

CHAPTER 3

Alternative Approaches to Federal Medicaid Financing

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Key Points

- The federal government and the states share responsibility for financing Medicaid. States receive federal matching funds toward allowable state expenditures on an open-ended basis. Therefore, as state spending increases, so does federal spending, and as state spending decreases, so does federal spending.
- The level and rate of growth in Medicaid spending reflects not only decisions made by federal and state policymakers but also factors beyond the control of government officials, including changes in the economy and the health system. Increases in spending also reflect the unique role that Medicaid plays in providing coverage to low-income families and high-cost, high-need populations.
- Concerns about the level and rate of growth in federal Medicaid expenditures have led some policymakers to consider alternatives to the existing financing structure that would reduce the future rate of growth. Changes also could be made within the current structure that would further incentivize the prudent use of Medicaid funds, and the Commission will focus on these options in the future.
- There are several major alternatives to Medicaid financing that could result in federal savings, including block grants, capped allotments, per capita caps, and shared savings. Proponents of capping the federal share of Medicaid suggest that this approach could lead to federal savings and eliminate state incentives to maximize their share of federal funds. Others raise concerns regarding the potential cost shift to states and the limited options states have to curb cost growth without affecting enrollment, access to care, and the quality of coverage.
- In developing proposals to change Medicaid financing, policymakers will need to establish spending limits, define the level of state contribution, decide which programmatic features to include, and determine the degree of state flexibility and accountability. Their choices will likely reflect the goals of reform. Although the specific effects of any financial restructuring will depend on the level of ongoing federal spending and how states respond, recent proposals have been designed to rein in federal spending, either initially or over time.
- As proposals to change financing are discussed and further specified, the Commission will continue to explore the implications of restructuring federal Medicaid financing. We will conduct more in-depth analyses on the design and technical considerations of particular approaches as well as on the potential effects on federal and state spending, beneficiaries, and providers.

CHAPTER 3: Alternative Approaches to Federal Medicaid Financing

Medicaid represents a growing portion of the federal budget, having increased from 1.4 percent of federal outlays in fiscal year (FY) 1970 to 9.5 percent in FY 2015. It also represents a growing share of state budgets, increasing from 6.9 percent of state-funded expenditures in 1990 to 15.3 percent in 2014. By FY 2024, Medicaid expenditures (both state and federal) are expected to reach \$890 billion (OACT 2015). The majority of the spending growth in Medicaid can be attributed to enrollment; spending per enrollee has grown at rates comparable to or lower than Medicare and private coverage. (For more detail on these and other Medicaid spending trends, see Chapter 1 of this report.)

The rate of growth in Medicaid spending reflects decisions made by federal and state policymakers about the size and scope of the program. It also reflects factors that are beyond the control of government officials, including population aging, changes in the economy, medical price inflation, and broader changes in the health system. Increases in spending and service use also reflect the unique role that Medicaid plays in providing coverage to individuals without other sources of health insurance, including low-income families and high-cost, high-need populations, such as people with disabilities and those in need of long-term services and supports (LTSS).

Concerns about the level and rate of growth in federal Medicaid expenditures have prompted some policymakers to consider changes that would alter the trajectory of spending, including alternatives to the current financing structure that would reduce the rate of growth in Medicaid

spending. In April 2015, the chairs of congressional committees with interest in Medicaid requested that MACPAC develop a long-term work plan to analyze and evaluate financing reforms that would reduce federal and state outlays. The ranking members of these committees further requested, in a May 2015 letter, that MACPAC also assess the effects that various financing reforms might have on states, enrollees, providers, and plans.

In this chapter, the Commission presents its initial analysis of several different financing alternatives. Although these approaches could be structured in a manner that does not reduce federal spending, financing reforms such as block grants and per capita caps have typically been proposed as a means of reducing the rate of future spending. Furthermore, given the direct request for MACPAC to examine these alternatives with reducing future spending in mind, the discussion presented here makes the assumption of federal budgetary savings. (Approaches that states are already using to limit growth in Medicaid spending within the existing statutory and regulatory framework are discussed in Chapter 2 of this report.)

We begin by describing the current financing structure, commenting on its origins as well as features that have been criticized. We then outline several major approaches to financing reforms—block grants, capped allotments, per capita caps, and shared savings—highlighting key design decisions. While other federal policy changes could be made to address some of the concerns regarding state incentives without changing the underlying financing structure (for example, moving to a blended matching rate or removing the floor on matching rates), these are not the focus of this chapter, but will be the subject of future Commission work.

Given congressional interest in structural reforms in Medicaid, we expect that specific proposals will become the focus of discussion in the coming months. As more detailed specifications are available, the Commission will extend its analyses

to assess specific alternative approaches to federal financing and program design. In doing so, the Commission will consider the potential effects of different proposals on federal and state spending, beneficiaries, and providers. We will also examine in greater detail the related policy considerations and technical issues raised in this chapter, such as the relationship between Medicaid and other federal programs. Finally, our work will consider potential outcomes associated with different alternatives; for example, the extent to which some approaches promote greater flexibility and others greater accountability. As the Commission contemplates the effects of various policy alternatives, we will explore the trade-offs associated with each.

Medicaid's Current Financing Structure

Financing the Medicaid program is a shared responsibility of the federal government and the states. As long as a state operates its program within federal requirements, it can receive federal matching funds toward allowable state expenditures. These include payments to health care providers and managed care plans as well as expenditures associated with administrative tasks such as making eligibility determinations, enrolling and monitoring providers, overseeing managed care organizations and other contractors, and paying claims. Because federal contributions match state spending on an open-ended basis, as state spending increases, so does federal spending; conversely, as state spending decreases, so does federal spending.

