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Per Capita Cuts:

Proposed American Health Care Act Costs Ohio $16-22 Billion

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Center for Medicaid Policy

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EXECUTIVE SUMMARY

On May 4, 2017, the Congressional House of Representatives narrowly passed the American Health Care Act.[1] Included in this legislation, the House proposes to establish an alternative financing scheme built on per capita caps. Since being released, a number of states' governors, including Governor John Kasich of Ohio, have expressed their concerns with what the changes may mean in terms of benefits and coverage for Medicaid.[2] While The Center for Community Solutions has conducted previous research[3] on what per capita caps are by definition, this brief seeks to outline the impact of the proposal in terms of funding for Ohio's Medicaid program, specifically.

HIGHLIGHTS

- The all funds reduction as the result of a Medicaid per capita cap in Ohio is between $16.3 and $22.3 billion between Fiscal Years 2019 and 2025.
- Ohio would need to contribute or cut $6.4 – $8.5 billion in state funding through 2025 to maintain projected funding levels for the entire program, with specific population state funding changes as follows:
    - Children: Shortfall of $2 - 2.3 billion
    - Adults: Shortfall of $3 - 4.3 billion
    - Disabled: Shortfall of $1.6 – 1.8 billion
    - Aged: Surplus of $2.3 billion
    - Group VIII: Shortfall of $900 million - 1.1 billion
- It is unclear if a per capita model would conflict with standards of actuarial soundness, potentially compromising the ability for Ohio to have a privatized delivery system through managed care.

THE PROPOSED LEGISLATION

The House GOP proposal contains a number of policy elements that change Medicaid, the Marketplace, and insurance regulations. This brief will only focus on the Medicaid portion of the bill as it relates to per capita caps.

As Medicaid is an entitlement, funding is theoretically unlimited and based on a process of combined federal and state financing known as the Federal Medical Assistance Percentage or "FMAP." While there are individual FMAP rates established for each state, based in part on poverty, those rates can change depending on the program in question. For example, Medicaid expansion had an "enhanced" FMAP, meaning the federal government picked up the majority of the expenses associated with covering that population. Typically, Ohio's FMAP is about 63 percent, which is what will be used as a reference point for this analysis.

In the legislation, Medicaid as an entitlement would essentially be eliminated, tying in state funds to the medical Consumer Price Index (CPI). The CPI tries to capture the prices of goods and services purchased for consumption, and this particular measure is tied to medical pricing.[4] The legislation identifies five different groups to which the CPI rate would be applied, including children, adults, the blind & disabled, the aged, and the expansion group. Because these populations often have differing costs associated with their care, the division of the populations through a per capita cap seeks to address that cost difference by tying in those historical variances to the CPI inflationary number. It should be noted that the version passed by the House included a 1 percent add on to the CPI for the aged and disabled categories which improved the funding gap for the disabled and enhanced the funding associated with the aged.

The Medicaid expansion as it is currently designed is eliminated. The research assumes a reduced matching rate for the expansion group given the churn of members, most likely exacerbating the state's financing obligation. The FMAP for Medicaid expansion under the ACA, which has a floor of 90 percent (meaning the state only contributes 10 percent of the cost), is reduced to 63 percent for new enrollees with grandfathered enrollees receiving 80 percent FMAP. The model in this brief attempts to capture the impact of the CPI and, as there will likely be significant churn, the FMAP for the expansion group is set to 63 percent.

It should be noted that in the proposed legislation, states have the option of moving to a block grant for certain populations, wherein all Medicaid funding would be capped, but that analysis is not included here. Moreover, there is language that would include the restoration of Disproportionate Share cuts from the Affordable Care Act (ACA), though that is not taken into consideration as those are supplemental payments intended to go to hospitals as opposed to state governments.

DATA & FINDINGS

The model in this brief is built by using the language in the draft legislation in conjunction with a data "toolkit" developed by Manatt, Phelps & Phillips[5] for the Robert Wood Johnson Foundation's State Health Reform Assistance Network. Data from the toolkit come from the Center for Medicare and Medicaid Services (CMS), the Medicaid and Children's Health Insurance Program Payment and Access Commission (MACPAC), Kaiser Family Foundation, and the U.S. Census Bureau. Data from the Ohio Department of Medicaid[6] were also used to establish trend estimates for expenditures and enrollment in Ohio's Medicaid expansion population, known as "Group VIII". Additionally, the CPI number used, 3.8 percent, comes from the Congressional Budget Office's (CBO) projection of the CPI from January.

