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MEMO

Date: July 5, 2017

Re: Kansas Per Capita Cap Simulation Results

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Introduction

This memo was prepared in response to inquiries about how the House health reform bill, the American Health Care Act (AHCA)[1], and the Senate bill, the Better Care Reconciliation Act of 2017 (BCRA)[2], might affect the federal and state shares of Medicaid spending in Kansas. The first part of the memo shows the results of a simulation using the Medicaid per capita cap methodology outlined in the AHCA applied to actual, historical Kansas Medicaid expenditure data. The second part of the memo describes the results of a similar simulation using the BCRA per capita cap methodology. The differences between the results of the AHCA and BCRA simulations are then discussed.

AHCA Simulation

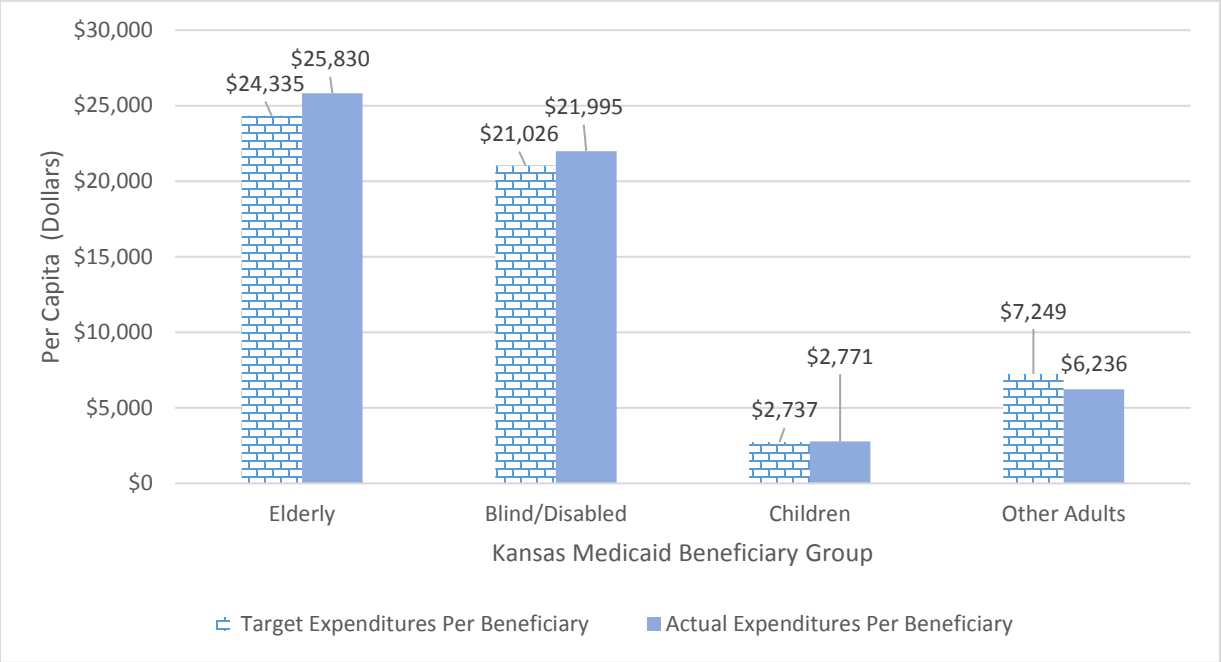
In the AHCA, the base year to establish per capita cap target amounts for each beneficiary group (Elderly, Blind/Disabled, Children and Other Adults) is FFY 2016, trended up to FFY 2019. In our simulation, the base year used was FFY 2014, which allows the resulting hypothetical cap to be compared to actual expenditures in FFY 2015 and 2016. As outlined in the AHCA, base year per capita cap targets were increased each year by the medical component of the Consumer Price Index (CPI-Medical) for the Children and Other Adults populations, and CPI-Medical plus 1 percent for the Elderly and Blind/Disabled populations. The resulting per capita cap targets were then compared to actual expenditures in 2015 and 2016. From this, expenditures over the target and the federal share to be repaid (also referred to as "excess payment penalties") were calculated.

