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Medicaid Per Capita Cap Would Disproportionately Harm Some States

Permanently Locks in Variation in State Medicaid Funding

By Hannah Katch

The American Health Care Act (AHCA), which the House passed on May 4, would cut federal Medicaid spending by $834 billion over ten years by converting the program to a per capita cap and effectively ending the Affordable Care Act's (ACA) Medicaid expansion.[1] Media reports suggest that Senate Republicans will retain the per capita cap without major changes in their version of the House bill.[2] While the per capita cap would shift substantial Medicaid costs and risks to *all* states, some states would likely face disproportionately large cuts. They include:

- **States with relatively low historical spending per beneficiary.** Each state's initial funding under the per capita cap would be based on its spending per beneficiary in 2016, so these states would receive less funding per beneficiary than other states. Moreover, each state's funding for subsequent years would be based on their initial-year funding, so the per capita cap would permanently cement this state variation in spending per beneficiary moving forward.
- **States with relatively fast growth in per-beneficiary spending.** The House bill adjusts the per capita cap amounts each year in all states by a national growth rate. This means that states with higher-than-average growth in per-beneficiary costs would face deeper cuts than other states.
- **States with more restrictive Medicaid benefits or eligibility.** Since states have wide flexibility to design their own Medicaid programs, benefits and eligibility vary significantly across the country. Under the per capita cap, states with more restrictive policies in these areas during the base year of 2016 would receive fewer funds than other states due to their lower spending. And they would have to finance any improvements to their programs entirely with their own funds, as no additional federal funds would be available.

[1] Center on Budget and Policy Priorities, "House Health Care Bill Ends Medicaid As We Know It," updated May 25, 2017, http://www.cbpp.org/research/health/house-health-care-bill-ends-medicaid-as-we-know-it.

[2] Associated Press, "Senate Republicans Claim Progress on Health Care Legislation," June 6, 2017, https://www.nytimes.com/aponline/2017/06/06/us/politics/ap-us-congress-health-overhaul.html.

- **States with demographic and other factors that will likely raise Medicaid spending per beneficiary in the future.** For example, each state's funding cap per senior beneficiary would effectively be based on the state's spending per senior beneficiary in 2016. But per-beneficiary costs among seniors will rise significantly over the long run as the share of elderly beneficiaries who are over age 85 — a group with higher health costs than other seniors — grows.
- **States at greater risk of natural disasters.** The per capita cap would not adjust to help states facing higher-than-anticipated per-beneficiary costs due to increased health care needs following a natural disaster like Hurricane Katrina, an epidemic like Zika, or a public health emergency like the lead poisoning in Flint, Michigan.
- **States with low provider payments or especially efficient health care delivery and financing.** States that have been more aggressive in implementing cost-containment strategies that lower per-beneficiary costs while preserving access to care, such as by expanding use of managed care or instituting innovative delivery system reforms, would receive lower per capita caps as a result.

Medicaid Cap Would Lead to Large and Growing Shortfalls for States

The AHCA would end Medicaid's federal-state financing partnership, in which the federal government pays a fixed percentage of state Medicaid costs — on average, 64 percent today. Instead, beginning in 2020, federal funding would be capped at a set amount per beneficiary. The overall cap would equal federal Medicaid spending per beneficiary in 2016, rising each year by a *slower* rate than the Congressional Budget Office's (CBO) current projection for Medicaid spending per beneficiary. That would cut federal Medicaid spending for all states, with the cuts growing each year. (In place of the per capita cap, states could convert Medicaid to a block grant for children, adults other than seniors and people with disabilities, or both.)

Starting in 2020, the AHCA would establish different per-beneficiary caps for different groups: children, seniors, people with disabilities, adults eligible through the Medicaid expansion, and other adults. Each year, states would receive a fixed amount of overall federal funding based on each of these caps and enrollment in each beneficiary group.

To compensate for this large cost shift, states would have to raise taxes, cut other budget areas like education, or as is far likelier, cut Medicaid spending. But Medicaid is already highly efficient, with per-beneficiary costs that are lower than (and growing more slowly than) private insurance.[3] So all states would likely have to make cuts that seriously harm beneficiaries, like restricting eligibility, reducing services, cutting payments to providers, or a combination of all three approaches to rationing care. Moreover, under the House bill, these federal funding shortfalls would be even greater if health care costs grow more quickly than anticipated due to a public health emergency, development of a costly new prescription drug, or changing demographics, as states would be responsible for 100 percent of all costs above the cap.

