The Case for Per Capita Caps

Improving the focus, equity, and accountability of Medicaid

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Medicaid Per Capita Caps

- Challenge of cost with management and financing split
- Inequity in distribution between the states
- What are the higher-spending states getting?
- Assessing Per Capita Caps as a reform proposal

Federal program spending/GDP

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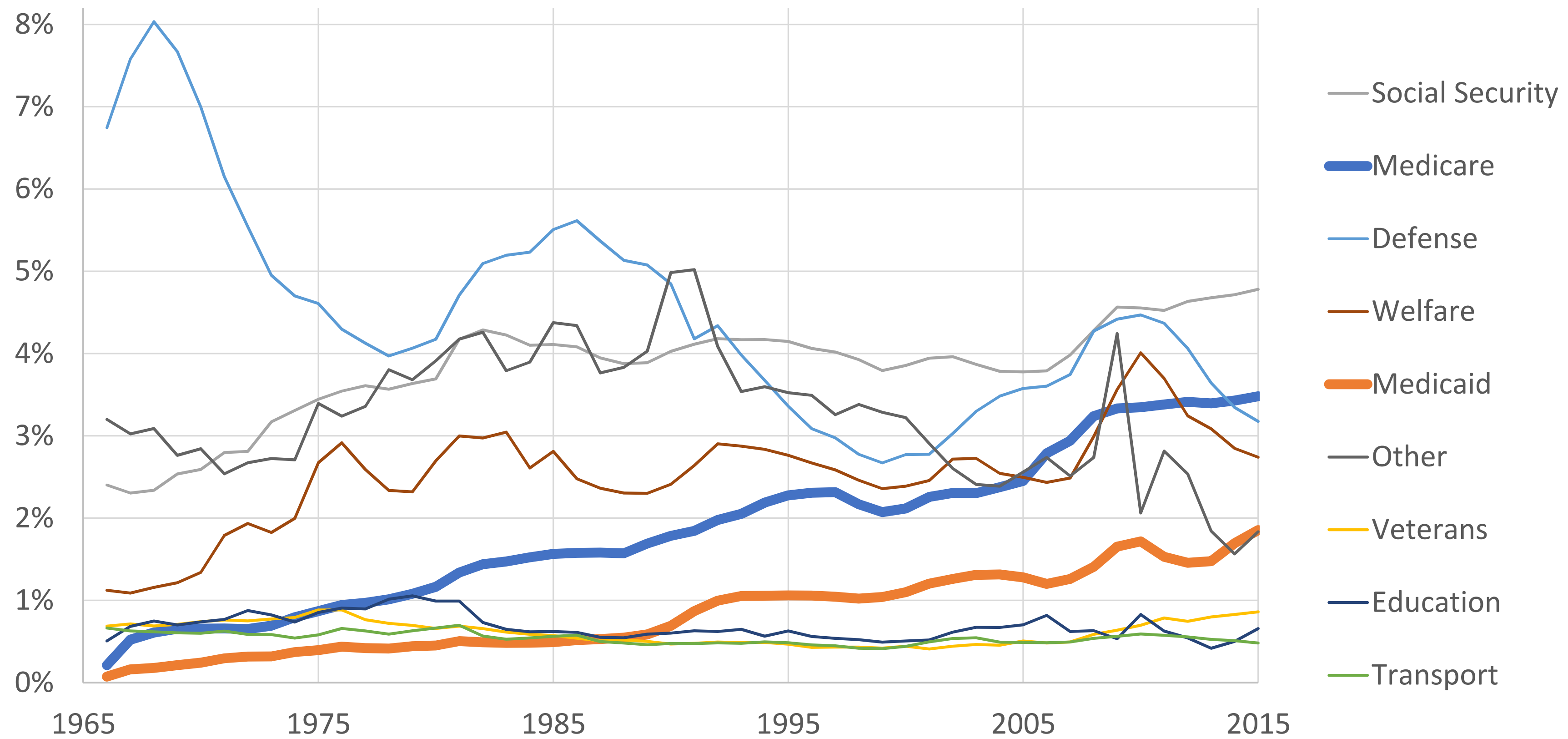

Medicaid program challenges

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- Medicaid is largely a 4th party payment system
- There is no objective "cost" to be covered. States will spend all the funds they are given.
- Medicaid maximization games (reclassifying spending, provider taxes)
- State management frustrates tracking of expenditures
- Allocations to states are the inverse of needs