Figures 1 and 2 (page 2) display the target expenditures and the actual expenditures by beneficiary group in 2015 and 2016, respectively. *Figure 3* (page 3) displays the excess expenditures (the amount of actual expenditures above target expenditures, including both the state and federal share) and excess payment penalties (the amount to be repaid by the state to the federal government) that would have applied in 2015 and 2016 if a per capita cap (based upon FFY 2014

[1] United States Congress. (2017). H.R.1628 - American Health Care Act of 2017. Retrieved June 10, 2017, from https://www.congress.gov/bill/115th-congress/house-bill/1628/text
[2] H.R. 1628 – Better Care Reconciliation Act of 2017. Retrieved June 22, 2017 from https://www.budget.senate.gov/imo/media/doc/BetterCareReconcilistionAct.6.26.17.pdf

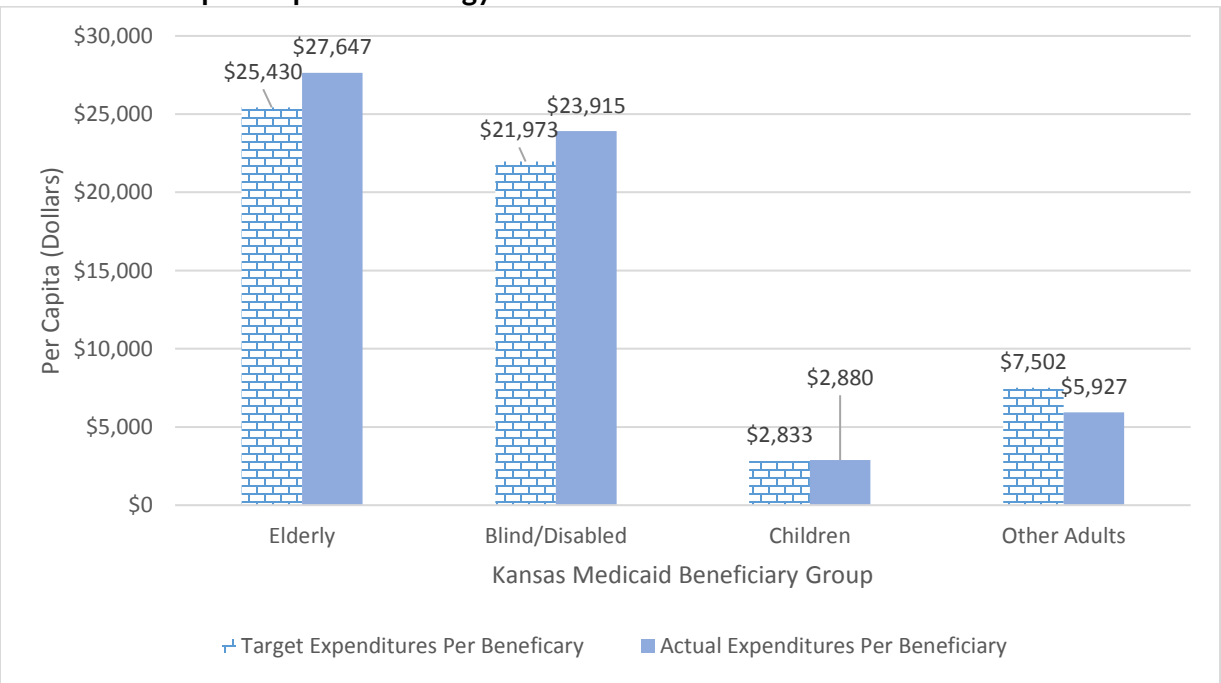
baseline expenditures) had been in effect. Detailed calculations for the results in *Figures 1-3* are included in Appendix A.

Figure 1: **Hypothetical Target and Actual Per Capita Expenditures by Beneficiary Group in Kansas if AHCA Per Capita Cap Methodology Had Been in Effect in FFY 2015**



Source: KHI analysis of the American Health Care Act; data from the Data Analytic Interface (DAI), Kansas Department of Health and Environment, June 2017; and FFY 2014-2015 CMS-64 forms.