[3] Edwin Park *et al.,* "Frequently Asked Questions About Medicaid," Center on Budget and Policy Priorities, updated March 29, 2017, http://www.cbpp.org/research/health/frequently-asked-questions-about-medicaid.

Disproportionate Harm Reflects Historical Variation Across State Medicaid Programs

As a new Kaiser Family Foundation analysis finds, "states with certain characteristics are more at risk" under the Medicaid per capita cap.[4] By basing states' per capita cap amounts on their 2016 spending, the House bill would permanently lock in states' variation in spending, population demographics, and historical decisions.[5] The kinds of states that this approach would particularly disadvantage are outlined below. (See Table 1.)

States with Relatively Low Per-Beneficiary Spending

States vary widely in per-beneficiary Medicaid spending. Among Medicaid beneficiaries in 2014 who would be subject to the per capita cap,[6] total federal and state Medicaid spending per beneficiary was $6,393 (total spending among seniors and people with disabilities was much higher). But spending varied widely among states: from $4,003 to $10,721, the Kaiser Family Foundation found.[7] (See Table 2.)

Per-beneficiary spending tends to be lower in southern states and higher in northeastern states.[8] Substantial variation exists across states among different beneficiary groups as well. For example, average per-beneficiary spending among the states ranges from $8,623 to $44,752 for seniors, from $9,448 to $38,442 for individuals with disabilities, and from $1,520 to $5,137 for children.

Under the House bill, states with relatively low Medicaid spending per beneficiary would initially receive less overall federal funding per beneficiary (or for specific populations) than other states. Since a state's funding for subsequent years would be based on this initial-year funding, the per capita cap would permanently cement this state variation in spending per beneficiary moving forward.

States with Relatively High Growth in Per-Beneficiary Spending

Growth in per-beneficiary Medicaid costs, both overall and for specific beneficiary groups, also varies considerably by state. For example, over the 2000-2011 period, average annual growth in annual Medicaid spending ranged from minus 1.4 percent to 13.3 percent for seniors,[9] from 5.7

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[4] Robin Rudowitz *et al.,* "Factors Affecting States' Ability to Respond to Federal Medicaid Cuts and Caps: Which States are Most at Risk?" Kaiser Family Foundation, June 9, 2017, http://www.kff.org/report-section/factors-affecting-states-ability-to-respond-to-federal-medicaid-cuts-and-caps-which-states-are-most-at-risk-issue-brief/.

[5] *Ibid.*

[6] Under the House bill, spending for Medicaid enrollees who are only eligible for partial benefits (such as emergency services) is not subject to the cap.

[7] Kaiser Family Foundation, "Data Note: Variation in Per Enrollee Medicaid Spending," June 9, 2017, http://www.kff.org/medicaid/fact-sheet/data-note-variation-in-per-enrollee-medicaid-spending/.

[8] Kaiser Family Foundation, "Data Note: Variation in Per Enrollee Medicaid Spending Across States," February 23, 2017.

[9] This calculation excludes prescription drug spending to account for the shift in prescription drug costs from Medicaid to Medicare for the dual eligibles starting in 2006 with the implementation of the Medicare drug benefit.

percent to 15.5 percent for individuals with disabilities, and from 0.4 percent to 11.6 percent for children.[10] (See Table 3.)

Because the House bill adjusts the per capita cap amounts each year in all states by a single national growth rate, states with higher-than-average growth in per-beneficiary costs would face deeper cuts than other states. In fact, under the House bill's per capita cap, states with relatively low per-beneficiary spending would not only be locked in at lower spending levels, but also would likely bear as much as 85 percent of the national federal spending cuts under the per capita cap, according to a Brookings Institution analysis.[11] That's because states with relatively low spending in a given year tend to experience faster cost growth in subsequent years, so states with the lowest spending during the base year (2016 under the House bill) could see higher per-beneficiary growth and therefore disproportionately larger cuts in subsequent years even though they are least able to reduce spending per beneficiary without harming beneficiaries.[12]

States with Limited Medicaid Benefits and Eligibility

Benefits. Medicaid gives states expansive flexibility to design their own programs — whom they cover, what benefits they provide, and how they deliver health care services. The federal government sets minimum standards, including specifying certain categories of people that all states must cover and certain health coverage they must provide. But other benefits and eligibility categories are at the option of the state.