Formula for federal financing

The vast majority of state Medicaid spending (95 percent) is for health care services provided to Medicaid enrollees, and the federal share for most of these expenditures is determined by each state's federal medical assistance percentage (FMAP).

The FMAP formula provides higher matching rates to states with lower per capita incomes relative to the national average (and vice versa) and is intended to account for states' differing abilities to fund Medicaid from their own revenues. The Social Security Act (the Act) requires the formula to be reapplied annually to calculate new FMAPs for each state for the following fiscal year using the most recent rolling three-year average per capita income data (§ 1905(b) of the Act). FMAPs have a statutory minimum of 50 percent and a statutory maximum of 83 percent. Mississippi currently has the highest FMAP at about 74 percent, and 13 states are currently at the minimum (MACPAC 2016a).

Certain exceptions to the FMAP formula apply, including exceptions for administrative costs (which are generally matched at 50 percent); for the territories and the District of Columbia (whose FMAPs are set in statute); and for special situations (such as temporary state fiscal relief). In addition, there are special matching rates for certain populations, providers, and services (such as family planning services and supplies) (MACPAC 2016b).¹

Policymakers have used the federal matching rate as a policy lever—increasing the rate, sometimes temporarily and sometimes permanently, to encourage states to adopt various changes to the program. For example, higher federal matching rates have been used to incentivize states to expand eligibility through the State Children's Health Insurance Program (CHIP) and the new adult group under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). Higher matching rates have also been made available to improve systems capacity, counter fraud and abuse, and increase the use of home and community-based services. The FMAP has also been reduced to motivate states to meet policy goals. For example, a temporary percentage point reduction in the federal matching rate was enacted as part of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) and was used to encourage states to target fraud and abuse.

Over the years, proposals have been discussed to change the FMAP, including creating an automatic trigger to increase rates during recessions, and using different data sources thought to better reflect demand, cost differences, and state resources. Such modifications to the methodology would require a statutory change (GAO 2016, 2013a, 2011). There have also been proposals to move to a blended matching rate—that is, applying one FMAP to all Medicaid and CHIP expenditures—to simplify the administrative complexity of claiming different matching rates for different populations, services, and administrative functions (HHS 2012). Other proposals have suggested reducing or eliminating the 50 percent floor for the federal share, because the floor provides a number of states with FMAPs above what they would receive in its absence (CBO 2011, 2008).

Non-federal share of Medicaid financing

Federal policy regarding both the permissible sources of non-federal Medicaid expenditures and federal contributions toward those expenditures dates to Medicaid's enactment (MACPAC 2012). Prior to 1965, health care services for low-income individuals were provided primarily through a patchwork of programs sponsored by state and local governments, charities, and hospitals (HCFA 2000). Payments were often in the form of direct investments in hospitals and clinics serving low-income individuals. Medicaid's financing approach was designed to build upon these existing programs by providing federal matching funds for state and local spending on approved health care services provided to certain populations. While the administration of Medicaid was centralized at the state level, this financing structure allowed the preexisting local programs to maintain primary responsibility for service delivery as well as non-federal funding of services that now qualified for federal payments.

The Medicaid statute permits states to generate their share of Medicaid expenditures through multiple sources, including state general revenue, contributions from local governments (including providers operated by local governments), and specialized revenue sources such as health care-related taxes. Although 40 percent of non-federal financing must come from the state, up to 60 percent may be derived from local sources (§ 1902(a)(2) of the Act). As a result, the extent to which states rely on funding sources other than general revenue varies considerably and may be influenced by states' traditional sources of general revenue and their historic approaches to financing health care for low-income individuals.

Although each state devises a tailored approach based on its own budgetary constraints and unique circumstances, the three most common sources of non-federal financing are state general revenue, local sources, and health care-related taxes.

- **State general revenue.** Most state financing for Medicaid is through general revenue collected through income taxes, sales taxes, and other sources. These general revenues accounted for 74 percent of the state share of financing in 2012 (GAO 2014).
- **Local sources of non-federal share.** Counties, municipalities, and other units of local government contribute to the non-federal share of Medicaid spending in many states through expenditures (such as services at government-owned and operated hospitals) that are eligible for federal match. These local sources totaled about 16 percent of the non-federal share in 2012 (GAO 2014).²
- **Health care-related taxes.** In FY 2016, all but one state (Alaska) had at least one health care-related tax (sometimes referred to as a provider tax, fee, or assessment) in place (Smith et al. 2015). In FY 2012, these taxes, typically levied on institutional providers, accounted for about 10 percent of state share (GAO 2014).³

At various points, particularly beginning in the early 1990s, this multisource approach to financing has been the subject of federal scrutiny, sometimes because of concern about state excesses, and sometimes in an effort to control federal spending by limiting the states' ability to make expenditures that qualify for federal contributions (GAO 2014, 2004, 1994). Over the years, the federal government has acted to limit some strategies used by states to maximize federal Medicaid revenue. Such actions include statutory limits on disproportionate share hospital (DSH) payments, creation of upper payment limits for hospitals and nursing facilities, and limits on state use of health care-related taxes.