The baseline spending is outlined by category using historical trends in expenditures. In order to make a more accurate assessment of the trend, the historical rates are tied to beneficiary trends built on projected enrollment. This projected enrollment uses population trend estimates, which tend to decrease as Ohio's population decreases, thus achieving a more constrained enrollment number. This is then projected out to 2025 to provide an expenditure estimate in each year. These projections are as follows:

CPI/Per Capita Cap Baseline	**3.8%**
Per Capita Category	***Ohio's Per Beneficiary Growth***
Children	6.9%
Adults	9.0%
Disabled	5.4%
Aged	1.2%
Group VIII	5.7%

Table 1: The per beneficiary formula is (1+historical spending trend)/(1+beneficiary trend) – 1. Spending and enrollment estimates use a future value formula built on most recent available data and assume population decreases of .3%, except for the "aged" category which assumes a 2.3% population increase.

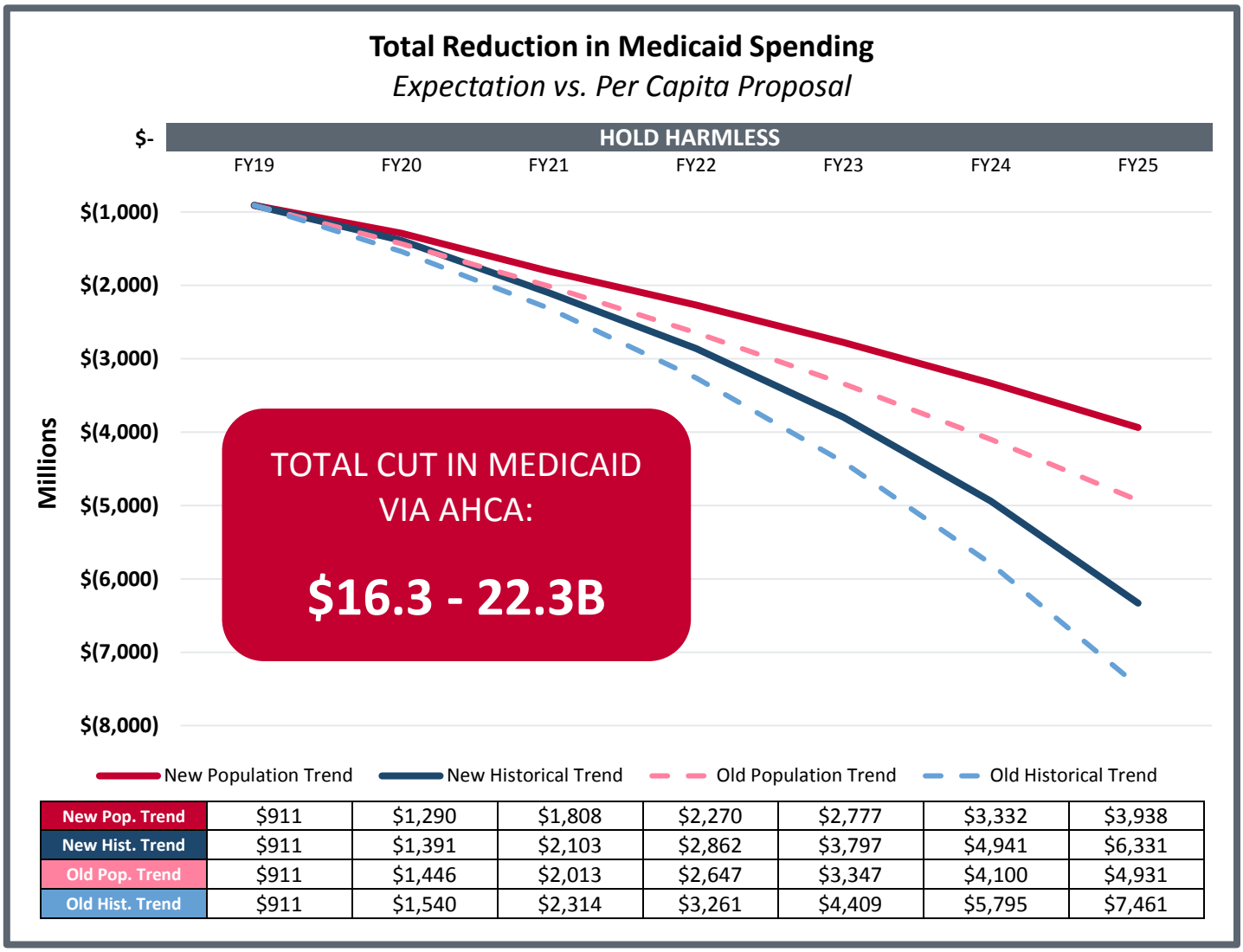
Aggregate Per Capita Cap Impact

In order to estimate the impact of the CPI per capita arrangement, the legislation language was converted into a formula. Simply put, the legislation seeks to compare historical growth between fiscal years (FY) 2016 and 2019 and removes other spending in the program outside of the categories identified (which is about 20 percent of the total program in Ohio). It also makes accommodations for supplemental funding such as disproportionate share payments to hospitals and payments in 1115 demonstration waivers.