As a result, Medicaid benefits vary significantly by state. But states with relatively narrow Medicaid benefits during the base year would receive fewer funds than other states due to their lower costs. Such states would have to finance any subsequent improvements to their Medicaid programs entirely with their own funds, as no additional federal funds beyond the per capita amount would be available. Moreover, these states would likely have to make cuts to critical benefits earlier — and to a deeper extent — to compensate for the federal Medicaid funding cuts under the per capita cap.

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[10] Kaiser Family Foundation, "Average Growth in Annual Medicaid Spending from FY2000 to FY2011 for Full-Benefit Enrollees," January 28, 2015, http://www.kff.org/medicaid/state-indicator/average-growth-in-annual-medicaid-spending-from-fy2000-to-fy2011-for-full-benefit-enrollees/.

[11] The Brookings analysis estimated the impact of the cap in 2011 if it were in effect starting in 2004 based on state spending in 2000. Loren Adler, Matthew Fiedler, and Tim Gronniger, "Effects of the Medicaid Per Capita Cap Included in the House-Passed American Health Care Act," May 10, 2017, Brookings Institution, https://www.brookings.edu/research/effects-of-the-medicaid-per-capita-cap-included-in-the-house-passed-american-health-care-act/.

[12] *Ibid.*

Medicaid Home- and Community-Based Services Are Vulnerable to Cuts

Federal waivers and other state options for home- and community-based services (HCBS), which give seniors and people with disabilities care at home instead of in a nursing home, have given states new ways to address the long-term service and support needs of their residents, including seniors as well as both children and adults with serious disabilities. Progress has been dramatic: HCBS accounted for 53 percent of state Medicaid expenditures for long-term services and supports in 2014, up from 18 percent in 1995, and the number of people served with HCBS has risen dramatically, to nearly 3 million.[a] States now spend more for HCBS than for nursing home care.

A Medicaid per capita cap would make HCBS especially vulnerable to deep cuts. Unlike most Medicaid services, which states must cover, most HCBS are optional, so states can cut them when they face funding shortfalls. Most states already limit HCBS due to funding constraints, and HCBS are a likely target if states must make substantial cuts due to federal funding shortfalls because they spend more on optional HCBS than on any other optional benefit.

The House bill would therefore likely generate large increases in HCBS waiting lists. States would likely curtail these services, and some states could eliminate their HCBS programs altogether.

[a] Judith Solomon and Jessica Schubel, "Medicaid Cuts in House ACA Repeal Bill Would Limit Availability of Home- and Community-Based Services," Center on Budget and Policy Priorities, May 18, 2017, http://www.cbpp.org/research/health/medicaid-cuts-in-house-aca-repeal-bill-would-limit-availability-of-home-and.

Eligibility. States must cover certain "mandatory" eligibility groups, but many states offer more generous coverage for some individuals, such as pregnant women. As a result, Medicaid eligibility varies substantially from state to state. The annual financial strain of a per capita cap is likely to prevent any state from increasing eligibility beyond 2016 levels. Therefore, states with lower eligibility levels will be locked into these lower limits, whereas states with higher eligibility levels will continue receiving federal funding for a greater share of their low-income residents.

States Where Health Care Needs Will Grow Over Time

Aging of the senior population. The House bill's per capita cap does not address demographic changes that will increase states' per-beneficiary health care needs, poorer health status, and higher health spending over time. For example, the share of seniors who are 85 and older will rise substantially in future decades as the huge baby-boom population moves into "old-old" age.[13] But seniors aged 85 and older have much higher health care costs than young elderly people: they have more serious and chronic health problems and are likelier to require nursing home and other long-term services and supports. In 2011, average Medicaid costs were more than 2.5 times higher for beneficiaries 85 and older than for those aged 65 to 74.[14]

[13] Matt Broaddus, "Population's Aging Would Deepen House Health Bill's Medicaid Cuts for States," Center on Budget and Policy Priorities, March 24, 2017, http://www.cbpp.org/blog/populations-aging-would-deepen-house-health-bills-medicaid-cuts-for-states.