Some argue that certain approaches to raising the non-federal share—such as provider taxes and intergovernmental transfers—are a means to draw down federal funds without providing any additional services or improving the value of services provided to Medicaid enrollees (Coughlin et al. 2004). But states have protested more robust action to limit how they raise the non-federal share, noting that they may find it difficult to raise the state share without this flexibility (CBO 2008). Given substantial pressure to balance state budgets and provide funds for other state functions, such as infrastructure and elementary and secondary education, governors, legislators, and state Medicaid officials have relied on a diverse set of financing sources to fund their Medicaid programs (GAO 2014).

Allowable state expenses

As mentioned above, states are reimbursed for allowable (also referred to as matchable) expenses, which include medical assistance to eligible individuals and the costs of administering the program. The federal statute describes the individuals who are eligible for coverage, what benefits they can receive, and which providers can be paid for those services. For example, states are generally barred from receiving federal matching funds for full Medicaid services provided to lawfully residing immigrants for five years from the date of

entry, although they can receive matching funds for emergency services provided to non-qualified aliens who meet income and all other eligibility criteria. The institutions for mental diseases (IMD) exclusion prohibits states from receiving federal payment for any Medicaid service provided to individuals over the age of 21 and under the age of 65 who are patients in an IMD.

The decisions behind what constitutes an allowable expense often reflect various policy goals. For example, the expansions of coverage to low-income infants and pregnant women in the 1980s allowed states to draw down federal match for new populations and reflected the interest of states and the federal government to use Medicaid as a means to reduce the rate of infant mortality (Hill 1990). Policymakers have also put additional constraints on what qualifies as an allowable expense, for example, by clarifying the definition of an administrative cost and stipulating how costs should be allocated across state agencies (OMB 2004).

Responsiveness of the current financing structure

Increases in federal spending can be the result of specific state or federal decisions, such as raising eligibility levels, or the result of factors that may be outside the control of states or the federal government, such as changes in the economy, medical and pharmaceutical innovations, emergence of new diseases, demographic changes, and other unforeseen events. The ability to increase federal and state spending in response to current events is one of the advantages of the current financing approach and helps Medicaid meet its unique and varied demands as a source of health coverage for low-income populations.

Specifically, the Medicaid financing structure as currently designed affords states and the federal government the funding flexibility to provide services at a time when health care markets and the larger economy have been buffeted by change. Because Medicaid is a countercyclical program,

federal funding rises as Medicaid enrollment increases when economic conditions worsen and the number of people living in poverty grows. In addition, like other payers, Medicaid is affected by changes in the practice of medicine, including the development of new technologies and treatments, as well as by the emergence of new illnesses and diseases. For example, the recent introduction of high-cost specialty drugs, such as those for treating hepatitis C, have driven increases in Medicaid spending in recent years (Smith et al. 2015). Medicaid has also played a critical role in the care of individuals with HIV since the beginning of the epidemic, and it is estimated to be the largest source of coverage for those with HIV/AIDS (Kates 2011).

States, in collaboration with the federal government and often through waivers, have also used Medicaid to respond to unforeseen events. For example, following Hurricane Katrina in August 2005 and the terrorist attacks of September 11, 2001, states were granted additional flexibility to ease access to health care (CMS 2005, UHF 2002). More recently, in response to potential lead exposure, the Centers for Medicare & Medicaid Services (CMS) approved a waiver to allow the state of Michigan to provide Medicaid coverage to children and pregnant women in Flint who would not normally be eligible for coverage (CMS 2016a). Furthermore, a number of other federal and state programs serving low-income individuals and families are designed with the assumption that Medicaid will cover certain health care needs. As debate around changes in the financing structure proceeds, policymakers should consider whether and how an alternative approach should respond to these factors and what the ongoing nature and scope of the program should be.

State incentives and spending decisions

The ability to draw down open-ended federal funding is a major component in state spending decisions, one that has raised concerns among some regarding the ability of the federal

government to limit its own financial exposure. This dynamic has led to concerns that the Medicaid financing structure does not necessarily promote efficiency, because the more states spend, the more federal dollars they draw down. However, other factors, such as the ability to raise the state match, competing funding priorities, and the policy and political environment, also influence state decisions. Furthermore, states desire to be parsimonious and efficient with their own spending, as evidenced by state legislature debates on Medicaid policy changes as part of their annual or biennial budgets.

The current financing structure may also encourage states to substitute federal funds for state funds by converting formerly state-funded programs or services to Medicaid in order to draw down federal match. For example, between 2001 and 2006, as New Jersey sought to coordinate services for the child welfare population, it incorporated a number of behavioral health services previously supported solely with state dollars into the state Medicaid plan, allowing the state to capture federal funding for these services (Manley 2016, MACPAC 2015a).⁴

Moreover, although there are some exceptions as noted below, the matching rate may not encourage states to pursue innovations or reward them for achieving improvements in quality or access. The FMAP formula is essentially agnostic with respect to the outcomes of spending; if spending is legally permissible, it can be matched. Another criticism is that the incentive to reduce spending is limited by the fact that states keep at most 50 percent of any savings despite bearing most of the administrative responsibility for implementing reforms.

On the other hand, the incentives created by the FMAP are not absolute. States may not claim federal share unless they spend public dollars, raised from lawful sources, on activities that are legally allowable. Mindful of their own budget constraints, as well as other political and economic factors that shape their health care markets and the design of their Medicaid programs, states

respond differently at different times and in different circumstances and thus do not always take the opportunity to draw federal match or even enhanced federal match. For example, Section 2703 of the ACA provides authority for state Medicaid programs to create health homes for persons with chronic conditions or serious mental illness. Although this option provides a 90 percent federal match for two years, fewer than half of states have adopted it. States also express concern that new federal requirements to cover particular populations and services and to perform a variety of administrative functions typically require increased state spending.