The comparison was achieved by using the CBO's CPI rate as outlined in the law and using the per beneficiary rates identified in Table 1 to create the contrast. For the per capita amounts, the model assumes that population trends are more accurate, meaning the enrollment figures tend to trend downward as described previously, thus achieving a more conservative approach. For the comparison figures in the trend analysis, population and historical numbers are used and

projected across the same timeframe. The "Population Trend" models the future years by projecting Medicaid enrollment based on general population trends in Ohio while the "Historical Trend" is based on historical Medicaid enrollment figures.

The following represents an all-funds comparison of what the per capita model would look like compared to the baseline trend with the revised calculation based on the add-on percentage for the disabled and aged for comparison purposes:



New Pop. Trend	$911	$1,290	$1,808	$2,270	$2,777	$3,332	$3,938
New Hist. Trend	$911	$1,391	$2,103	$2,862	$3,797	$4,941	$6,331
Old Pop. Trend	$911	$1,446	$2,013	$2,647	$3,347	$4,100	$4,931
Old Hist. Trend	$911	$1,540	$2,314	$3,261	$4,409	$5,795	$7,461

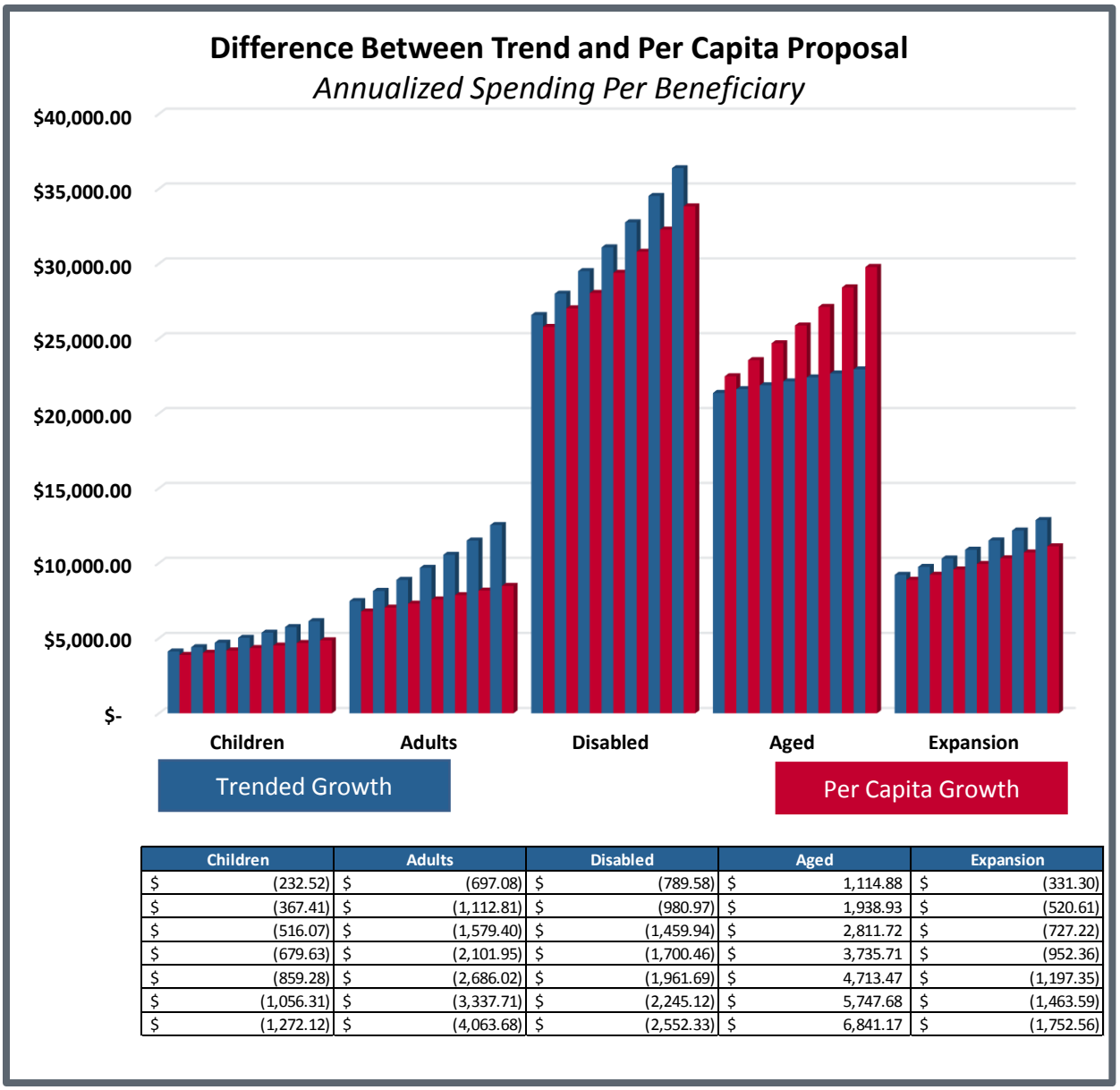
Figure 1: The gray line at the top of the chart represents "budget neutrality" or what should have been the trend in spending if no caps had been put in place.