Figure 2: **Hypothetical Target and Actual Per Capita Expenditures by Beneficiary Group in Kansas if AHCA Per Capita Cap Methodology Had Been in Effect in FFY 2016**



Source: KHI analysis of the American Health Care Act; data from the Data Analytic Interface (DAI), Kansas Department of Health and Environment, June 2017; FFY 2014-2015 CMS-64 forms; and FFY 2016 CMS-64 estimates as of January 2017.

Figure 3: **Total Expenditures Over Hypothetical Targets and Federal Share to be Repaid Under AHCA Per Capita Cap Methodology, FFY 2015 and 2016**

	2015	2016
Expenditures Over Target	$49,878,066	$90,235,491
Federal Share to be Repaid	$28,380,619	$50,712,346

Source: KHI analysis of the American Health Care Act; data from the Data Analytic Interface (DAI), Kansas Department of Health and Environment, June 2017; FFY 2014-2015 CMS-64 forms; and FFY 2016 CMS-64 estimates as of January 2017.

The results of this simulation indicate that Medicaid spending in Kansas would have exceeded spending targets by $49,878,065 in FFY 2015 and $90,235,491 in FFY 2016 if a per capita cap based on a FFY 2014 baseline had been in effect. Excess payment penalties of $28,380,619 would have been incurred in 2015, and $50,712,346 in 2016.

Per capita spending for the Elderly, Blind/Disabled and Children eligibility categories would have exceeded targets in both years. Per capita spending for the Other Adults population was less than the targets in 2015 and 2016, but the savings in that population did not offset the higher expenditures in the other beneficiary groups.

This simulation illustrates how a per capita cap might have applied to Kansas Medicaid in recent years. However, if a per capita cap had been in effect, state program managers and policymakers could have attempted to make modifications to the program to reduce per-person spending, potentially altering the outcome.

BCRA Simulation

The per capita caps in the Senate's Better Care Reconciliation Act of 2017 (BCRA) initially would use the same growth rate as the AHCA provides, the CPI-Medical (for Children and Other Adults) and CPI-Medical plus 1 percent (for Elderly and Blind/Disabled beneficiary groups). However, starting in 2025, the BCRA adjusts the annual spending targets for states using the CPI for All Urban Consumers (CPI-U). The CPI-U measures the change in the price of a basket of goods and services purchased by urban consumers, in contrast to the CPI-Medical, which is the medical component of the CPI-U that measures medical care commodities and medical care services. An additional difference in the BCRA methodology is the removal of blind or disabled children from the per capita caps.

Historically, the CPI-U has increased at a slower rate than CPI-Medical. In FFY 2015 and 2016, the CPI-Medical was 2.6 percent and 3.5 percent, respectively, while the CPI-U was 0.3 percent and 0.9 percent. Using the CPI-U instead of the CPI-Medical (when adjusting the per capita cap allocations beginning in 2025) results in lower spending targets for states, greater expenditures over the targets, and larger repayments of federal expenditures.

Comparing AHCA and BCRA Effects on Kansas Medicaid

In the simulations, the AHCA methodology and BCRA methodology (from 2020-2024) resulted in similar estimates of the spending targets and penalties owed by Kansas Medicaid (Simulations 1 and 2, *Figure* 4, page 4). Both use the CPI-Medical annual growth rate over this time period, and

the fiscal effect of removing blind or disabled children from the per capita cap under the BCRA was small. However, changing the annual growth rate from CPI-Medical to CPI-U (Simulation 3), as the BCRA does starting in 2025, significantly increases the total expenditures over target and the federal share to be repaid. The federal share to be repaid by Kansas in that scenario would increase from $28,380,619 to $67,980,136 in 2015 and from $50,712,346 to $143,351,748 in 2016 (*Figure 4*).