It is also important to note the many approaches states have taken to find savings and efficiency in their Medicaid programs. For example, states have turned to managed care to provide predictability in costs, and more recently, have attempted value-based purchasing arrangements, such as accountable care organizations (ACOs) and bundled payments. Some of these strategies are discussed in Chapter 2 of this report. Additionally, federal initiatives are supporting state innovations to re-engineer payment and delivery systems to focus on improved outcomes while holding down costs. These initiatives include the Medicaid Innovation Accelerator Program, the State Innovation Models initiative, and Delivery System Reform Incentive Payment (DSRIP) demonstration programs.

Alternative Financing Proposals

Changes could be made within the existing financing approach that would further incentivize the prudent use of state and federal Medicaid funds but that would not necessitate a fundamental restructuring of federal Medicaid financing. For example, as discussed above and in more detail in Chapter 2 of this report, there are other means to generate savings and promote

efficiency and value in the Medicaid program. Modifications to the existing funding approach, such as further limiting the use of provider taxes, could also help address some of the concerns regarding state incentives to increase spending in pursuit of federal matching funds. In addition, there may be more discrete changes that could be made to particular funding streams that serve specific program purposes, such as capping expenditures for program administration or information technology. These are topics that the Commission may further explore at a later date.

The remainder of this chapter, however, per the request of the chairs of committees with interest in Medicaid, discusses more fundamental changes to Medicaid's financing structure, the design considerations, and the potential implications. The most commonly discussed approaches to limiting federal financing in Medicaid include the following:

- block grants to states for the federal share of spending;
- capped allotments for each state (similar to the financing structure used for CHIP);
- capped federal contributions to each state based on a per capita amount reflecting enrollee characteristics; and
- shared savings (and risk) for spending relative to per capita targets.

(See Appendix 3A for a side-by-side comparison of Medicaid financing approaches.)

We note that these approaches can be designed so that the future level of federal spending is higher or lower and that they could have differing results depending upon how they are constructed and which program features are included. For example, as discussed below, initial capped allotments under CHIP were increased by statute when states raised concerns about their sufficiency. Even so, past proposals to fundamentally change federal Medicaid financing have typically been offered in the context of achieving substantial federal

budget savings. Moreover, because MACPAC has been asked specifically to examine alternative approaches to federal financing that would reduce federal outlays, we discuss the alternatives within this budgetary context.

Proponents of capping the federal share of Medicaid below spending projections suggest that such a change would lead to both federal savings and more predictable federal spending in the future. Additionally, a cap on federal spending could potentially eliminate some of the incentives that lead states to maximize their federal share by shifting state spending to Medicaid or by generating the state share through increasing use of provider taxes or intergovernmental transfers. Finally, depending upon the approach, spending limits could be accompanied by giving states additional flexibility in designing and implementing their programs, potentially reducing state costs and increasing both efficiency and innovation (Dilger and Boyd 2014, CBO 2013). Advocates of capped funding also suggest that such changes would allow states to design and manage their programs in ways that are more consistent with their preferences and to reduce the role of the federal government in setting program parameters and oversight (Dilger and Boyd 2014, Waller 2005, Finegold et al. 2004).

Concerns about federal spending caps focus on the potential for them to result in a cost shift to states if the federal share or rate of growth is set too low. If other aspects of the program stay the same (such as federal requirements affecting eligibility and benefits), it may be difficult for states, especially in a short time frame, to find enough savings through program efficiencies or other cost-saving innovations to offset the reductions in federal funds. States would then have to weigh whether to cut eligibility, benefits, or payment rates or to increase state spending to maintain their existing programs. Furthermore, given that the majority of the increase in program spending has been the result of growth in the number of people covered (as described in Chapter 1), states

may have limited options to curb cost growth without making changes that affect enrollment. This scenario could be particularly acute during an economic downturn because historically, Medicaid enrollment and spending increased as individuals lost jobs and health coverage.

Establishing capped financing structures that can account for the various needs of states and the mix of beneficiaries enrolled in state Medicaid programs can be administratively complex (CBO 2013). In addition, capped payments may make it difficult to measure performance, hold states accountable, collect uniform data, and provide effective oversight unless new mechanisms are put in place to do so (Dilger and Boyd 2014).

Block grants

Block grants are typically structured to provide lump-sum grants to states with grant amounts based on a predetermined formula. States spend the funds on a specified range of activities with some level of federal oversight. States typically do not need to provide matched funding to secure the grant, but they may be subject to a maintenance-of-effort requirement on existing spending. The specifics of Medicaid block grant proposals have varied, but past proposals have generally sought to limit federal liability for Medicaid spending by reducing federal funding relative to current law.

A block grant approach would change the nature of the program by eliminating the automatic increases in federal funding in response to enrollment growth and the increases in per enrollee spending that can be triggered by a change in disease pattern or the introduction of a new blockbuster drug. Proponents of the block grant approach contend that by limiting federal spending and increasing state flexibility, block grants could give states a stronger incentive to seek efficiency and spend Medicaid dollars more prudently (Dilger and Boyd 2014). Some cite the Medicaid Section 1115 waivers in Rhode Island and Vermont (Box 3-1) as examples of how a block grant can work in Medicaid. Detractors point out

BOX 3-1. Aggregate Limits under Section 1115 Demonstrations

The Section 1115 demonstrations in Vermont and Rhode Island have been cited as examples of how block grants could work in Medicaid, providing insight on how states can operate within a fixed budget. In contrast to states that calculate budget neutrality for the purposes of Section 1115 approval using projected spending for each enrollee (as noted in the discussion on per capita caps), the waivers in Vermont and Rhode Island established statewide spending limits based on projections of enrollment growth.