Medicaid distribution in theory

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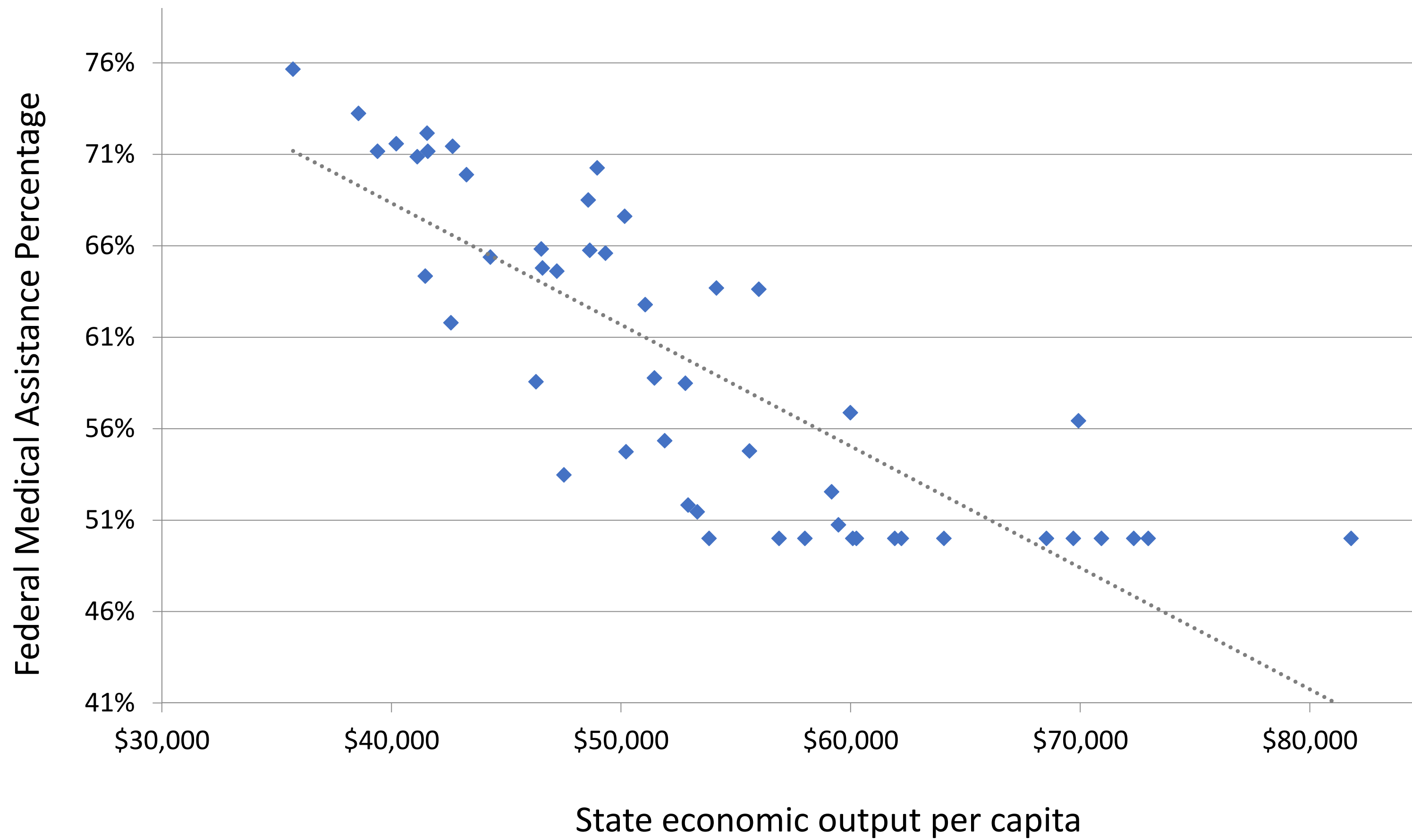