Figure 4: **Comparing AHCA and BCRA Simulated Effects on Kansas Medicaid**

	Legislation and Growth Rate	Simulation Year	Expenditures Over Target	Federal Share to be Repaid
Simulation 1	AHCA CPI-Medical	2015	$49,878,066	$28,380,619
		2016	$90,235,491	$50,712,346
		Total	$140,113,557	$79,092,965
Simulation 2	BCRA CPI-Medical (2020-2024)	2015	$45,927,214	$26,132,585
		2016	$94,203,344	$52,942,279
		Total	$140,130,558	$79,074,864
Simulation 3	BCRA CPI-U (2025 and on)	2015	$119,472,997	$67,980,136
		2016	$255,074,285	$143,351,748
		Total	$374,547,282	$211,331,884

Note: Detailed calculations for Simulation 1 are in Appendix A, Simulation 2 are in Appendix B, and Simulation 3 in Appendix C.

Source: KHI analysis of the American Health Care Act and Better Care Reconciliation Act of 2017; data from the Data Analytic Interface (DAI), Kansas Department of Health and Environment, June 2017; FFY 2014-2015 CMS-64 forms; and FFY 2016 CMS-64 estimates as of January 2017.

Key Points

1. *Base Year Matters*. All future expenditures are based on the base year, and if that year had uncharacteristically high or low expenditures, it will affect future funding. As shown in this simulation, exceeding the cap in one year does not reset target expenditures; the base year would remain the same, and target per capita expenditures would grow annually by the medical component of the Consumer Price Index (CPI-Medical), or CPI-Medical plus 1 percent for the Elderly and Blind/Disabled eligibility categories.

2. *Medicaid Growth Rate Matters.* The applied Medicaid growth rate will significantly affect annual expenditure targets. As seen in *Figure 4* (Simulation 3), changing from an annual growth rate of CPI-Medical to CPI-U would have resulted in significantly higher expenditures over target and federal share to be repaid.

3. *There is potential down-side risk to states, but likely no potential up-side risk.* In the AHCA legislation, there is no mechanism for sharing savings with states in the per capita cap methodology. If total spending is less than target spending, the savings are not realized by the state. However, if total spending exceeds target spending, excess payment penalties

are assessed to the state. The BCRA does allow states whose Medicaid spending is under target spending levels to qualify for new quality-based incentives. But these potential incentive payments are small compared to the potential penalties states may face.

4. *Performance-to-Date Matters*. If a state has already transitioned the majority of its Medicaid beneficiaries to managed care (like Kansas), or implemented other comprehensive cost controls, identifying additional savings to meet new spending targets may be difficult.

5. *Actual expenditures for the Other Adults beneficiaries were lower per-person in 2016 than they were in 2014*. This could be because of differences in the beneficiaries served or the services provided during those years. Further investigation is warranted to determine what might have led to this outcome. If the "welcome mat" effect of the Affordable Care Act (ACA), which led to increased enrollment among already-eligible children and adults in Kansas, had any dampening effect on per capita costs for those groups, repeal of the ACA could lead to higher per-person costs. This could financially disadvantage states even if they did not expand Medicaid because of this "welcome mat" effect.

6. *This analysis did not include identification of key drivers for the increases in spending for the Elderly and Blind/Disabled populations*. Further investigation could identify beneficiary, process or program changes which led to accelerated per-person spending in these populations. If a per capita cap had been in effect, finding per-person savings in these categories – perhaps by the state further incentivizing community-based care over nursing facilities and other institutions – may have altered outcomes.

Data Sources

Kansas Data Analytic Interface (DAI)[3]
Kansas Medicaid claims data from FFY 2014 to FFY 2016 were accessed from the DAI with the support of KDHE. This data was used to identify beneficiaries, group beneficiaries into per capita groups, and access expenditures.

Bureau of Labor Statistics (BLS)[4]
Consumer Price Index – Medical (CPI-Medical) and CPI-U data was accessed from the Bureau of Labor Statistics website. CPI-Medical and CPI-U rates were used to calculate annual adjustments to federal per capita allotments.

Medicaid.gov[5]
Kansas CMS-64 quarterly expense documents were accessed from the Medicaid.gov website. CMS-64 documents provide data on Disproportionate Share Hospital (DSH) payments and provides historical total federal and state expenditures.

