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Financing of the NGA Proposal

Base. In determining base expenditures a state may choose from the following—1993, 1994, or 1995 expenditures. The base includes disproportionate share spending.

Growth. The growth in a states base over time will be composed of two factors. First, a weighted average of the projected growth in the guaranteed populations of that state and second, an adjustment factor. Both factors will be applied to the entire base including disproportionate share as long as a states share of disproportionate share is below the 12 percent national average. If a states disproportionate share is above 12 percent, the disproportionate share portion will not receive any growth until it falls to 12 percent.

The average weighted population growth will reflect the prospective growth in the five population categories in a given state.

The Adjustment Factor. The adjustment factor will be a percentage by which each state's base will be adjusted (along with the unique average weighted population growth for the state) each year to account for increases in the cost of providing health care services. The adjustment factor, which will never be below 3 percent for any year, will be specified in the legislation over the seven year period and cannot be altered. The adjustment factor will be computed based on the savings required in the legislation.

Adjustment Base. After a state chooses the base year, i.e., 1993, 1994, or 1995, it will be necessary to update the base to 1996. This will be based on the state's actual weighted population growth for that year coupled with the national adjustment factor that is derived by subtracting the actual national weighted population growth from total growth in Medicaid. This calculation does not imply a cap on FFY 1996 expenditures in the program. Rather, this calculation is for the sole purpose of establishing a 1996 base to calculate 1997 and future allocations.

The Path of the Adjustment Factor Overtime. The adjustment factor that is written into the legislation will reflect a three year phase down to the steady state. For example, if the average adjustment factor over seven years is 4.6 percent it would have a path such as 6.0, 5.5, 5.0, 4.0, 4.0, 4.0, 4.0 over years 1-7.

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The State Allocation. An executive agency board will estimate each states' allocation every year for the next three years. This allocation would be based on the states unique projected growth and the national adjustment factor. The next year will represent a permanent allocation that will represent a minimum state allocation if matched by the state. The two additional years would represent a planning horizon that would be updated each year. The cost differences among states should be addressed, but Governors have not determined the appropriate mechanism for doing so.

Efficiency Incentives. Each year for the seven years, each state would receive the full adjustment factor applied to the prior year base regardless of their actual per capita expenditure. If states become more efficient and reduce per capita spending they would reap savings which could be used to expand health care to other low-income populations.

Actual and Proxy Variables may be used for Prospective Allocation. As previously stated, each year the executive board will project for the next three years the amount of money that will be available to each state for their base allocation. The projection will represent the board's best estimate of the growth in the five populations but will be applied to the entire base. The prospective allocation will be based on recent actual state Medicaid data and, only when necessary the use of proxy variables. Some proxy variables may be collected by the Bureau of the Census, the Bureau of Economic Analyses, or other federal agencies for each of the categories. It is true that some of these proxy variables are already projected by some federal agencies. The use of any proxy variables will also be specified by the executive board.

Reconciliation or Truing Up. There would be a periodic look back to see if states provided care to more of the populations than was estimated in the original allocation. If there was additional case load growth above that assumed in the states allocation, states could draw from the umbrella funds. For each guaranteed population as well as the optional elderly, optional disabled, and medically needy, individual states would be paid the state per capita spending with adjustment for that category of that population. (The per capita spending would not include disproportionate share spending.) States would have to use any surplus funds resulting from a population over-estimate in one guaranteed population category to offset a deficit in another guaranteed population prior to being able to draw from the umbrella fund. The matching share would be the

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same for the umbrella as the base program. The draw-down from the umbrella would be automatic since it would be an entitlement to the state. It would not be capped and it would not need to be appropriated. This reconciliation would be done on a quarterly basis. However, a federal agency would audit the states population draw-downs, after the fact.