Figure 1 shows the fundamental structural issue with the per capita approach when compared to expectation. While money will still be allocated in a manner that reflects changes in volume, the overall funding does not fall in line with the projected growth of the program. If tied to the medical CPI, even when accounting for a reduction in total members due to population loss, the all-funds reduction to Ohio Medicaid would be about $16.3 to $22.3 billion between FY19 and

FY25. This is true even when adjustments are made for the disabled and aged, resulting in a softening of impact of about $3 billion–$4 billion over the time frame.

Categorical Funding

To understand the impact by category, Figure 2 applies the formula in the bill to forecast a per capita comparison using the CPI and the per-beneficiary amounts. Even without the adjustment of volume associated with applying the population and historical trends to gauge an overall impact, the majority of the individual rates themselves fall short of expectation.



Children	Adults	Disabled	Aged	Expansion
$ (232.52)	$ (697.08)	$ (789.58)	$ 1,114.88	$ (331.30)
$ (367.41)	$ (1,112.81)	$ (980.97)	$ 1,938.93	$ (520.61)
$ (516.07)	$ (1,579.40)	$ (1,459.94)	$ 2,811.72	$ (727.22)
$ (679.63)	$ (2,101.95)	$ (1,700.46)	$ 3,735.71	$ (952.36)
$ (859.28)	$ (2,686.02)	$ (1,961.69)	$ 4,713.47	$ (1,197.35)
$ (1,056.31)	$ (3,337.71)	$ (2,245.12)	$ 5,747.68	$ (1,463.59)
$ (1,272.12)	$ (4,063.68)	$ (2,552.33)	$ 6,841.17	$ (1,752.56)