[3] Data Analytic Interface, KDHE 2017
[4] Bureau of Labor Statistics. (2017). Databases, Tables and Calculators by Subject. Retrieved April 12, 2017, from https://data.bls.gov/timeseries/CUUR0000SAM?output_view=pct_12mths
[5] Medicaid.Gov. 2017. Expenditure Reports from MBES/CBES. Retrieved April 12, 2017, from https://www.medicaid.gov/medicaid/financing-and-reimbursement/state-expenditure-reporting/expenditure-reports/index.html

Methodology

To perform the per capita analysis, the methodology in the AHCA and BCRA was followed as much as possible. To calculate possible scenarios, the legislation uses federal fiscal years (October–September). The simulation used actual data for FFY 2014 (October 2013-September 2014) as the base year and then implemented the per capita caps for FFY 2015 and FFY 2016 to identify trends. Using FFY 2014 allowed for an accurate representation of the current Medicaid system, as that was the first full fiscal year to include the implementation of the KanCare comprehensive managed care model.

Determining Beneficiaries and Per Capita Groups

One of the challenges of the AHCA and BCRA legislation is that they both categorize beneficiaries and expenditures differently than states currently report them on CMS-64 forms. Therefore, KHI worked with KDHE to categorize and extract data from the Data Analytic Interface (DAI) according to the guidelines of the legislation. Beneficiaries were identified per the hierarchy in the legislation (Elderly, Blind/Disabled, Children, Other Adults) and excluded beneficiaries in the following programs: Children's Health Insurance Program (CHIP), Indian Health Service (IHS), breast and cervical cancer program, partial Medicaid beneficiaries (identified as undocumented immigrants, participants in the tuberculosis program, Qualified Medicare Beneficiaries and beneficiaries in subsidized premium programs), and blind or disabled children (from the BCRA calculations only).

Determining Expenditures

The criteria established to calculate per capita targets per beneficiary group specified an adjusted Medicaid expenditure total. The adjusted Medicaid expenditure total was the annual expenditure total minus Disproportionate Share Hospital (DSH) payments, Medicare cost-sharing payments, safety net provider payment adjustments, and administrative fees. KHI worked with KDHE to calculate and extract the adjusted Medicaid expenditure total by each of the beneficiary groups from the DAI.

Calculating 2015 and 2016 Per Capita Payments

The base year caps were calculated by dividing total expenditures per beneficiary group by the average number of beneficiaries in each group using Kansas Medicaid FFY 2014 data. The next step was to multiply this number by the total amount of non-DSH supplemental payments for FFY 2014 divided by the adjusted total medical assistance expenditures for 2014[6]. That total was then increased by the average annual percentage change[7] of CPI–Medical for the Children and Other Adults beneficiary groups and CPI–Medical plus 1 percent for the Elderly and Blind/Disabled beneficiary groups for 2015 and 2016 in the AHCA simulation and in the BCRA simulation using 2020-2024 methodology. In the 2025 BCRA simulation, CPI-U was used as the annual growth rate. These calculations created the target federal per capita spend per beneficiary group in 2015 and 2016.

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[6] Per subtitle C, section (d). Per the AHCA, this calculation would be done on 2016 data before accounting for yearly CPI-Medical adjustments. In our simulation, it was applied to 2014 data before accounting for yearly CPI-Medical adjustments in 2015 and 2016.

[7] Annual averages are the sum of 12 months of CPI data points divided by 12. An annual average change is not the same as an over-the-year percent change. G. Perrins and D. Nilson, Bureau of Labor Statistics, "Math calculations to better utilize CPI data". Retrieved June 22, 2017, from https://www.bls.gov/cpi/cpimathfs.pdf.

In FFY 2015 and 2016, CPI-Medical was 2.6 percent and 3.5 percent, while CPI-U was 0.3 percent and 0.9 percent. Because both pieces of legislation use CPI measures, the inflation rate for each fiscal year would not be known with certainty until the end of the fiscal year in question. This analysis used the annual average CPI for each federal fiscal year, which is the sum of the 12 applicable monthly indexes divided by 12. Annual averages represent an average index for a given year. An annual average change is not the same as an over-the-year percent change, which compares the index in a month to the index in the same month of the previous year. For example, in FFY 2015, the annual average CPI-Medical was 2.6 percent, while the September-to-September over-the-year percent change was 2.5 percent. The method of calculating the inflation rate would affect each year's expenditure target.