It is important to note that these waivers were sought and negotiated by each state and included features that were uniquely tailored to each one, including the budget neutrality calculations. In addition, the U.S. Government Accountability Office (GAO) has criticized the methodology that the U.S. Department of Health and Human Services (HHS) used to establish these limits, questioning the higher-than-expected growth factors that resulted in an overall spending limit for the states that was likely higher than what the states would have spent in the absence of the waiver. Specifically:

- In Vermont, HHS used projections for enrollment growth that were higher than state or national trends and included hypothetical costs that would not have been spent in the absence of the demonstration (GAO 2008).
- In Rhode Island, HHS used per capita spending growth projections that were higher than historical spending trends (GAO 2013b).

that if growth rates are set lower than the current expected rate of growth of Medicaid spending, it is likely that states would face the choice of increasing their share of funding for the program over time, or reducing program costs through eligibility, benefit, or provider payment cuts (CBO 2013, Holahan et al. 2012).

Historically, once put in place, block grants have changed in ways not necessarily anticipated by their architects. For example, the real value of block grant funding has tended to decrease over time even though the initial funding for block grants has not been consistently higher or lower than the programs they replaced (Finegold et al. 2004). The experience with Temporary Assistance to Needy Families (TANF) is illustrative of a social service program that shifted from an entitlement to a block grant (Dilger and Boyd 2014). Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996

(PRWORA, P.L. 104-193), Aid to Families with Dependent Children (AFDC) was converted from an open-ended entitlement grant to the TANF block grant. States have broad flexibility to use their federal TANF funds to meet the statutory purpose of the welfare reform law—including providing assistance to needy families, promoting job preparation and work, preventing and reducing out-of-wedlock births, and encouraging marriage—but are not required to use TANF funds to provide cash benefits. On the other hand, federal law requires that half of a state's caseload meet work participation standards (Title IV of the Act). The amount of the state family assistance grant—which totals \$16.5 billion across the states—has not changed since it was established in 1996. As a result, the real (inflation-adjusted) value of the TANF block grant has declined 32.5 percent since 1997, an average of 2.2 percent each year (Falk 2016).⁵

The level of state flexibility in federal block grants has also shifted over time as Congress has added reporting requirements, in part to enhance oversight, or created other programmatic constraints (Dilger and Boyd 2014, Feingold et al. 2004). For example, the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981, P.L. 97-35) created nine block grants by consolidating about 50 categorical grant programs and giving states broad discretion over what services to provide in the areas of health, energy assistance, substance abuse, mental health, social services, community development, and community services. In doing so, OBRA substantially reduced the level of federal data collection and reporting. However, in response to concerns that states were not adequately meeting national needs, Congress instituted restrictions, such as requiring a minimum portion of the funds to be used for particular purposes (GAO 1995).

Capped allotments

Another approach to limiting federal financial exposure is to create capped allotments for states that act as a ceiling with federal funds provided as matching payments up to that cap. CHIP is financed as a capped allotment, with state spending matched by federal dollars up to a set amount.⁶ Medicaid financing for the territories provides another example of capped allotments.

Under a capped allotment approach, states are required to contribute state share to draw down federal matching funds from their state-specific allotment. They may receive less than the full allotment in a given year depending upon their level of spending, but are limited in the total amount of federal financing by the amount of the allotment. This differs from a block grant under which states receive the full grant amount without providing state match (although states may be required to maintain a certain level of state Medicaid spending under a block grant). Capped allotments may allow greater control and predictability in federal spending relative to the current Medicaid financing

approach because states are prospectively allocated a set amount of funding each year.

The capped allotment approach used to finance CHIP has led some policymakers to conclude that this approach may be equally well suited to Medicaid. A key issue is the level of state allotments. For the first several years of CHIP, state allotments tended to be much greater than the amount states actually spent. Over time, as CHIP programs matured and states expanded eligibility (including, in some instances, to parents and childless adults), several states were slated to experience shortfalls of federal CHIP funding (GAO 2007). This occurred in part because the original formula used for calculating allotments did not accurately project what states would spend to cover the target population. Congress intervened to appropriate additional funding for FY 2006 and again for FY 2007 to prevent these shortfalls.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) extended CHIP appropriations through FY 2013 at much higher levels than under the original legislation and overhauled the formula for allotting these funds. Specifically, the original state-specific allotments were based on estimates related to the size of the target population and the cost of providing services in each state, while the allotments established under CHIPRA are based on state spending in the program, with adjustments for health care inflation and child population growth.⁷

Other changes were also made to the financing structure through CHIPRA that made it less likely that states would experience shortfalls. For example, CHIPRA limited the amount of time states could retain unspent allotments before they were redistributed to other states and it provided contingency funding for states that exhausted their allotments. CHIP funding extensions since CHIPRA have not materially changed the structure or overall level of federal CHIP financing.

CHIPRA stabilized CHIP financing such that, since 2009, only two states—Iowa and Michigan—have used contingency funds after exhausting their allotments.⁸ In the aggregate, total state spending remains below the capped amount with actual allotments in FY 2016 totaling \$13.5 billion, well under the annual limit on federal appropriations for CHIP allotments of \$19.3 billion. It is not clear, however, whether state-specific allotments actually encouraged states to be more judicious in their spending or if the amount of funding available for the allotments was simply more than sufficient for states to run their programs.