Figure 2

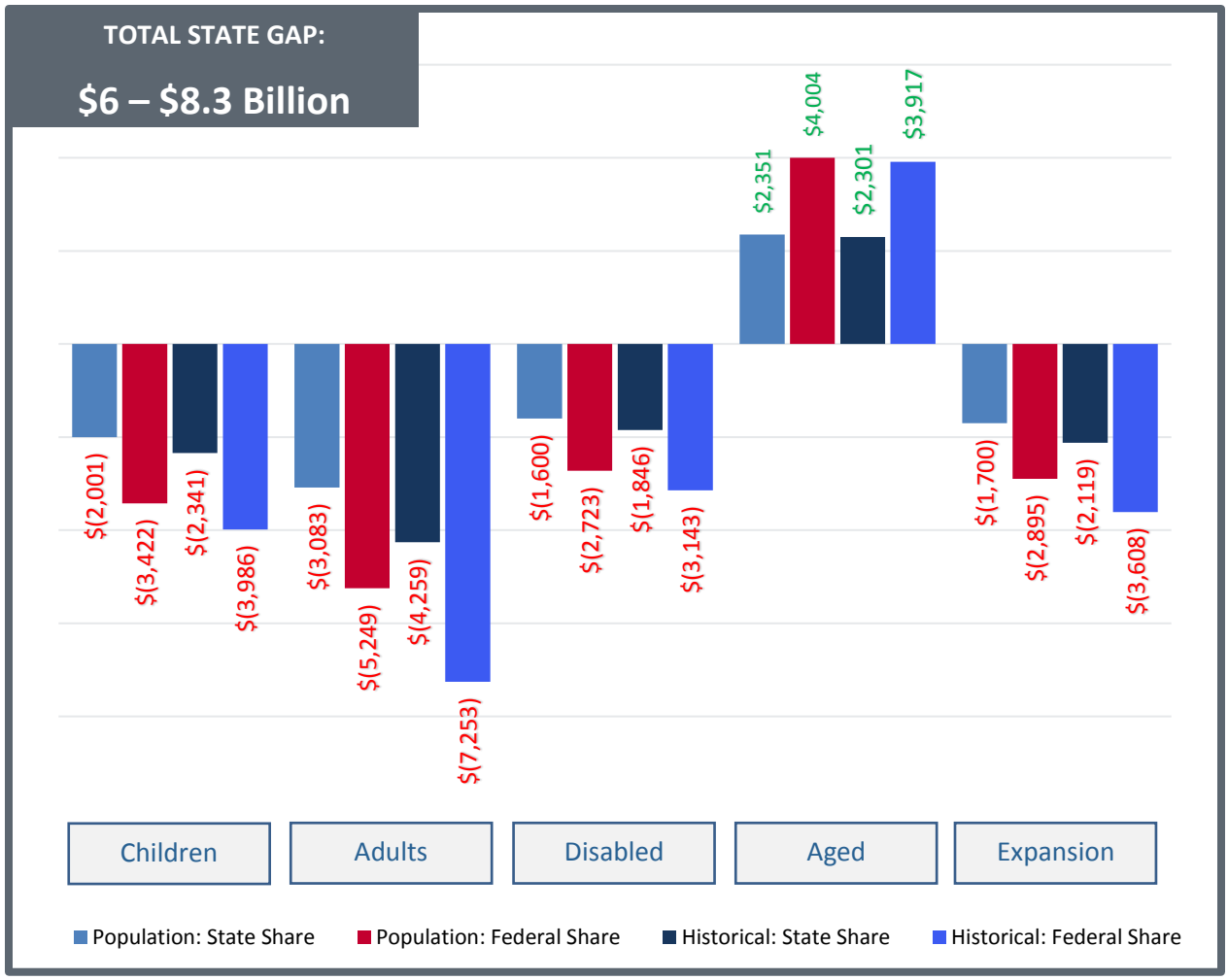


Figure 3: Numbers listed are in millions.

Figure 3 compares the CPI per capita effect utilizing the same historical and population trends identified in Figure 1, with the added dimensions of category and financial share. In terms of share, the model assumes a 63 percent federal match for all categories.

The only category that seems to have a surplus in the new model is associated with the aging population. Mathematically, this is due to the lower average per beneficiary growth rate relative to the Medical CPI + 1 percent (1.2 percent vs. 4.8 percent). Programmatically, this may also be a function of Ohio's efforts to move to lower-cost, community-based programs for long-term care, though much of that has been achieved through additional funding associated with the ACA.[7]

Per Member Per Month

Often, costs in Medicaid are expressed in terms of a "per member per month" amount, called PMPM. This amount reflects the average monthly spending for a category of Medicaid enrollees. The private insurance companies which manage 90 percent of Ohio's population,

known as Managed Care Organizations (MCOs), typically express their costs and reimbursement in this way.

