Per Capita Caps in Medicaid Under the House Republicans' ACA Repeal Bill

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On March 6, House Republicans introduced the American Health Care Act (AHCA) which would eliminate the current financing structure of Medicaid as well as repeal the Affordable Care Act (ACA). Overall, the Congressional Budget Office estimates that AHCA would decrease direct Medicaid spending by $880 billion from 2017 to 2026 and result in 14 million individuals losing Medicaid.[1] This issue brief outlines the problems associated with the use of the per capita caps AHCA imposes on Medicaid.[2]

How would the per capita cap work?

Under AHCA, the Department of Health and Human Services (HHS) would determine each state's per capita caps (PCCs) based on the state's 2016 Medicaid spending. Separate per capita caps would be established for different categories of enrollees – older enrollees; people who are blind or have disabilities; children; Medicaid expansion enrollees; other adult enrollees (including pregnant women, parents and caretakers).[3] Each category would have its initial PCC determined by dividing the category's FY 2016 Medicaid expenditures by its FY 2016 enrollment. These five separate PCCs (one per enrollee category) would then be multiplied by the enrollment within the category to determine the state's total expenditure amount. Certain expenditures would be excluded

[1] Congressional Budget Office Cost Estimate, American Health Care Act at 6, *available at* https://www.cbo.gov/publication/52486.

[2] This fact sheet is current as of March 21, 2017 and analyzes the bill including the Manager's Amendment after the bill was voted out of the House Energy and Commerce Committee.

[3] AHCA does not map eligibility categories from current eligibility categories (*see* 42 U.S.C. § 1396a(a)(10)(A)) to these groups; this could be done through Administrative action or a state could risk misclassification and repayment.

from a state's total, including administrative expenses[4] and expenses for partial-benefit Medicaid enrollees.[5] The total amount would differ by state, locking in existing state-by-state spending differences.

After setting the FY 2016 base PCCs, HHS would create state-specific "provisional" PCCs for FY 2019 based on the FY 2016 PCC adjusted by an inflation index. AHCA sets the annual inflation index for all enrollees for FY 2017-2019 as the Consumer Price Index for medical services (CPI-M).[6] After determining the provisional PCC, HHS would estimate the state's ***target*** spending cap (multiplying each category's provisional PCC by the expected number of FY 2019 enrollees for that category and adding the five totals together). At the end of the fiscal year, HHS would determine the state's ***actual*** spending cap (based on actual enrollment data). If a state overspent its cap, it would have to repay the federal government during the next fiscal year. Thus states would be strongly incentivized to ensure that their overall spending is at or below its actual (as well as target) cap to avoid having to pay back HHS. It is important to note, however, that the penalties for exceeding the cap do ***not*** apply on an individual or category basis; they only apply if the state's total spending for the year exceeds its total actual spending cap.

The PCCs would overlay, not replace, existing Medicaid financing structures. States would still have to pay their share of costs to draw down the federal funding and existing matching requirements and matching rates would still apply. The state does not get to keep extra federal funding, for example, if its total spending ends up below its actual cap. The main change under a PCC is that the federal government will not pay any Medicaid expenses above a state's total cap and that amount can only be determined ***after*** actual enrollment data is reported for the relevant fiscal year.

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[4] This includes administrative expenses as well as DSH (Disproportionate Share Hospital) costs and payments under the AHCA-created adjustments for safety net providers (for providers in states that did not expand Medicaid).

[5] Partial-benefit enrollees include those receiving help paying for Medicare premiums (if not also receiving Medicaid services) and those receiving limited services such as treatment for Tuberculosis or breast or cervical cancer; emergency Medicaid; Medicaid premium support for employer sponsored insurance; and family planning services and supplies (if not receiving them as a regular Medicaid enrollee). Enrollees of the Children's Health Insurance Program and those receiving services through the Indian Health Service are also excluded.

[6] FY 2019 total spending cannot exceed FY 2016 total spending trended forward by CPI-M. Further, Congress could decide to change the inflation index in the future, potentially further reducing federal funding.