The capped allotments to the territories provided under Medicaid work somewhat differently than those under CHIP. The territories' Medicaid caps are statutorily specified and grow with the medical component of the Consumer Price Index for All Urban Consumers (CPI-U) (§ 1108(g) of the Act). Their FMAP is also specified in statute at 55 percent (§ 1905(b) of the Act). Once the territories exhaust their allotments, they must fund the program entirely with local funds—and the territories have historically exhausted their federal Medicaid allotment prior to the end of the fiscal year (Mach 2016). In response, Congress has provided several temporary funding increases, most recently in the ACA. The ACA provided \$6.3 billion in additional Medicaid federal funding; these funds are available to be drawn down between July 2011 and December 2019, or until their depletion. Despite the increase in the allotment, Puerto Rico and the Northern Mariana Islands are projected to fully expend their additional allotments under the ACA before they expire (CMS 2016b).

Per capita caps

A per capita cap would establish per enrollee limits on federal payments to a state, with federal spending rising based on the number of enrollees, but not on the cost per enrollee. Per capita caps could be designed on an aggregate level or on a more targeted basis for each eligibility group. The latter recognizes that some eligibility groups

(such as low-income families and children) have substantially lower health care costs, on average, than others (such as people with disabilities and adults age 65 and older). Similar to block grants and capped allotments, per capita caps may limit total federal spending and can be designed to allow states greater flexibility in operating their programs so they stay under their caps. However, unlike fixed block grants and capped allotments, the total amount of federal spending would vary with enrollment changes.

Proponents of per capita caps argue that this approach creates greater incentives for program efficiency than the current financing structure does, and that it could also provide states with increased budget predictability. This approach would provide states with additional funding in situations such as economic downturns when states face decreased revenues but higher Medicaid enrollment. Critics argue that in order to achieve budget savings, the rates of growth likely to be proposed for the caps would lead to program cuts. Others note the complexity involved in establishing and risk-adjusting caps for each state and eligibility category (Cassidy 2013, CBO 2013). Furthermore, given that Medicaid spending growth is primarily driven by enrollment increases, per capita caps would not get at the underlying driver of growth.

The use of per capita caps in Medicaid under Section 1115 research and demonstration waivers to establish budget neutrality has been cited as an example of how per capita caps could work. Under budget neutrality, federal spending under the waiver cannot exceed what it would have been in the absence of the waiver, but it is not required to be less than current spending. In most cases, budget neutrality is determined by setting per member, per month limits on federal costs for each Medicaid eligibility group included in the demonstration. These are typically established based on two factors: (1) baseline historical spending for the eligibility groups included in the demonstration, and (2) a trend rate, often calculated as the lower

of either the state's historical spending trends or national Medicaid spending projections.⁹

The caps used in Section 1115 budget neutrality negotiations are likely different than those that have been offered under alternatives that would apply per capita caps to all states. Under a Section 1115 waiver, budget neutrality is determined in the aggregate, so states may exceed the per capita limit placed on an eligibility group as long as the state spends less than the per capita limit on other eligibility groups. In addition, the CMS determines budget neutrality over the life of a waiver and may permit states to apply prior year savings to new expenditures in future years of the demonstration. Recent waivers expanding coverage to the new adult group require states to revisit their per capita caps after they gain experience covering these individuals.

Previous proposals to replace the current financing method with per capita caps have not permitted states to apply savings from one group or one year to other groups or other years, presumably because this would dampen the impact of the caps on savings. Similarly, such proposals have not anticipated allowing states to negotiate the level of their initial caps or renegotiate them over time, as is done currently when establishing the terms of Section 1115 waivers.

Medicaid shared savings

Under a shared savings approach, the federal government would establish a per capita spending target based on historical program spending while continuing to provide matching funds for eligible state expenditures based on the FMAP. States would be eligible for a higher than normal percentage of the savings that resulted from spending less than the targets in a given year and would be responsible for a higher percentage of per capita spending above the targets. Shared savings would be contingent upon meeting standardized performance and quality metrics. Proponents of shared savings models argue that this approach

would provide a stronger incentive for states to seek program efficiency than the current financing structure of Medicaid without resorting to financial constraints, while also aligning state and federal incentives, and preserving state flexibility (McClellan 2013, Weil 2013).

Shared savings is fairly new, but similar approaches have been attempted in both Medicare and Medicaid; however, they operate on a small scale and are tied to provider performance rather than state-level measures. Creating a shared savings approach on a program-wide level would likely be more complex. Established under Section 3022 of the ACA, the Medicare Shared Savings Program (MSSP) was designed to facilitate coordination among groups of providers (e.g., ACOs) to improve the quality of care and reduce unnecessary costs among the fee-for-service Medicare population. The MSSP rewards ACOs that lower growth in health care costs for beneficiaries while meeting performance standards. These programs have demonstrated savings and quality improvement based on early reports.¹⁰

Minnesota and New Jersey have adopted a shared savings approach and methodology that is similar to ACOs in their Medicaid programs. In Minnesota, the Health Care Delivery Systems demonstration established provider groups analogous to ACOs, and in New Jersey, certified ACOs serving a defined geographic area can establish a shared savings arrangement with a Medicaid managed care organization (Houston and McGinnis 2013).