Using the baseline and projecting out to 2025, this is how the PMPM for each category would be affected:

PER MEMBER PER MONTH ANALYSIS *Estimated PMPM Reduction Needed by 2025*				
	CATEGORY	PMPM	HOW TO CALCULATE PMPM PMPM is calculated by taking the annual spend of a given category, dividing it by the number of members for the year, and then dividing the total by 12 to produce a monthly average.	
TREND	***Children***	$510.69		
	Adults	$1,044.88		
	Disabled	$3,031.41		
	Aged	$1,911.44		
	Group VIII	$1,072.32		
			THE DIFF	PERCENT
PER CAPITA	***Children***	$404.68	$106.01	-21%
	Adults	$706.24	$338.64	-32%
	Disabled	$2,818.71	$212.69	-7%
	Aged	$2,481.54	$(570.10)	30%
	Group VIII	$926.28	$146.05	-14%

Table 2

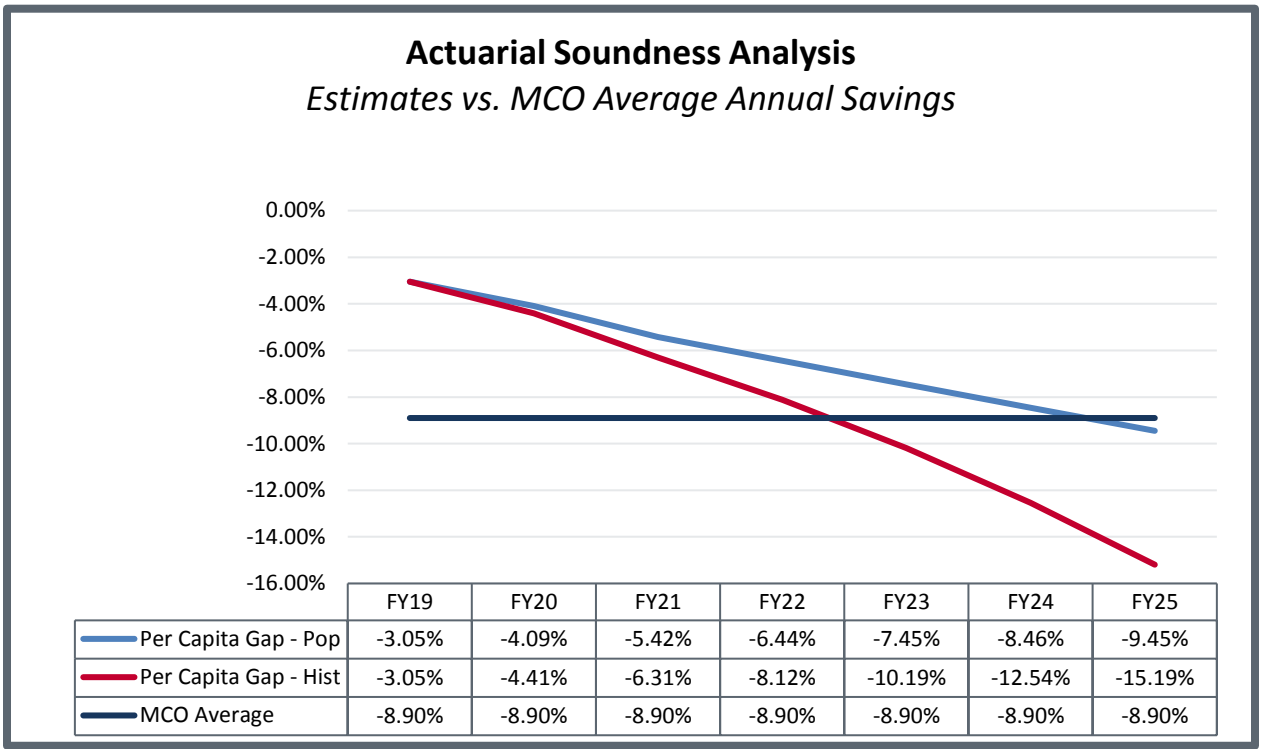
Actuarial Soundness

Ohio's reliance on managed care as a model of delivery has increased significantly over the last decade. It is important to note, however, that federal regulation requires that rates paid to MCOs are "actuarially sound." According to federal law and regulatory guidance, rates must "provide for all reasonable, appropriate and attainable costs."[8] Additionally, through recent guidance from the Centers for Medicare and Medicaid Services, actuarial soundness principles prohibit cross-subsidization from one group to another and rate development must include trend data tied to "the actual experience of the Medicaid population."[9]

