Research

Primer: Medicaid Per Capita Caps

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INTRODUCTION

Medicaid is a federal entitlement program, jointly managed by the Centers for Medicare and Medicaid Services (CMS) and the states for the purpose of providing health coverage to low-income individuals. At present, it is an open-ended entitlement with unlimited funding. The federal government is responsible for covering a portion of each state's Medicaid costs, determined by a formula known as the Federal Matching Assistance Percentage (FMAP). In 2012 the FMAP ranged from a low of 50 percent in several states to a high of 73 percent in Mississippi. States can obtain a waiver from CMS to experiment with different methods of providing coverage and different payment reforms.

There are a variety of proposals for reforming the Medicaid program, one of which is per-capita caps on annual spending. Having a per-capita cap on the entitlement program would limit the federal government's financial liability by capping the federal funding, on a per beneficiary basis. Per capita caps would leave the state financially responsible for any additional costs above and beyond the cap, ideally giving state Medicaid offices the incentive to ensure beneficiaries are receiving preventative care, cost-effective medical services and sufficient chronic care management in order to reduce hospitalizations.

MEDICAID OVERVIEW

Over the course of 2012, Medicaid covered 73 million individuals , or about one in every five U.S. citizens. Changes to Medicaid under the Affordable Care Act (ACA) will further increase enrollment as the ACA includes an optional Medicaid expansion to cover all Americans below 138 percent of the Federal Poverty Level (FPL), which is computed using family income and household size. The Centers for Medicare & Medicaid Services (CMS) projects that by 2020, enrollment will increase to over 77 million.

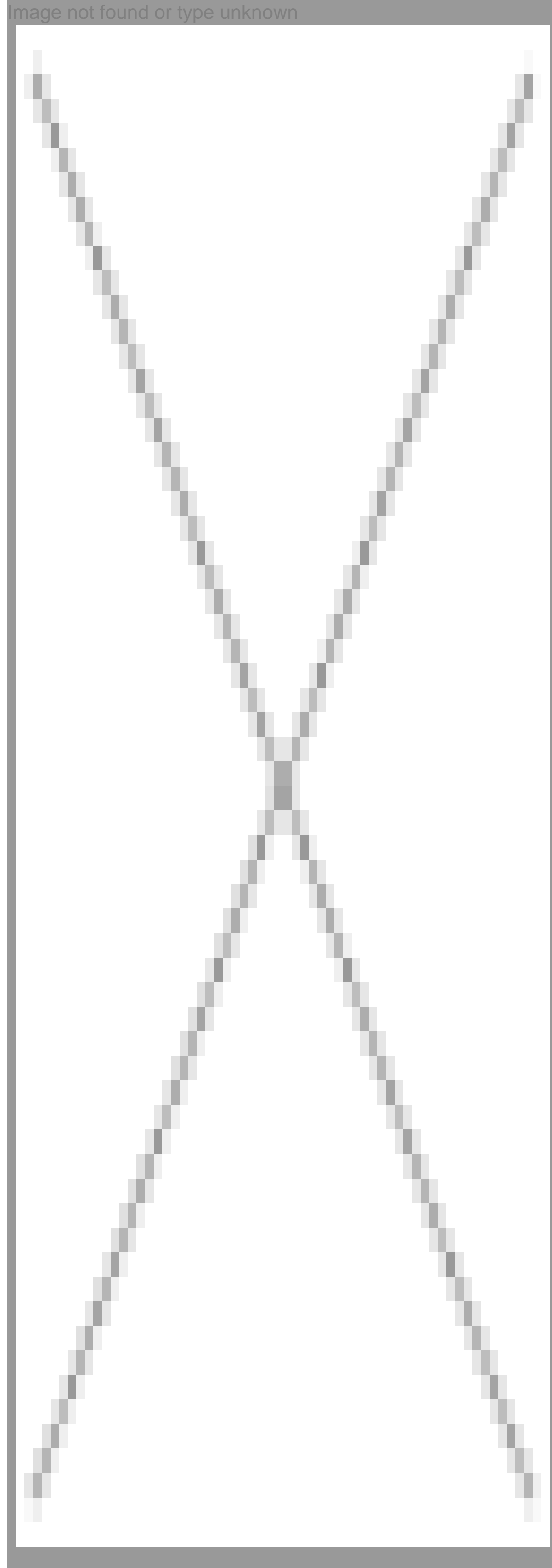
The details of the Medicaid program cannot be summarized easily, as the program is run by distinct Medicaid offices in every state, and the spending and benefits are different depending on eligibility category. Currently, the Medicaid program varies widely from state to state with regard to eligibility rules, provider reimbursement, and available services. All states must provide coverage for low-income children, pregnant women, individuals with disabilities, and those needing long-term care in nursing homes, but income levels, as well as the available coverage for parents and other low-income adults, can be vastly different. Eligibility ranges from very generous to minimal. In some states, children are covered at family income levels of 400 percent of the Federal Poverty Levels (FPL), both parents are covered as opposed to just pregnant women, and other impoverished adults are eligible. In others, eligibility is restricted to children under 200 percent of FPL, working parents under 50 percent of FPL and no coverage exists for childless adults.