States would begin applying PCCs in FY 2020 after adjusting the FY 2019 provisional PCC. Starting with FY 2020, the index would be CPI-M for children and adults and CPI-M plus 1% for older individuals and individuals who are blind or have disabilities. Each subsequent year, the state's PCC for each category would be adjusted by CPI-M or CPI-M plus 1%.

How would a state be worse off with per capita caps?

Implementing limits on how much the federal government will contribute to a state's Medicaid expenditures is a drastic departure from Medicaid's fifty year history. Since its inception, Medicaid has operated as a federal-state partnership where states receive on average 63% of the costs of Medicaid from the federal government. The federal share is based on actual costs of providing services and not subject to prior spending or arbitrary or upper limits. Here are 10 ways in which AHCA's PCCs shift more risk and financial responsibility to the states, which will only increase over time:

1. **The PCC index rises more slowly than predicted Medicaid growth.** For FY 2017-2019, AHCA's yearly growth rate would be CPI-M. According to the CBO, CPI-M is expected to grow 3.7% per year while Medicaid costs are expected to grow 4.4%. So each year, states would start out with .7% less than they would under current financing and the difference would compound over time creating an even larger gap between the PCC limits and actual funding needed. Even when the index for older individuals and individuals who are blind or have disabilities is increased to CPI-M plus 1% in FY 2020, states will already be disadvantaged from using the CPI-M for the first years. And since the state aggregates all of its funding, having a higher index for certain categories does not require the state to use that funding on those enrollees.

2. **States are responsible for 100% of costs above PCCs and are locked into their 2016 funding decisions.** By using 2016 as the baseline, states are effectively locked in to their prior funding decisions. State-by-state variations would also be locked in. Any attempts by a state to expand coverage or services would be subject to its 2016 spending. Thus states would either have to reduce eligibility, spending or provider rates to offset new costs not incurred in 2016 or pay 100% of the costs of the new coverage or services. This is a radical departure from current law where if a state spends more than it anticipates, it can continue to draw down matching federal funds. If a state spends more than its aggregated PCC expenditures, it will be responsible for 100% of the costs.

3. **HHS will "clawback" funding if a state overspends its PCC.** States generally submit claims for reimbursement to HHS after each quarter of a fiscal year. While

each state would have a "target" spending cap, the actual cap will not be known until after the end of the fiscal year. At that point, HHS would determine the final cap based on actual enrollment and whether the state overspent its aggregate medical assistance expenditure. If the state overspent, it will have to reimburse HHS for any overage spread out over the next fiscal year (25% of the overage per quarter). This "clawback" would further penalize states by lessening the federal payments to the state the following year. The clawback will strongly incentivize states to ratchet down services and provider reimbursement and impose eligibility restrictions so that a state would not risk exceeding its cap.

4. **States will face challenges in collecting data required to document PCCs.** AHCA requires states to document which enrollees are in which PCC group as well as their claims to establish the PCCs. As noted by Georgetown's Center for Children and Families, **states do not currently report data as required to determine the PCC yet the PCC is anchored to FY 2016 data.** While AHCA provides additional funding to pay for technology upgrades, many states faced significant costs and challenges when upgrading legacy computer systems to meet the requirements of determining eligibility pursuant to MAGI under the ACA. AHCA will require significant new coding and programming to document enrollment and expenditure data. HHS and states are going to have to differentiate between partial and full benefit dually eligible individuals, between family planning services and supplies provided to a full Medicaid enrollee versus a partial benefit enrollee, between medically frail individuals who may fall into an "adult" category rather than a "disability" category, and for states that keep the Medicaid expansion, and between a "grandfathered" Medicaid expansion enrollee versus other adults. If a state fails to report data, it will have its index reduced by 1%, effectively a 27% decrease.