Calculating Excess Expenditures and Payments

If there are excess expenditures at the end of the federal fiscal year (if actual spending exceeds targets), the amount of excess payments that must be paid back to the federal government needs to be calculated. Excess payments are calculated as the product of the excess expenditures and the Federal Average Medical Assistance Matching Percentage (FAMAMP). The FAMAMP is the ratio of total (unadjusted) federal payments for state medical assistance over the total (unadjusted) medical assistance expenditures, including both federal and state portions[8]. In any given year, the FAMAMP is likely to closely approximate the more familiar Federal Medical Assistance Percentages (FMAP). The excess payment then is divided by four and taken out of quarterly distributions to the state the following year.

[8] Using data from the FFY 2015 CMS-64, the 2015 FAMAMP was calculated as the ratio of unadjusted federal payments to the state for medical assistance, $1,713,713,591, to total medical assistance expenditures, $3,010,910,864, or 56.9 percent. Using January 2017 estimates of the FFY 2016 CMS-64, the 2016 FAMAMP was calculated as the ratio of unadjusted federal payments to the state for medical assistance, $1,840,189,952, to total medical assistance expenditures, $3,274,359,345, or 56.2 percent.

Appendix A: Modeling the AHCA Per Capita Cap Methodology in Kansas Using Historical Data, FFY 2014-2016

2014 Data and Calculations									
Beneficiary Group	**2014 Actual Expenditures**	**Non-DSH Increase**	**2014 Baseline Expenditures**	**2014 Beneficiaries**	**2014 Baseline Expenditures per Beneficiary**				
Elderly	$542,254,421	0.8%	$546,848,556	23,281	$23,489				
Blind/Disabled	$1,241,624,529	0.8%	$1,252,143,928	61,695	$20,296				
Children	$581,420,837	0.8%	$586,346,801	219,816	$2,667				
Other Adults	$305,475,435	0.8%	$308,063,511	43,605	$7,065				
2015 Data and Calculations									
Beneficiary Group	**2014 Baseline Expenditures per Beneficiary**	**2015 CPI Medical Increase**	**2015 CPI-Adjusted Target Expenditures per Beneficiary**	**2015 Beneficiaries**	**2015 Target Total Expenditures**	**2015 Actual Total Expenditures**	**2015 Actual Expenditures Per Beneficiary**	**Difference Between Target and Actual Expenditures Per Beneficiary**	**Difference Between Target and Actual Expenditures**
Elderly	$23,489	3.6%	$24,335	22,992	$559,502,388	$593,888,748	$25,830	($1,496)	($34,386,360)
Blind/Disabled	$20,296	3.6%	$21,026	60,456	$1,271,169,453	$1,329,722,562	$21,995	($969)	($58,553,110)
Children	$2,667	2.6%	$2,737	225,798	$617,963,339	$625,644,042	$2,771	($34)	($7,680,703)
Other Adults	$7,065	2.6%	$7,249	50,100	$363,152,515	$312,410,408	$6,236	$1,013	$50,742,107
									($49,878,066)
2015 Penalty Calculation									
			Difference Between Target and Actual Expenditures	**FAMAMP**	**Total Excess Federal Payment**	**Quarterly Deduction**			
			($49,878,066)	56.9%	**($28,380,619)**	**($7,095,155)**			
2016 Data and Calculations									
Beneficiary Group	**2015 CPI-Adjusted Target Expenditures per Beneficiary**	**2016 CPI Medical Increase**	**2016 CPI-Adjusted Target Expenditures per Beneficiary**	**2016 Beneficiaries**	**2016 Target Total Expenditures**	**2016 Actual Expenditures**	**2016 Actual Expenditures Per Beneficiary**	**Difference Between Target and Actual Expenditures Per Beneficiary**	**Difference Between Target and Actual Expenditures**
Elderly	$24,335	4.5%	$25,430	22,742	$578,322,567	$628,750,095	$27,647	($2,217)	($50,427,528)
Blind/Disabled	$21,026	4.5%	$21,973	60,387	$1,326,855,973	$1,444,172,850	$23,915	($1,943)	($117,316,878)
Children	$2,737	3.5%	$2,833	242,441	$686,734,770	$698,350,840	$2,880	($48)	($11,616,070)
Other Adults	$7,249	3.5%	$7,502	56,585	$424,514,961	$335,389,976	$5,927	$1,575	$89,124,984
									($90,235,491)
2016 Penalty Calculation									
			Difference Between Target and Actual Expenditures	**FAMAMP**	**Total Excess Federal Payment**	**Quarterly Deduction**			
			($90,235,491)	56.2%	**($50,712,346)**	**($12,678,087)**			
					Total Penalties (2015 & 2016)				
					($79,092,965)				