Recently, a study of Ohio's Managed Care system (henceforth the "MCO Report") showed that Ohio is saving $1 billion annually.[10] The study, authored by the trade association representing the plans, highlighted how the industry leveraged business process strategies from the private sector to control costs and save over $2.5 billion compared to what the costs would have been under a traditional fee for service model between 2013 and 2015. With that said, a per capita cap may violate the standards set out by the principles of actuarial soundness, thereby bringing into question the ability of Ohio's privatized system to continue without significant policy change at the federal level.

Looking at the MCO report, you can see an average annual savings of 8.9 percent between 2013 and 2015. Because the data from the toolkit use averages between 2000 and 2011, incorporating the downward inflationary influence of the managed care system on the baseline, while

appropriate, may not be useful, a more restrained approach may be best. If, then, you look at the difference in funding between the baseline and the per capita as a percentage, and compare that to the annual average savings from the MCO report, you get the following:



	FY19	FY20	FY21	FY22	FY23	FY24	FY25
Per Capita Gap - Pop	-3.05%	-4.09%	-5.42%	-6.44%	-7.45%	-8.46%	-9.45%
Per Capita Gap - Hist	-3.05%	-4.41%	-6.31%	-8.12%	-10.19%	-12.54%	-15.19%
MCO Average	-8.90%	-8.90%	-8.90%	-8.90%	-8.90%	-8.90%	-8.90%

Figure 4

While Ohio's MCO efforts seem to be controlling costs, a per capita cap may hinder the ability for the MCOs to appropriately manage care for the populations they cover. Based on the analysis represented by Figure 4, it seems that the average cost savings realized by MCOs may be eclipsed by reductions in funding represented by the proposed per capita financing arrangement in both the population and historical models. As such, the per capita proposal would likely cause MCOs to reduce the benefit structure, impose more rigorous utilization controls, decrease rates in their contracts with providers, or leave the market altogether.

CONCLUSION

Historically, Medicaid is a complex partnership between the states and the federal government. The variability between states, the populations they serve, the trends that exist economically, demographically, and through policy, affect how Medicaid is operated from one state to the next. One way to measure the differences between states, and their respective policy contexts, is through the value that is being created through the investment of these combined state and federal resources. Ohio's achievement in value, defined as the combination of outcomes and spending, is currently ranked 46 out of 50.[11]

In many respects, the desire for value is why the Kasich administration has leveraged managed care and taken advantage of a number of ACA policies that have moved Ohio into episodic-based payments, increased use of home and community-based waivers, and expanded Medicaid. However, given Ohio's historical trends of expenditure in Medicaid, a per capita arrangement would ultimately force the state to reduce costs at a pace that may force cuts to benefits or restrict eligibility. Moreover, it could compromise Ohio's privatized system of managed care, despite its successes, without significant changes to the standards of actuarial soundness. The choice for policymakers, then, is to determine if the federal policy proposal's effect of reducing costs is worth the likely expense of coverage and benefits reductions for Ohio's children, low-income adults, and disabled.

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[2] Nuckols, Ben. "Plan to repeal Obama health law shows GOP governors are torn." The Big Story. February 27, 2017. Accessed February 28, 2017. http://bigstory.ap.org/article/e358c32fe324460e9c0331e171bbcd81/report-warns-gaps-if-federal-health-care-dollars-are-cut.

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[6] United States. The Ohio Department of Medicaid. Medicaid Expenditures and Eligibles Reports. Accessed February 27, 2017. http://medicaid.ohio.gov/RESOURCES/ReportsandResearch/MedicaidEligiblesandExpendituresReports.aspx.

[7] United States. Department of Health and Human Services. Centers for Medicare & Medicaid Services. Balancing Incentive Program. Accessed February 28, 2017. https://www.medicaid.gov/medicaid/ltss/balancing/incentive/index.html.

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[10] Rowland, Darrel. "Latest study: Ohio-style Medicaid may save $1B a year." The Columbus Dispatch. February 15, 2017. Accessed March 01, 2017. http://www.dispatch.com/news/20170214/latest-study-ohio-style-medicaid-may-save-1b-year.

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