressures:
 - Continued worsening of substance use epidemic or other public health crisis
 - Breakthrough treatments or medications
 - Increase in pre-term births that drives up per capita cost of serving children
- Trend rate diverges from expectations:
 - Higher or lower medical CPI than projected
 - Further legislative changes to the trend rate used in determining the cap

Actual Trend Rates – Which Are Highly Volatile – Will Determine Impact on California

BCRA Trend Rates

- 2020-2024
 - Children and adults: medical CPI
 - Seniors and people with disabilities: medical CPI + 1 percentage point
- 2025+
 - All groups: CPI

CPI has historically trended well below medical CPI, meaning states will face a dramatic increase in the size of cuts when the allowable trend rate switches to CPI in 2025



California's Federal Cuts Vary Considerably Based on Growth Rate Assumptions (FY 2020-2027, billions)

Lower medical CPI growth rate, unless actual Medi-Cal spending similarly drops, means larger cuts.†

If Congress ties caps to overall CPI for entire period, cuts are larger.

Assumption regarding benchmark trend rate for per capita cap growth:

4.2%*

3.7%*

3.2%*

2.4%

-\$22.5

-\$37.6

-\$52.4

-\$75.0

Reflects assumptions used for estimates throughout this presentation

Operational Considerations

The Per Capita Cap Is Retrospective

California's Medicaid budget will be set nearly *two years ahead* of knowing what federal funding is available for its Medicaid program.

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

Fall-Spring
2018-2019

End of federal fiscal year 2020.

September 30,
2020

October 1,
2019

Start of federal fiscal year
2020.

Late 2020

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

The distribution of billions of dollars in Medicaid funding under a per capita cap will depend on California and other states providing reliable enrollment and expenditure data.

- Lack of current capacity:** States do not currently face a requirement to produce data in the specific format called for by the per capita cap; these new data will be audited by the federal government and must reflect expenditures and enrollment by eligibility group in a way that accounts for the varying populations and services inside and outside of caps.
- Lag in reporting:** States currently have up to two years to finalize Medicaid expenditure data for claiming of federal funds (e.g., to accommodate provider payment adjustments and corrections), meaning that they may face a clawback long after the end of a fiscal year or potentially receive a “high/low” adjustment based on incomplete data.
- Complexity of data systems improvements:** Congress may give states more resources to build the infrastructure required to produce data needed for a cap, but earlier efforts to upgrade Medicaid data systems are several years behind schedule.

State Options and Implications

Options for Responding to Lost Federal Funds

California will need to respond to the loss of federal funds due to the cap, and is likely to find few easy options.

Raise taxes or cut spending on other programs

- Option would be politically challenging to implement.
- Other state priorities, such as education or justice reform, could be adversely affected.

Reduce reimbursement rates

- California already is a relatively low-spending state, making it more difficult to reduce rates without adversely affecting access.

Cut optional benefits or increase cost sharing

- The most costly “optional” benefits, such as prescription drugs and home and community-based services, contribute to cost-effective care and could increase other spending if eliminated.
- Low-income beneficiaries are highly sensitive to cost sharing and likely to reduce their use of both appropriate and inappropriate care.

Reduce enrollment of individuals whose costs are higher than average

- California will face significant fiscal pressure to scale back coverage of individuals whose costs exceed the per capita limits.

California has much to lose under a per capita cap:

- The state is facing an estimated cut of \$37.6 billion through FY 2027.
- But the actual reduction in federal funding could be higher or lower if the trend rate for the cap differs from projections.

Unlike under the current financing structure, California alone bears the risk for unexpected public health crises, increases in drug prices, or breakthrough treatments.

As a relatively low-spending state, California has less room than many other states to cope with federal cuts, making it more likely that a cap could threaten important California-specific efforts to improve Medi-Cal.

California has no easy options for responding to the cap; it can substantially increase its own spending on Medi-Cal, cut reimbursement rates, drop optional benefits, attempt to eliminate eligibility for particularly high-cost beneficiaries and/or increase cost sharing — or some combination of these actions.

Appendix

Who Is Subject to the Per Capita Cap?

Included

All full-benefit Medi-Cal beneficiaries, including dual eligibles:

- Seniors (65+)
- People with disabilities
- Children
- Expansion adults
- Other adults (e.g., pregnant women and low-income parents)

Excluded

Partial-benefit enrollees with coverage limited to:

- Medicare premiums and cost sharing
- Emergency services
- Family planning
- Premium assistance for employer coverage

Others:

- Children who qualify for Medicaid based on disability
- CHIP-financed children
- Individuals receiving any Medicaid-funded services through an Indian Health Service or tribal facility
- Individuals enrolled via the breast and cervical cancer eligibility pathway
- Individuals enrolled via tuberculosis pathway

Which Medi-Cal Expenditures Are Subject to the Cap?

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Included

- Medical expenditures under state plan
- Medical expenditures under waivers
- Supplemental payments, other than disproportionate share hospital (DSH)

Excluded

- Administrative expenses
- DSH payments
- Medicare premiums and cost sharing
- Expenditures on the Vaccines for Children Program
- New funding pool for non-expansion states