Appendix B: Modeling the 2020-2024 BCRA Per Capita Cap Methodology in Kansas Using Historical Data, FFY 2014-2016

2014 Data and Calculations									
Beneficiary Group	**2014 Actual Expenditures**	**Non-DSH Increase**	**2014 Baseline Expenditures**	**2014 Beneficiaries**	**2014 Baseline Expenditures per Beneficiary**				
Elderly	$542,254,421	0.8%	$546,848,556	23,281	$23,489				
Blind/Disabled	$1,034,941,173	0.8%	$1,043,709,491	50,060	$20,849				
Children	$581,420,837	0.8%	$586,346,801	219,816	$2,667				
Other Adults	$305,475,435	0.8%	$308,063,511	43,605	$7,065				
2015 Data and Calculations									
Beneficiary Group	**2014 Baseline Expenditures per Beneficiary**	**2015 CPI Medical Increase**	**2015 CPI-Adjusted Target Expenditures per Beneficiary**	**2015 Beneficiaries**	**2015 Target Total Expenditures**	**2015 Actual Total Expenditures**	**2015 Actual Expenditures Per Beneficiary**	**Difference Between Target and Actual Expenditures Per Beneficiary**	**Difference Between Target and Actual Expenditures**
Elderly	$23,489	3.6%	$24,335	22,992	$559,502,388	$593,888,748	$25,830	($1,496)	($34,386,360)
Blind/Disabled	$20,849	3.6%	$21,600	49,025	$1,058,916,650	$1,113,518,908	$22,713	($1,114)	($54,602,258)
Children	$2,667	2.6%	$2,737	225,798	$617,963,339	$625,644,042	$2,771	($34)	($7,680,703)
Other Adults	$7,065	2.6%	$7,249	50,100	$363,152,515	$312,410,408	$6,236	$1,013	$50,742,107
									($45,927,214)
2015 Penalty Calculation									
			Difference Between Target and Actual Expenditures	**FAMAMP**	**Total Excess Federal Payment**	**Quarterly Deduction**			
			($45,927,214)	56.9%	**($26,132,585)**	**($6,533,146)**			
2016 Data and Calculations									
Beneficiary Group	**2015 CPI-Adjusted Target Expenditures per Beneficiary**	**2016 CPI Medical Increase**	**2016 CPI-Adjusted Target Expenditures per Beneficiary**	**2016 Beneficiaries**	**2016 Target Total Expenditures**	**2016 Actual Expenditures**	**2016 Actual Expenditures Per Beneficiary**	**Difference Between Target and Actual Expenditures Per Beneficiary**	**Difference Between Target and Actual Expenditures**
Elderly	$24,335	4.5%	$25,430	22,742	$578,322,567	$628,750,095	$27,647	($2,217)	($50,427,528)
Blind/Disabled	$21,600	4.5%	$22,572	48,744	$1,100,236,571	$1,221,521,301	$25,060	($2,488)	($121,284,730)
Children	$2,737	3.5%	$2,833	242,441	$686,734,770	$698,350,840	$2,880	($48)	($11,616,070)
Other Adults	$7,249	3.5%	$7,502	56,585	$424,514,961	$335,389,976	$5,927	$1,575	$89,124,984
									($94,203,344)
2016 Penalty Calculation									
			Difference Between Target and Actual Expenditures	**FAMAMP**	**Total Excess Federal Payment**	**Quarterly Deduction**			
			($94,203,344)	56.2%	**($52,942,279)**	**($13,235,570)**			
					Total Penalties (2015 & 2016)				
					($79,074,864)				