Oregon has taken a broader approach to shared savings in its entire Medicaid program under its Section 1115 waiver. Specifically, the state expects to reduce costs by 2 percent each year in exchange for an up-front federal investment of more than \$600 million in federal funds over five years. If these savings are not realized, the state is at risk for losing some of this funding (OHPB 2016).

Design Considerations

In each of the approaches to restructuring Medicaid financing outlined above, a number of design considerations must be addressed. Some of these decisions are relevant to all the above-mentioned proposals, while some apply only to a subset. How policymakers choose to address these considerations will depend in part upon the goals of reform. Different factors may play a larger role based upon the particular objectives—that is, whether the change is meant to limit federal costs, promote state flexibility, reduce disparities in the federal contribution across states, or improve value and quality. Below, we discuss the following design considerations: establishing spending limits, defining the level of state contribution, deciding which programmatic features to include, and determining the level of state flexibility and accountability.

Establishing spending limits

Under a proposal to limit federal Medicaid spending, policymakers would need to determine how to define the overall spending level, how to establish a growth trend, and, in some cases, how to set state-specific or eligibility group-specific limits.

Base year for overall spending caps. The first step policymakers are likely to take in setting a national spending threshold under a block grant or capped allotment is choosing a base year. Using administrative data from a prior year (the base year) allows for a set level of funding based on actual program spending. However, given the lag in the availability of Medicaid data, even data from the most recent years available may not provide an accurate reflection of current spending. Information from the Form CMS-64, which states must submit quarterly to claim reimbursement for expenses, would provide current state-level Medicaid spending, but would not allow calculations to take into account the enrollment mix or other characteristics. The most recent Medicaid Statistical Information System (MSIS)

data, which provide detailed eligibility, enrollment, and claims data, predate implementation of the ACA and therefore do not represent the ensuing enrollment growth and changes in the composition of beneficiaries and their service utilization. The Transformed Medicaid Statistical Information System (T-MSIS), which builds on existing person-level and claims-level MSIS data submitted by the states, should address the lag in availability of Medicaid administrative data; however, T-MSIS data are not yet available for most states. In addition, if policymakers wish to make other program changes simultaneously, such as limiting coverage to certain populations, the base year would have to be adjusted to reflect anticipated effects on future spending.

On the other hand, selecting a base year for which data are not available would require projecting current spending forward based on assumptions about growth. Policymakers could choose a future year (e.g., 2018) to serve as the base year and wait until actual spending data are available for that year, but a lag in the availability of data might make this untenable. Although projections may not be exact, a future base year might allow states to inflate spending, for example, by making additional one-time supplemental payments to increase base year spending (CBO 2013).

In addition, policymakers would likely want to consider the larger economic climate of the base year, because depending upon the year chosen, the level of spending may be higher or lower than a typical year. For example, if policymakers chose a year during a recession, spending levels would likely be higher than if they chose a year of high economic growth—although per capita spending may be lower during a recession if individuals forgo care. Finally, policymakers may want to decide whether or not to make initial funding reductions to whatever base year funding they identify.

Growth factors. In any of the alternatives, policymakers may also want to consider whether and how to increase spending in future years and

whether to devise a national growth factor or to inflate spending based on state-specific factors. Decisions regarding such growth factors could vary depending on the specific policy goals. For example, if the goal is to reduce federal spending, policymakers may wish to limit the growth of spending by choosing a factor that is lower than the expected growth under current law. Growth factors can be pegged to overall economic growth (for example, gross domestic product), economy-wide inflation, or medical care inflation (which has historically grown more quickly than general inflation) with differing results (KFF 2012). For example, including the rising cost of medical care in any growth factor might result in a more accurate measure, but it might not stem the growth in federal spending. Additionally, policymakers could consider including a measure of population growth to account for increases in enrollment due to the growth in or aging of the population (CBO 2013). For example, in CHIP, state allotments are calculated using growth factors for both health care inflation and child population growth. Amounts provided to states could also be designed to respond to changes in uninsurance or unemployment.

Setting caps for states. Determining how to allocate spending across the states is another decision policymakers will have to make in a block grant or capped allotment design. In doing so, policymakers may want to weigh whether it is important to make the distribution of federal funds more equitable across states or whether state-specific differences, such as per capita income, should be accounted for. Basing future state spending on current spending would lock in existing differences across states, differences that reflect both policy preferences (for example, willingness to cover optional eligibility groups) and the availability of resources (for example, differences in revenues reflecting state economies and tax structures). This would presumably minimize disruption and maintain a level of funding that fits each state's current programmatic needs, which may be a goal of reform. On the other

hand, if a spending cap were designed based on a national average, states with lower spending levels would receive more funding and states with higher spending levels would receive less—although depending upon the level of federal spending reductions, all states may see reductions in spending.

In addition, although a national methodology would provide a consistent approach to allocating funds across the states, its effects on states may vary to the extent that conditions vary across states in ways that are not accounted for by the national growth factor. This could be addressed by policies that take into account state-specific conditions to tailor the amounts awarded. For example, under the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5), all states received a standard percentage point increase in their FMAP, and certain states received an additional increase related to their level of unemployment.

Finally, policymakers could also consider various options to provide states the flexibility to make future policy decisions, such as an option to allow states to expand benefits or eligibility (for example, to the new adult group) and receive an increase in their funding level. The financing structure established under CHIPRA provides an example of how allotments can be adjusted to account for policy changes. Beyond adjusting for annual state-specific changes in health care inflation and child population growth, state CHIP allotments are recalculated every two years based on a state's actual spending of CHIP funds in the preceding year. Furthermore, CHIPRA allowed states that made policy changes to apply for an allotment adjustment. Another approach would be to establish a contingency fund—similar to CHIP—where additional federal dollars are available to qualifying states if they exhaust their allotments. For example, contingency funds or an allotment adjustment could be made available in response to a surge of enrollees with a new disease. However, such adjustments may not result in federal savings.