Medicaid distribution in practice

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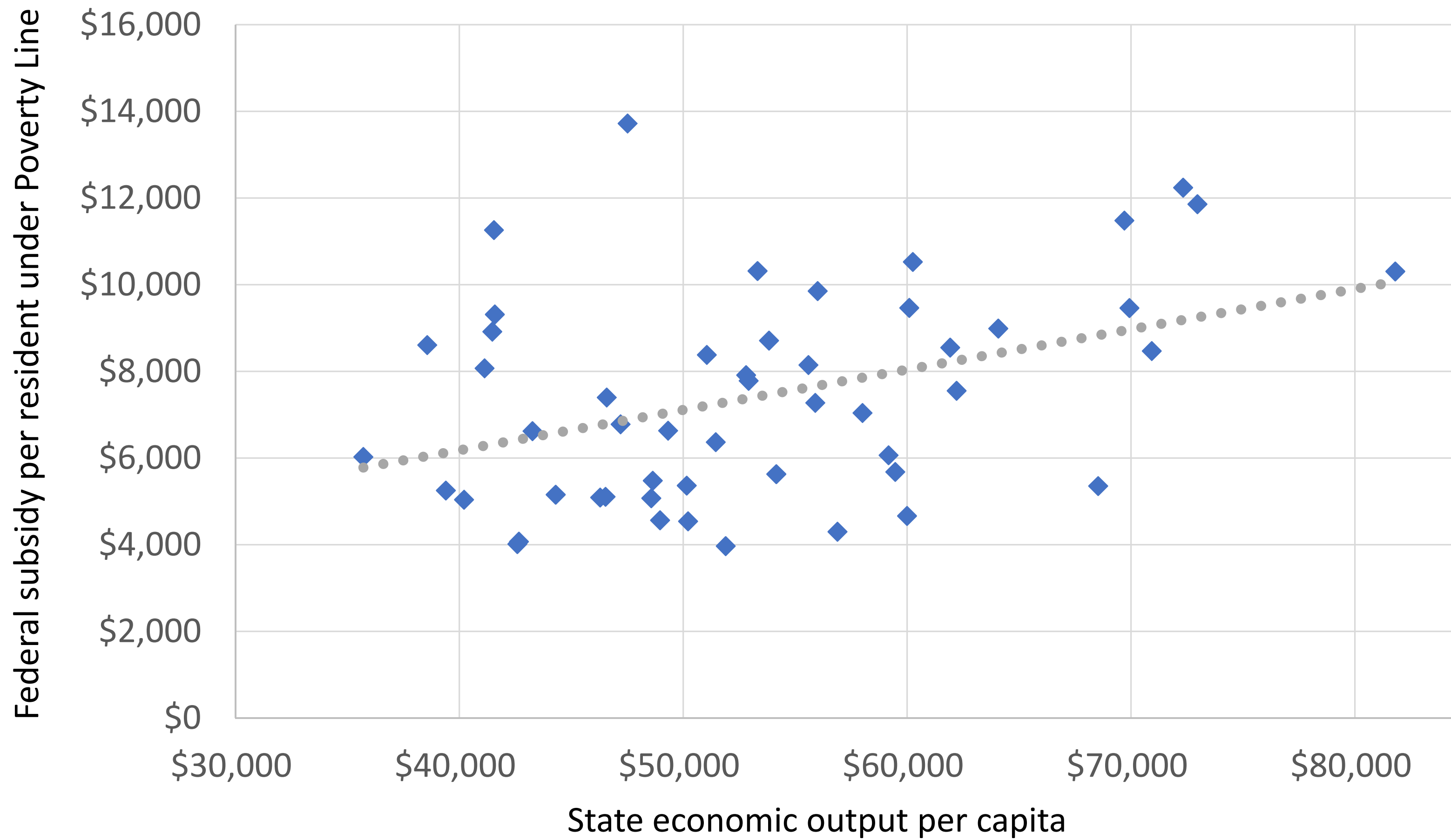

Two very different Medicaid programs

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	Alabama	Connecticut
Under Federal Poverty Level	17%	9%
Federal Medicaid subsidy per capita	$786	$1,253
Enrolled in Medicaid	18%	21%

A medical safety net under strain?

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Medicaid Per Capita Spending (2015)

Hospital care

$410

$520

$0 $200 $400

Limited access to providers?