In addition, some state Medicaid programs pay providers with reimbursements comparable to Medicare's rates, while other states' reimbursement levels are drastically lower. For example, New Jersey's Medicaid rates are, on average, 45 percent of those paid by Medicare, while Delaware's rates average 97 percent of Medicare

reimbursement. North Dakota, Alaska, and Wyoming have the most generous reimbursement levels, averaging 134 percent, 124 percent, and 116 percent of Medicare rates, respectively. The low reimbursement in many states is one factor contributing to the difficulty of recruiting specialists and sufficient levels of primary care physicians (other difficulties center around the challenge of treating a low income population such as low health literacy, lack of transportation and childcare, and frequent "churning" on and off the Medicaid program), and thus access is compromised for some beneficiaries.

Similarly, Medicaid programs vary widely with regard to services available. For individuals with disabilities and functional limitations the cost of nursing home care can be ten-fold the cost of providing other services, dubbed Home and Community Based Services (HCBS), that allow the individual to live at home. However some states do not have sufficient HCBS and thus spend significantly more on individuals in those eligibility categories.

Because the federal government's share of spending, based on the FMAP, ranges from 50 percent to 75 percent, critics of Medicaid's current operation note that states have every incentive to expand their program, as they only pay $.50-$.25 per dollar of additional coverage, but little incentive to reduce costs as the state only recoups $.25- $.50 per dollar cut. Put differently, in order to save a dollar of state funds, the Medicaid program may have to find $2-4 in benefit cuts. Similarly, the current structure makes it unlikely that states will invest funds in rooting out Medicaid fraud.



WHAT IS A MEDICAID PER CAPITA CAP?

A per capita cap reform proposal refers to a change in Medicaid funding from an unlimited entitlement to one with ceilings on the federal government's financial liability, but unlike a block grant, per capita caps are indexed to the number of enrollees. It is not a new idea; per capita caps were proposed by President Clinton for the Medicaid program in the 1990s. There are many avenues for implementing per capita caps and many levers for achieving desired policy and budget outcomes, but they generally vary the capped amount by state and eligibility category. Ideally, per capita caps would give states the incentive to ensure services that keep beneficiaries healthy and reduce expensive hospitalizations, such as preventative medicine and chronic care management, are covered.

One recent per-capita cap proposal, the Medicaid Accountability and Care Act (H.R. 1853), would keep eligibility constant, and states would receive the capitated payments every quarter, the amount of which would be determined by eligibility category. In this proposal, the per capita funding would be based on current spending, and thus differ from state to state in addition to the variation between eligibility categories. Over time the adjustments to the caps would be indexed to GDP growth plus 1 percent and be adjusted based on the national average to narrow the differences in spending between the states and ensure that states are not outside a "corridor" of 90-110 percent of national averages. In this proposal, the FMAP would be consistent across the states at 75 percent, with states required to match federal funding with 25 percent, paying anything above and beyond the expected amount. Should the federal funding paid in advance be more than 75 percent of medical expenditures, future payments would be adjusted to ensure that states are always contributing a minimum of 25 percent.

A similar proposal released by the Energy and Commerce Committee Chairman Fred Upton and the Senate Finance Committee Ranking Member Orrin Hatch in May, 2013 also included state-by-state caps that varied according to eligibility. While no growth rate was specified, the proposal included directions to the Secretary of Health and Human Service (HHS) to set growth rates in a way that minimizes state variation, i.e. lower growth rates for states with expensive Medicaid programs and higher growth rates for less costly states.

HOW DO PER CAPITA CAPS DIFFER FROM BLOCK GRANTS

Per capita caps are paid to states based on the number of individuals that qualify for Medicaid, therefore if enrollment increases, program funding increases in turn. Under such an arrangement, Medicaid would continue to be a counter-cyclical program, by providing more funding for states and low-income individuals when the economy is poor or unemployment increases. In contrast, block grant proposals for Medicaid, such as that included in Budget Committee Chairman Paul Ryan's FY 2012, FY 2013, and FY2014 House Budgets give states a lump sum of money that is indexed to inflation and US population growth, but not dependent on the economy or eligibility levels.

Criticism of block grants centers on both the specific cuts to Medicaid relative to the projected baseline, and the likelihood that states would reduce eligibility, cut benefits, increase cost-sharing, and or reduce provider reimbursement in order to stay within the financial constraints of the block grant amount plus what the state can afford to contribute. Similar criticism could apply to caps, but unlike block grants, caps are less likely to incentivize states to reduce eligibility, when the enrollment numbers are a factor in the federal funding. Block grants, by nature, have a more definite cap on spending, and thus can guarantee savings in a way per capita caps cannot. However, they can also leave states with increased financial liability, or the need to make deeper benefit

cuts, because of the capped federal liability.

CONCLUSION

Per capita caps are one method in which the Medicaid program could be reformed and a proposal could be structured to achieve federal savings. Proposals that cap spending per-beneficiary have less “bite” than proposals that cap spending overall, as they allow for fluctuations in the enrollee population, and while they give states the incentive to reduce costs, they do not compel states to reduce eligibility.