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PER CAPITA CAPS COULD REDUCE FUNDING FOR CHILDREN COVERED BY MEDICAID

All 50 states and DC would receive fewer Medicaid dollars for non-disabled children

New research from Avalere finds that funding for non-disabled children could decrease by $43 billion over 10 years if recent proposals to limit federal spending on Medicaid by using per capita caps are passed into law. Medicaid capped funding arrangements—including per capita caps and block grants—were included in the American Health Care Act (AHCA) that passed the House. Nationally, children are the largest group covered by Medicaid at a national level.

"Over time, per capita caps could significantly reduce the amount of funding that goes towards Medicaid coverage for children," said Dan Mendelson, president at Avalere Health. "While local control and more efficient operation of Medicaid programs are laudable goals, coverage and access for low income children are ultimately dictated by federal funding, and reductions of this magnitude could disrupt access."

Under AHCA, a Medicaid per capita cap model would go into effect in 2020 with the option for a state to select a block grant that same year. Baseline per capita cap funding figures would be determined by 2016 federal Medicaid spending for each of the five beneficiary groups: adults, children, aged, disabled, and newly-eligible adults. Avalere's modeling finds that federal funding for "traditional children" (i.e., those who are eligible based off family income level and not disability status) would be reduced by $43 billion over a 10-year period if AHCA is signed into law.

Table 1: Total 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**

State-by-State Findings

Avalere also examined the impact of per capita caps at the state-level, and found that all 50 states and the District of Columbia would lose Medicaid funding for traditional children. The reductions ranged from $59 million in North Dakota to $5.1 billion in Texas.

Avalere Health
An Inovalon Company

1350 Connecticut Ave, NW
Washington, DC 20036

P | 202.207.1300
F | 202.467.4455
avalere.com

Table 2: State-Level Change in Federal Medicaid Spending for Traditional Children under AHCA Per Capita Cap, Cumulative 2020-2026

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

Avalere also looked at how block grant funding could impact Medicaid coverage for children. The research found that if all states and the District of Columbia were to convert to the block grant option, states could see a cumulative reduction in federal funding of $78 billion over 10 years. Currently, states are required to provide Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefits to those under the age of 21. However, the Manager's Amendment eliminated this requirement under the block grant option and limited services to those under the age of 18.

“Block grants provide states with an aggregate amount of federal funding with which to manage their Medicaid program in exchange for greater flexibility,” said Caroline Pearson, senior vice president at Avalere. “This flexibility could include eliminating requirements to cover routine prevention and screening tests for children, including well child visits, vision and hearing tests, and vaccinations.”

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.

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