[14] CBPP analysis of fiscal year 2011 Medicaid Statistical Information System data.

Under the House bill, each state's funding cap per senior beneficiary would effectively be based on the state's spending per senior beneficiary in 2016, when the share of elderly beneficiaries aged 85 and over was significantly smaller than it will be when the boomers reach old-old age. This is a serious flaw, which virtually guarantees that the formula will cause growing difficulties for states over time. For example, Alaska will see a *76 percent increase* in the share of seniors who are 85 and older between 2025 and 2035.[15] As AARP explains, "shifting to capped financing in Medicaid, as proposed under the AHCA, could constrain the Medicaid program in its ability to adequately serve consumers, including millions of older adults and people with disabilities enrolled in the program today."[16]

Faster rise in disability. Approximately 10 million people with disabilities rely on Medicaid for medical and long-term care services.[17] But states expected to see a faster rise in the incidence of serious disabilities among Medicaid beneficiaries would face higher costs, and thus deeper Medicaid cuts, than other states under the House bill's per capita cap.

Moreover, per capita caps would make it difficult for states to provide all needed care if the proportion of individuals with serious disabilities rises due to a new epidemic or medical condition (or the growing prevalence of such a condition). For example, Medicaid played a central role in helping states disproportionately affected by the HIV/AIDS epidemic in the late 1980s and 1990s. But capping and cutting federal Medicaid spending would make it more difficult for states to prevent and treat similar public health emergencies in the future.[18]

TABLE 1

Some States Would Be Disproportionately Harmed by Medicaid Per Capita Cap

Poor health status	Low eligibility limit for parents	High growth projected among seniors 85+	High share of residents reporting disability	High penetration of managed care organizations
Mississippi	Alabama	Alaska	West Virginia	Tennessee
Louisiana	Texas	Nevada	Arkansas	Hawaii
Arkansas	Missouri	Arizona	Alabama	Iowa
Alabama	Idaho	New Mexico	Kentucky	New Hampshire
Oklahoma	Mississippi	Wyoming	Maine	Kansas

Source: Kaiser Family Foundation estimates based on analysis of data from the federal fiscal year 2014 Medicaid Statistical Information System and Urban Institute estimates from CMS-64 reports. Robin Rudowitz *et al*., "Factors Affecting States' Ability to Respond to Federal Medicaid Cuts and Caps: Which States Are Most at Risk?" Kaiser Family Foundation, June 9, 2017, http://www.kff.org/report-section/factors-affecting-states-ability-to-respond-to-federal-medicaid-cuts-and-caps-which-states-are-most-at-risk-issue-brief/

[15] *Ibid.*

[16] Brendan Flinn and Ari Houser, "Capped Financing for Medicaid Does Not Account for the Growing Aging Population," AARP Public Policy Institute, June 2017, http://www.aarp.org/ppi/info-2017/ahca-capped-financing-for-medicaid1.html.

[17] Center on Budget and Policy Priorities, "GOP Health Bill's Medicaid Cuts Threaten Care for People with Disabilities," June 2, 2017, http://www.cbpp.org/research/health/gop-health-bills-medicaid-cuts-threaten-care-for-people-with-disabilities.

[18] *Op cit.,* Kaiser Family Foundation, June 9, 2017.

States at Greater Risk of Natural Disasters

The House bill's per capita cap would not adjust to help states that face higher-than-anticipated per-beneficiary costs due to a natural disaster. Thus, the states most likely to face natural disasters — including Florida, Rhode Island, Louisiana, California, Massachusetts, Kansas, Connecticut, Oklahoma, South Carolina, and Delaware[19] — would be at risk of even larger Medicaid cost shifts.

Today, federal Medicaid funding rises automatically when state needs increase, allowing states to react quickly to natural disasters like Hurricane Katrina, as well as epidemics like Zika or public health emergencies like the lead poisoning in Flint, Michigan. In contrast, under a per capita cap, Michigan would have received no additional federal Medicaid funding to deal with the Flint lead poisoning crisis. It took Congress 32 months after the lead poisoning — and 11 months after President Obama declared a state of emergency in Flint — to send additional non-Medicaid aid to the city.

As noted, states would be responsible for 100 percent of Medicaid costs in excess of the per capita cap. States facing a natural disaster would be in no position to absorb those extra costs, as they likely would already be under significant financial strain given the need to rebuild and support families facing devastating losses.