Appendix C: Modeling the 2025 and Beyond BCRA Per Capita Cap Methodology in Kansas Using Historical Data, FFY 2014-2016

2014 Data and Calculations									
Beneficiary Group	**2014 Actual Expenditures**	**Non-DSH Increase**	**2014 Baseline Expenditures**	**2014 Beneficiaries**	**2014 Baseline Expenditures per Beneficiary**				
Elderly	$542,254,421	0.8%	$546,848,556	23,281	$23,489				
Blind/Disabled	$1,034,941,173	0.8%	$1,043,709,491	50,060	$20,849				
Children	$581,420,837	0.8%	$586,346,801	219,816	$2,667				
Other Adults	$305,475,435	0.8%	$308,063,511	43,605	$7,065				
2015 Data and Calculations									
Beneficiary Group	**2014 Baseline Expenditures per Beneficiary**	**2015 CPI-U Increase**	**2015 CPI-Adjusted Target Expenditures per Beneficiary**	**2015 Beneficiaries**	**2015 Target Total Expenditures**	**2015 Actual Total Expenditures**	**2015 Actual Expenditures Per Beneficiary**	**Difference Between Target and Actual Expenditures Per Beneficiary**	**Difference Between Target and Actual Expenditures**
Elderly	$23,489	0.3%	$23,560	22,992	$541,680,401	$593,888,748	$25,830	($2,271)	($52,208,347)
Blind/Disabled	$20,849	0.3%	$20,912	49,025	$1,025,186,679	$1,113,518,908	$22,713	($1,802)	($88,332,229)
Children	$2,667	0.3%	$2,675	225,798	$604,110,360	$625,644,042	$2,771	($95)	($21,533,683)
Other Adults	$7,065	0.3%	$7,086	50,100	$355,011,669	$312,410,408	$6,236	$850	$42,601,261
									($119,472,997)
2015 Penalty Calculation									
			Difference Between Target and Actual Expenditures	**FAMAMP**	**Total Excess Federal Payment**	**Quarterly Deduction**			
			($119,472,997)	56.9%	**($67,980,136)**	**($16,995,034)**			
2016 Data and Calculations									
Beneficiary Group	**2015 CPI-Adjusted Target Expenditures per Beneficiary**	**2016 CPI-U Increase**	**2016 CPI-Adjusted Target Expenditures per Beneficiary**	**2016 Beneficiaries**	**2016 Target Total Expenditures**	**2016 Actual Expenditures**	**2016 Actual Expenditures Per Beneficiary**	**Difference Between Target and Actual Expenditures Per Beneficiary**	**Difference Between Target and Actual Expenditures**
Elderly	$23,560	0.9%	$23,779	22,742	$540,773,374	$628,750,095	$27,647	($3,868)	($87,976,721)
Blind/Disabled	$20,912	0.9%	$21,106	48,744	$1,028,800,666	$1,221,521,301	$25,060	($3,954)	($192,720,635)
Children	$2,675	0.9%	$2,700	242,441	$654,670,139	$698,350,840	$2,880	($180)	($43,680,700)
Other Adults	$7,086	0.9%	$7,152	56,585	$404,693,749	$335,389,976	$5,927	$1,225	$69,303,772
									($255,074,285)
2016 Penalty Calculation									
			Difference Between Target and Actual Expenditures	**FAMAMP**	**Total Excess Federal Payment**	**Quarterly Deduction**			
			($255,074,285)	56.2%	**($143,351,748)**	**($35,837,937)**			
					Total Penalties (2015 & 2016)				
					($211,331,883)				