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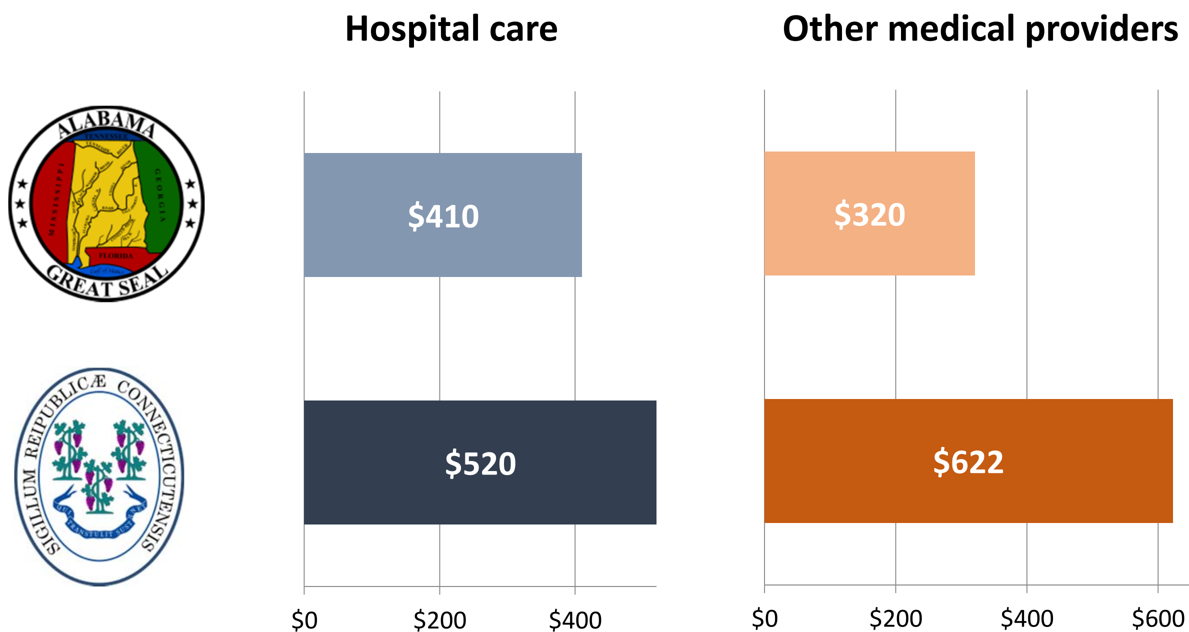
Medicaid Per Capita Spending (2015)



or LTC for those with equity <$840,000?

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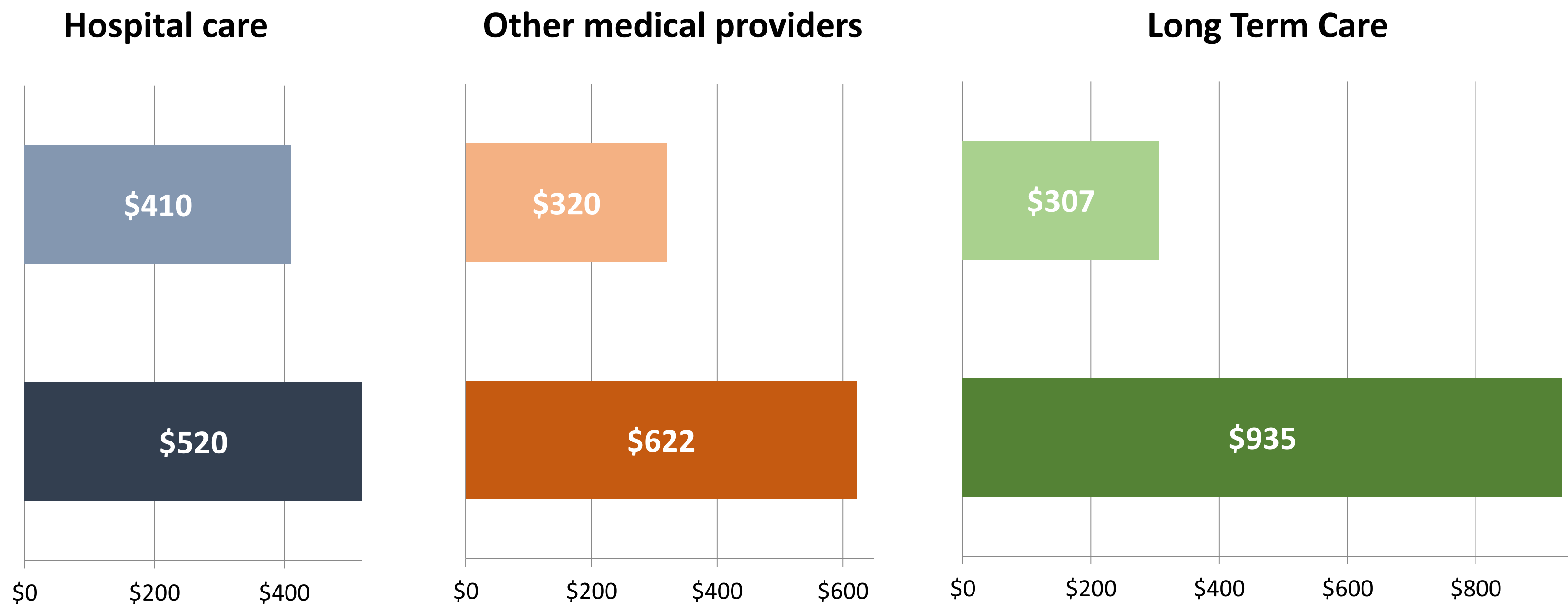
Medicaid Per Capita Spending (2015)