States with Especially Efficient Health Care Delivery and Financing

The House bill would penalize states that have already instituted efficiencies to lower their per-beneficiary costs by giving them a lower per capita cap than less efficient states. Medicaid cuts under a per capita cap would disproportionately harm these states, which would likely have to cut Medicaid benefits and eligibility more than other states in order to balance their budgets. These efficiencies include:

Lower provider payments. A per capita cap would effectively lock in state cuts to Medicaid provider payment rates. Most states have made substantial cuts in the last decade to help close the budget shortfalls resulting from the recession and slow recovery, and many of these cuts have not been restored.[20] These reductions have lowered states' per-beneficiary costs and would be built into the base used to determine a state's initial per capita cap. This could pose particular problems in states that imposed especially severe restrictions on provider reimbursements — restrictions that may not be sustainable indefinitely.[21] At the same time, the cap would also lock in the significant variation in states' provider payment rates, allowing states with higher rates to continue to pay providers more generously.

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[19] "CoreLogic Identifies US States at Highest Risk of Property Damage Loss from Natural Hazards," September 10, 2014, http://www.corelogic.com/about-us/news/corelogic-identifies-us-states-at-highest-risk-of-property-damage-loss-from-natural-hazards.aspx.

[20] Vernon Smith *et al.,* "Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends," Kaiser Commission on Medicaid and the Uninsured, October 2011, https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8248.pdf.

[21] Edwin Park and Matt Broaddus, "Medicaid Per Capita Cap Would Shift Costs to States and Place Low-Income Beneficiaries at Risk," Center on Budget and Policy Priorities, October 5, 2012, http://www.cbpp.org/research/medicaid-per-capita-cap-would-shift-costs-to-states-and-place-low-income-beneficiaries-at.

Other cost-containment strategies. States that have been more aggressive in implementing cost-containment strategies, and therefore have lower per-beneficiary costs, would receive lower per capita caps. For example, a state that has instituted efficiencies in prescription drug coverage or successfully experimented with delivery system reforms like medical homes would receive lower funding per beneficiary. It is questionable whether such a state could do much more to lower costs to stay within its per capita cap over time without impairing access to needed health care services.[22]

Managed care. Some 39 states (including the District of Columbia) have contracts with Medicaid managed care organizations,[23] and more than 60 percent of Medicaid beneficiaries are enrolled in a managed care plan.[24] (In total, 77 percent of beneficiaries are enrolled in some form of managed care, including primary care case management).[25] Some states with managed care contracts have achieved savings by improving access to primary care, providing care management, and reducing overuse of hospitals and other high-cost care.[26] These states would receive lower caps than states with lower managed care penetration, even if the non-managed care states later increase their managed care enrollment.

Innovations. Medicaid offers states significant flexibility to innovate and improve delivery of care.[27] Federal funding cuts of the House bill's magnitude would endanger this innovation. Medicaid caps' inadequate funding would make it much harder for states to make the upfront investments generally needed to develop systems that provide high-quality care at less cost. States that have not yet made these investments will likely be prevented from doing so in the future due to their lower per capita caps.

Moreover, the per capita cap significantly reduces states' return on investment in Medicaid, since each dollar of state spending would no longer be matched with federal funding.[28] This would create a further disincentive for states to invest in innovative ways to provide care to Medicaid beneficiaries.

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[22] *Op cit.*, Park and Broaddus 2012.

[23] Kaiser Family Foundation, Medicaid MCO Enrollment, March 2017, http://www.kff.org/other/state-indicator/medicaid-enrollment-by-mco/.

[24] Centers for Medicare & Medicaid Services, Medicaid Managed Care Enrollment and Program Characteristics, 2014, Spring 2016, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf.

[25] Kaiser Family Foundation, Total Medicaid Managed Care Enrollment, July 2014, http://www.kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/.

[26] Kaiser Commission on Medicaid and the Uninsured, "Medicaid Managed Care: Key Data, Trends, and Issues," February 2012, https://kaiserfamilyfoundation.files.wordpress.com/2012/02/8046-02.pdf.