Protection for Significant Cost Changes. If the CPI fluctuates between 0 and 5 percent then states will not receive any adjustment to their spending, i.e., they will gain to the extent the CPI is lower than expected and there will be a risk to the extent that the CPI is above the expectation, but below 5 percent. If, however, the CPI for the preceding year is above 5 percent then states will be able to receive the difference between the actual CPI and 5 percent for its entire population served. For example, if the CPI went to 7.5 percent in a year then states would be able to enter the umbrella for the 2.5 percent cost increase for their entire population. This amount would be included in the base for the next year. States would have to match these funds.

Rollover Provision. Unobligated funds from the initial allocation that have not been drawn down by a state will remain available to the state, without limit.

Funding Formula

In any given year, maximum fed allocation to a state is I where:

$$I = (((H + D) \times E) + G) \times FMAP + F$$
$$\text{where } H = A \times B \times C$$

A is the base year total Medicaid spending in the state in dollars. If DSH is less than or equal to 12% of that total, all DSH funds are included in A. If DSH is greater than 12%, the DSH amount is not included in A. Instead the DSH amount is frozen and added back in the end (see G)

B is a growth rate attributable to enrollment changes.

In the formula that follows, the summation is across all guaranteed categories. In addition, so long as a state continues to serve any optional categories that the state served on January 1, 1996, those optional categories are included as well. Cost per enrollee is the cost, by enrollee, in the base year.

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$$B = \frac{\Sigma\,(\textit{Est. This Year Enrollees In Category x Cost Per Enrollee})}{\Sigma\,(\textit{Prior Year Enrollees In Category x Cost Per Enrollee})}$$

C is an adjustment factor that compensates for cost growth. It cannot be below 3%, but is calculated to meet the budget savings target. In addition, it is phased down over three years to give states a few years to reach this lower rate.

H is a dollar amount, which is the base increased by B and C

D is the enrollment umbrella. It is a dollar amount, calculated by taking the actual enrollment amount for all guaranteed populations as well as optional elders, disabled, and spend-down that a state had in place on January 1, 1996, and subtracting the actual enrollment from the estimated enrollment for each category. While certain components of D may be less than 0 (when actual is below estimated), the sum that is D is the greater of 0 or the formula below. In the formula below, cost per enrollee is the cost, by category, in the base year, inflated by the factor C up to the current year.

$D = \Sigma(\textit{Actual Enrollment} - \textit{Est. Enrollment}) * \textit{Cost Per Enrollee}$ (cost per enrollee in the base period increased over time by the adjustment factor)

E is the inflation umbrella. It is a growth factor that is 1 (meaning it has no effect) when CPI is less than 5%, but when CPI is above 5%, is 1 + CPI – 5.

F is the special grants amount for each state. F also includes any carry forward of unexpended allocations from prior years.

G is the base year DSH allocation to the state if a state's DSH is greater than 12%. (Otherwise, DSH is in the base at A.

FMAP FMAP is the match rate for that year calculated using the same formula as is used currently, but adjusted by the modification in NGA policy (i.e. maximum state share is 40%).

The population categories are as follows:
All children with guaranteed eligibility
All pregnant women with guaranteed eligibility
All other adults with guaranteed eligibility
All persons with disabilities
All elderly

Example of Average Weighted Population Growth

	Year 1			Year 2			Proposed Option: Weight by Avg. Cost			Alternative: Weight by Total costs		
	Beneficiaries	Cost / Beneficiary	Total Spending	Beneficiaries	Growth		Cost / Beneficiary	Percent	Weight	Total Spending	Percent	Weight
Women	300	2,000	600,000	309	3.0%		2,000	20%	0.6%	600,000	24%	0.7%
Children	500	1,000	500,000	530	6.0%		1,000	10%	0.6%	500,000	20%	1.2%
Disabled	200	7,000	1,400,000	204	2.0%		7,000	70%	1.4%	1,400,000	56%	1.1%
Total	1,000	2,500	2,500,000	1,043	4.3%		10,000	100%	2.6%	2,500,000	100%	3.0%

Counts, cost per beneficiary and growth rates from the 2/22 draft.