The (very modest) goals of Per Capita Caps

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- PCCs do nothing to prevent future expansions of benefits or eligibility by future Congresses
- Congress can revise caps in the budget every year
- PCCs give federal taxpayers a say over unilateral attempts by states to expand benefits greatly beyond current spending path
- PCCs establish regular scrutiny and a conversation about priorities, purposes, and opportunity costs in the Medicaid program

The AHCA's "deep cuts to Medicaid"

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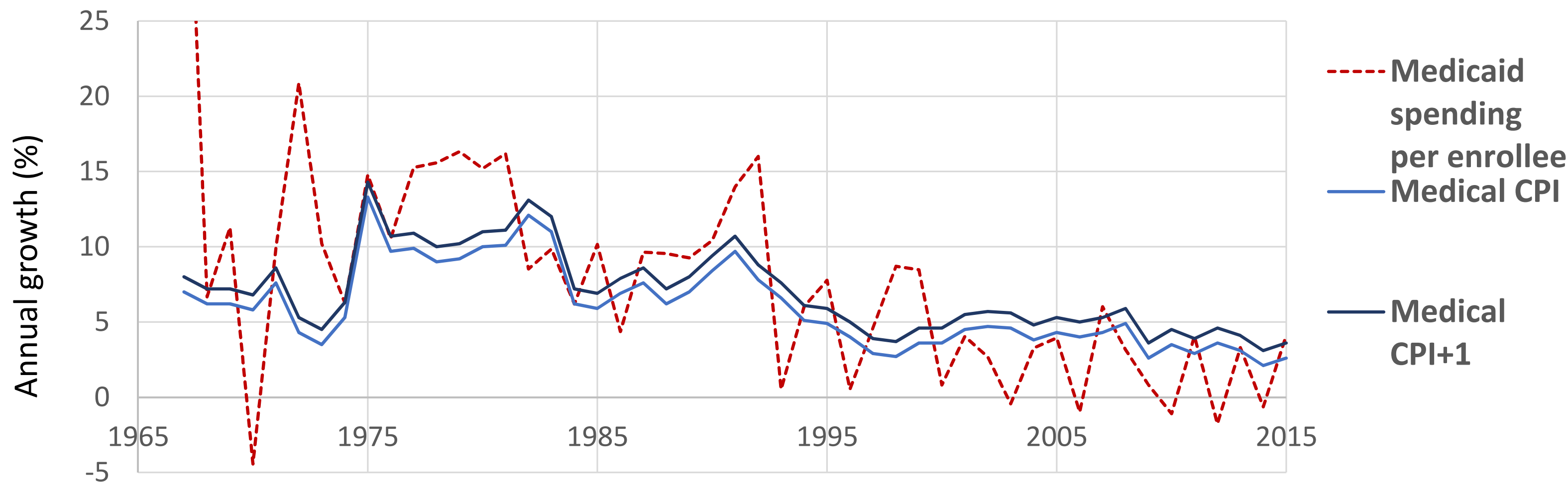
- Cap on growth of aggregate per-enrollee payments to states
  - Increases at Medical-CPI for children, expansion adults, and other adults
  - Increases at Medical-CPI+1 for elderly, blind, and disabled
  - Excludes payments for DSH and Medicare cost-sharing

- Caps loosen in recessions as proportion of younger enrollees increases



A few worthwhile tweaks

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- Defining “per capita” as “per enrollee” is problematic
  - Enrollment is the main cost-driver of Medicaid in recent years
  - The most fixable part of looming LTC spending boom is on enrollment side
  - Medicaid cost per enrollee is falling as recent expansions have added relatively healthier beneficiaries
  - It is likely very easy for states to game by adding low-cost enrollees
  - Residents under the Poverty Level is a better objective metric of need, and would similarly automatically loosen caps during recessions

- AHCA caps constrain low-spending and high-spending states equally
  - Increasing scrutiny may stop disparities getting worse
  - Locks in advantage for states with more fat in the system
  - Better to have different cap growth rates for states relative to national average payments