[27] Judith Solomon, "Caps on Federal Medicaid Funding Would Give States Flexibility to Cut, Stymie Innovation," Center on Budget and Policy Priorities, January 18, 2017, http://www.cbpp.org/research/health/caps-on-federal-medicaid-funding-would-give-states-flexibility-to-cut-stymie.

[28] *Op cit.,* Adler, Fiedler, and Gronniger, 2017.

Financing. Every state except Alaska uses taxes on health care providers such as hospitals and nursing facilities, as well as managed care plans, to help finance Medicaid.[29] States with lower provider taxes may be able to raise them to help them offset a portion of the per capita cap's cost shift to the state. But states that already rely on the maximum allowable provider taxes could not further utilize this financing tool and would likely have to make deeper cuts to benefits, eligibility, and provider rates to balance their state budgets.

[29] Kaiser Family Foundation, "State and Medicaid Provider Taxes or Fees," March 14, 2016, http://kff.org/medicaid/fact-sheet/states-and-medicaid-provider-taxes-or-fees; see also Edwin Park, "Limiting State Provider Taxes Would Shift Costs to States and Weaken Medicaid," Center on Budget and Policy Priorities, updated March 16, 2016, http://www.cbpp.org/health/limiting-state-provider-taxes-would-shift-costs-to-states-and-weaken-medicaid/.

TABLE 2

States Vary Widely in Per-Beneficiary Medicaid Spending

	Per-enrollee spending in 2014 ($)					Rank among states (high to low spending)				
	Total	Seniors	People with disabilities	Other adults	Children	Total	Seniors	People with disabilities	Other adults	Children
United States	6,396	17,476	19,033	3,955	2,602					
Alabama	4,827	18,927	9,448	4,263	2,083	48	27	51	31	44
Alaska	10,001	27,020	28,756	6,890	5,133	2	7	6	2	2
Arizona	5,801	12,232	19,313	4,521	2,972	36	45	25	22	19
Arkansas	6,109	21,342	16,799	1,657	3,372	30	23	33	51	10
California	5,318	10,976	20,672	2,672	2,500	43	48	20	49	32
Colorado	4,898	12,532	16,252	2,915	2,026	46	44	35	46	45
Connecticut	8,446	33,824	33,435	5,237	3,377	11	2	2	14	9
Delaware	9,041	44,752	29,827	6,723	3,835	5	1	4	3	6
District of Columbia	9,237	26,350	22,309	5,400	4,443	4	11	16	10	4
Florida	4,788	13,356	14,779	2,866	1,816	49	42	46	48	49
Georgia	4,838	12,670	11,008	5,305	2,825	47	43	49	11	23
Hawaii	6,084	18,098	21,915	4,268	2,577	31	31	17	30	29
Idaho	5,452	15,096	18,215	4,036	2,204	41	39	27	35	40
Illinois	5,301	13,539	17,313	3,350	2,108	44	41	30	43	43
Indiana	7,777	30,276	25,092	4,917	2,158	14	4	11	18	42
Iowa	6,223	24,317	21,341	3,183	2,217	29	17	19	45	39
Kansas	6,670	22,928	15,754	5,300	2,662	22	18	39	12	26
Kentucky	6,572	18,465	15,929	4,837	3,123	25	29	37	19	16
Louisiana	5,740	19,148	15,501	3,904	1,930	37	26	41	38	48
Maine	7,507	15,929	17,387	3,906	3,164	16	36	29	37	13
Maryland	8,118	26,971	28,402	5,027	3,082	13	8	7	16	17