5. **PCCs will also hurt states that use managed care capitation in Medicaid.** In capitated managed care systems, the managed care plan receives a fixed per capita payment for each enrollee. Most Medicaid beneficiaries are enrolled in capitated plans and, in a number of states, nearly 100% of enrollees receive services through such plans. While capitated Medicaid managed care is based on similar principles as PCC financing, states that use capitated managed care for their Medicaid programs will still feel the squeeze from the switch to PCCs. Currently, states have the flexibility to raise their capitated rates if, for example, the cost of services rise for any reason. And, as states' expenditures rise, the federal match rises correspondingly and enables them to adjust to meet additional needs. Under PCCs, however, the federal funding will not increase at the same rate, which means that states will eventually be forced to cut their managed care capitation rates, in turn forcing managed care plans to cut services or stop participating in Medicaid. Or, states may simply choose to cover fewer services or limit eligibility similar to states with fee for service systems.

6. **PCCs discourage coverage of new prescription drugs and new medical breakthroughs and technology.** One reason health care costs continue to increase is due to the development of new drugs and medical technology. For example, new but expensive treatments that effectively cure hepatitis C infections were approved in 2013. Although some Medicaid agencies initially balked at the high costs for these new treatments, the one-time expense of curing hepatitis C would be offset by savings over a number of years, such as continued care (including expensive liver transplants), for hepatitis C patients with worsening conditions. If these treatments were introduced in 2017 instead of 2013 or other similar breakthrough treatments are approved by the FDA, their costs would be excluded from the PCC. Similarly, new diagnostic tests or scans may be developed that are better able to detect or treat cancer, autism or Alzheimer's in the future, likely accompanied with high costs of advanced technology. States would have to find ways to lower other Medicaid costs to cover these treatments or pay 100% of the additional costs.

7. **Growing long term care costs are not addressed by PCCs.** With the population aging and living longer, a greater number of older individuals are going to become eligible for Medicaid or are already enrolled in the "elderly" group and will need additional services as they age. Children receiving long term care can cost up to twelve times as much as other Medicaid-enrolled children. States already spend significant portions of their Medicaid budgets on long term care, including nursing homes and home and community based services. By limiting spending to 2016 levels, many states will quickly fall behind as the costs of long term care continue to rise and more individuals become eligible or need higher levels of care. States will have to limit these services, lower costs for other enrollees to make up the costs, or pay 100% of the additional costs themselves.

8. **Waivers are subject to Per Capita Caps.** Under current law, § 1115 waivers must be budget neutral over the entire period of the waiver (*e.g.* 5 years). AHCA subjects waivers to the same PCCs on a ***yearly*** basis. Thus states that were able to "front-load" certain waiver costs (e.g. creating new infrastructure or providing intensive services) would be constrained by the PCC and have to limit these services, lower costs or limit eligibility for other enrollees to make up the higher waiver costs, or pay 100% of the additional costs themselves.

9. **Future waivers would be constrained by 2016 funding.** Waivers have provided an opportunity for states to provide more intensive or expansive services to certain populations that can have both short- and long-term benefits. For example, some states have waivers to provide intensive treatment to individuals with developmental disabilities. And recently, a number of states have sought waivers to provide substance use disorder treatment in response to the

opioid epidemic. Traditionally, a state would only have to show that the cost is budget neutral over the course of the entire waiver. Under AHCA, waiver enrollees would also be subject to the same PCCs as other enrollees so a state could not spend more on a waiver enrollee unless it reduces spending elsewhere or pays 100% of the additional costs.

10. **PCC categories are not well defined.** While AHCA establishes five categories of enrollees, it is unclear whether or how current eligibility categories might map to these categories. Under Medicaid's current financing, regardless of the eligibility pathway (*e.g.* eligibility as a "child" or "person with a disability"), a child with a disability has access to all needed services. Since the PCCs are based on spending by eligibility group under AHCA, if a child with a disability is not included in the "disability" group, the state would receive a lower PCC for that child. This would put additional pressure on a state to limit services or provider rates so it does not overspend its cap.