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	Total	Seniors	People with disabilities	Other adults	Children	Total	Seniors	People with disabilities	Other adults	Children
Massachusetts	8,620	24,689	15,410	2,913	3,508	8	16	42	47	8
Michigan	6,411	16,174	16,972	4,719	2,405	28	35	31	20	35
Minnesota	8,973	26,970	30,925	5,132	3,569	6	9	3	15	7
Mississippi	6,780	21,087	15,063	4,473	2,568	19	24	44	26	30
Missouri	8,501	21,856	22,781	4,481	3,187	10	20	15	25	12
Montana	6,733	21,581	14,575	9,135	3,132	20	21	47	1	15
Nebraska	6,455	16,743	17,612	4,990	2,163	27	33	28	17	41
Nevada	4,003	16,589	15,589	2,323	1,520	51	34	40	50	51
New Hampshire	7,472	25,455	29,780	4,361	2,984	17	14	5	28	18
New Jersey	4,969	9,085	16,906	3,768	2,484	45	49	32	40	33
New Mexico	6,026	n/a	19,675	3,564	5,137	32	n/a	23	42	1
New York	8,618	28,227	28,382	4,709	2,653	9	6	8	21	27
North Carolina	5,573	11,178	15,238	4,495	2,349	39	47	43	24	36
North Dakota	10,721	31,970	38,442	6,377	4,366	1	3	1	4	5
Ohio	7,010	26,219	22,993	4,498	2,591	18	12	14	23	28
Oklahoma	5,608	15,924	16,309	3,912	2,734	38	37	34	36	25
Oregon	6,604	21,416	20,544	5,667	2,783	23	22	21	8	24
Pennsylvania	9,638	25,625	18,310	4,139	2,889	3	13	26	34	21
Rhode Island	8,315	22,832	27,192	5,479	3,297	12	19	9	9	11
South Carolina	4,169	8,623	10,340	4,292	1,945	50	50	50	29	47
South Dakota	5,988	18,678	20,107	4,223	2,336	33	28	22	32	37
Tennessee	6,718	18,302	16,187	6,048	3,145	21	30	36	7	14
Texas	6,495	18,078	23,485	3,854	2,962	26	32	13	39	20
Utah	5,326	11,638	19,510	4,201	2,483	42	46	24	33	34

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	Per-enrollee spending in 2014 ($)					Rank among states (high to low spending)				
	Total	Seniors	People with disabilities	Other adults	Children	Total	Seniors	People with disabilities	Other adults	Children
Vermont	8,787	26,524	24,082	5,289	4,612	7	10	12	13	3
Virginia	7,678	20,070	21,370	6,137	2,840	15	25	18	6	22
Washington	5,510	15,590	15,891	6,238	1,994	40	38	38	5	46
West Virginia	5,854	24,997	14,957	3,222	2,538	34	15	45	44	31
Wisconsin	5,828	14,266	13,923	3,600	1,807	35	40	48	41	50
Wyoming	6,602	29,268	25,242	4,382	2,292	24	5	10	27	38

Note: These calculations include only full-benefit Medicaid beneficiaries.

Source: Kaiser Family Foundation analysis based on data from the federal fiscal year 2014 Medicaid Statistical Information System and Urban Institute estimates from CMS-64 reports, as published in Data Note: Variation in Per Enrollee Medicaid Spending, June 2017, http://files.kff.org/attachment/Data-Note-Variation-in-Per-Enrollee-Medicaid-Spending-Across-States
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TABLE 3

Growth in Medicaid Per Beneficiary Spending Varies Widely Among States and Eligibility Groups

	Average annual growth in per-enrollee spending, 2000-2011				Rank (high to low annual growth)			
	Seniors	People with disabilities	Other adults	Children	Seniors	People with disabilities	Other adults	Children
United States	3.71%	4.53%	5.63%	5.33%				
Alabama	4.81%	5.14%	6.63%	5.46%	20	16	30	24
Alaska	8.29%	5.37%	5.74%	5.80%	3	14	36	22
Arizona	3.44%	8.12%	9.86%	8.32%	32	2	9	6
Arkansas	8.25%	5.39%	12.12%	6.34%	4	13	2	15
California	6.31%	6.61%	6.86%	7.20%	12	5	28	9
Colorado	3.89%	3.85%	4.50%	1.69%	27	34	41	48
Connecticut	2.92%	3.49%	6.11%	3.85%	39	37	35	36
Delaware	4.74%	3.69%	7.11%	5.84%	21	35	26	21
District of Columbia	6.63%	6.54%	7.20%	3.65%	9	6	25	38
Florida	7.34%	6.12%	7.41%	5.64%	5	8	22	23
Georgia	4.88%	2.71%	6.85%	4.46%	19	43	29	33
Hawaii	6.45%	15.47%	6.32%	1.05%	11	1	33	50
Idaho	1.64%	4.63%	7.75%	6.71%	44	23	18	11
Illinois	-0.67%	1.48%	2.53%	3.19%	49	49	48	41
Indiana	4.30%	3.87%	5.52%	3.87%	24	33	37	35
Iowa	3.76%	3.12%	0.35%	3.75%	29	41	51	37
Kansas	3.08%	1.43%	5.33%	5.35%	36	50	38	28
Kentucky	4.22%	4.80%	7.57%	5.38%	25	20	20	26
Louisiana	7.26%	5.64%	7.71%	7.95%	6	11	19	7
Maine	6.91%	2.06%	1.75%	0.39%	7	47	49	51
Maryland	5.49%	6.26%	9.91%	6.23%	16	7	7	16
Massachusetts	6.17%	2.21%	7.29%	7.85%	13	45	24	8
Michigan	-0.29%	4.28%	3.13%	2.55%	47	29	46	46

TABLE 3

Growth in Medicaid Per Beneficiary Spending Varies Widely Among States and Eligibility Groups

	Average annual growth in per-enrollee spending, 2000-2011				Rank (high to low annual growth)			
	Seniors	People with disabilities	Other adults	Children	Seniors	People with disabilities	Other adults	Children
Minnesota	2.95%	3.94%	6.32%	6.45%	38	31	33	13
Mississippi	10.83%	6.94%	4.39%	6.23%	2	3	43	16
Missouri	3.81%	4.76%	11.72%	6.99%	28	21	4	10
Montana	5.91%	4.88%	9.05%	5.99%	14	18	11	20
Nebraska	-0.49%	2.17%	7.46%	3.33%	48	46	21	40
Nevada	4.19%	4.56%	3.57%	3.13%	26	24	45	42
New Hampshire	3.42%	0.51%	4.54%	3.50%	33	51	40	39
New Jersey	2.60%	3.89%	7.05%	5.11%	42	32	27	30
New Mexico	n/a	4.85%	14.41%	11.58%	n/a	n/a	1	1
New York	3.15%	4.31%	2.88%	3.01%	35	28	47	43
North Carolina	3.01%	3.35%	6.48%	6.03%	37	39	31	19
North Dakota	5.15%	3.07%	4.76%	3.96%	18	42	39	34
Ohio	3.52%	5.06%	8.68%	6.54%	30	17	13	12
Oklahoma	5.27%	4.48%	9.90%	6.19%	17	26	8	18
Oregon	4.59%	4.50%	8.52%	1.78%	23	25	14	47
Pennsylvania	0.80%	5.69%	10.91%	5.44%	45	9	5	25
Rhode Island	2.52%	1.97%	10.70%	9.42%	43	48	6	3
South Carolina	4.71%	3.40%	8.80%	4.73%	22	38	12	31
South Dakota	3.17%	3.95%	7.32%	5.38%	34	30	23	26
Tennessee	13.29%	6.85%	1.50%	2.97%	1	4	50	44
Texas	5.60%	4.74%	6.33%	8.44%	15	22	32	5
Utah	2.77%	3.15%	4.23%	1.58%	41	40	44	49
Vermont	2.81%	3.52%	11.97%	10.22%	40	36	3	2
Virginia	3.51%	5.26%	9.65%	8.92%	31	15	10	4
Washington	-1.37%	5.68%	4.45%	4.68%	50	10	42	32

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Growth in Medicaid Per Beneficiary Spending Varies Widely Among States and Eligibility Groups

	Average annual growth in per-enrollee spending, 2000-2011				Rank (high to low annual growth)			
	Seniors	People with disabilities	Other adults	Children	Seniors	People with disabilities	Other adults	Children
West Virginia	6.53%	4.40%	8.22%	6.43%	10	27	15	14
Wisconsin	0.13%	2.40%	7.88%	2.81%	46	44	17	45
Wyoming	6.80%	5.45%	8.07%	5.14%	8	12	16	29

Note: These calculations include only full-benefit Medicaid beneficiaries.

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis based on data from 2000, 2001, 2010 and 2011 Medicaid Statistical and Information System (MSIS) and CMS-64 reports, http://www.kff.org/medicaid/state-indicator/average-growth-in-annual-medicaid-spending-from-fy2000-to-fy2011-for-full-benefit-enrollees/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. All growth rates are for Medicaid beneficiaries with full Medicaid benefits for all months in which they were enrolled in the program. Growth rates for seniors exclude prescription drugs due to the shift of prescription drug coverage from Medicaid to Medicare for the dual eligibles with the implementation of the Medicare Part D benefit in 2006.