Per enrollee caps. In establishing per capita limits in a per capita cap or shared savings approach, policymakers would need to decide whether the caps would apply across all beneficiaries or apply by eligibility category (e.g., children, adults, aged, and disabled). By setting caps for each eligibility group, the per capita amounts may more accurately reflect costs because per enrollee spending varies among eligibility groups. (This would be similar to the process used to set managed care rates in Medicaid, which requires rate groupings specific to eligibility category, age, gender, locality, and, on an optional basis, diagnosis or health status.) In FY 2012, average spending per enrollee was \$6,833, but ranged from \$2,679 per child to \$17,848 per individual with disabilities (MACPAC 2015b). As a result of these spending differences, the average Medicaid spending per enrollee is heavily influenced by the enrollment mix across eligibility groups. An average cap across all enrollees would obscure these differences and would have a disproportionate impact in states with a greater number of adults age 65 and older and people with disabilities in their programs. In addition, policymakers would need to decide whether to use national or state-specific per enrollee caps. The considerations here mirror those laid out for the state-specific caps noted above.

Establishing and risk-adjusting caps for each state and for each of the four eligibility categories would be complex, particularly given limitations and inconsistencies in Medicaid administrative data. Specifically, although the Form CMS-64 provides a more complete accounting of spending than the MSIS and is preferred when examining state or federal spending totals, it cannot be used for analysis of benefit spending by eligibility group and other enrollee characteristics. On the other hand, the MSIS data allows for such comparisons, but there is a greater lag in data availability. Additionally, some spending information, such as supplemental payments, is missing from MSIS. Decisions would need to be made about how to allocate these lump-sum payments across eligibility groups. T-MSIS may provide more timely

and complete data, but is still in the final stages of implementation.

Policymakers will have to decide whether to include or exclude the approximately 7 million enrollees receiving only limited Medicaid benefits when establishing per enrollee caps (MACPAC 2015c). For example, the Breast and Cervical Cancer Treatment Program, is one of a number of current Medicaid eligibility pathways that provide limited coverage. Because spending on these groups differs from the larger categorical groups discussed above, decisions will also need to be made as to whether separate caps apply to them or if they will be included in the larger categorical caps (and if so, how).¹¹ In addition, policymakers could also consider whether to include or exclude other populations, such as individuals with disabilities or those using LTSS, when establishing caps. Finally, as is done in Section 1115 waivers, policymakers could allow states to cross-subsidize each category—for example, allowing savings accrued for children to be used for people with disabilities—as long as overall spending remained under the cap.

Defining the level of state contribution

Given the size of state and local contributions to Medicaid, policymakers will need to clarify expectations about continued state financing as the federal portion of the program is restructured. If policymakers decide to require ongoing state spending under block grants, it might take the form of some type of maintenance-of-effort requirement. For example, under TANF, states are required to maintain the same level of funding they were providing when the block grant was established in 1996, although the range of activities on which they can spend these funds is broad (Falk 2016).

Under a capped allotment or shared savings approach, policymakers would need to specify the federal matching rate or rates that would apply. When designing a restructured approach, policymakers could also consider changing the

FMAP formula to address some of the issues raised above. For example, GAO has noted in the past that per capita income is not an accurate representation of states' population needs or geographic differences and has suggested that a revised FMAP could be based on measures of demand for services, geographic cost differences, and state resources (GAO 2013a). Policymakers could also build in a response to enrollment growth during an economic downturn by including an automatic increase in matching rate based on the employment-to-population ratio (GAO 2016). Another alternative would be to eliminate the existing floor of 50 percent, requiring higher-income states to contribute at a higher rate than they do now.¹² Decisions would also need to be made as to whether to maintain the differential matching rates that apply to certain populations, providers, services, and administrative costs.

Finally, policymakers may want to reexamine or redefine what are considered allowable (i.e., matchable) state expenses. As discussed above, states currently receive federal matching dollars for a range of activities, including administrative tasks and payments to health care providers and managed care plans. Policymakers could consider further limits on which of these activities are entitled to federal matching funds.

Deciding which programmatic pieces to include

Given the breadth of Medicaid's scope, in redesigning the approach to Medicaid financing policymakers must weigh which aspects of the program will fall under the new approach, whether to exclude certain groups of enrollees or types of spending, and whether different approaches may be appropriate for different program purposes and activities. These decisions would be driven by the specific policy goals of financing reform and would affect the level of federal savings.

For example, Medicaid plays a major role in financing LTSS for people who are functionally impaired or critically ill. Because Medicaid is the primary payer for LTSS in the United States, policymakers may wish to consider alternative forms of financing for this population or exclude them from a restructured program (Antos et al. 2015). However, because this population is responsible for the greatest share of spending, excluding them would reduce potential savings (see Chapter 1). Alternatively, responsibility for providing LTSS could be transferred to the federal government with states maintaining responsibility for the other portions of the Medicaid program (in the form of a swap). Policymakers may also want to consider some sort of hybrid approach—for example, maintaining the existing matching rate structure for those needing LTSS while providing a block grant for coverage of non-disabled children and adults.

Payments to certain providers, such as federally qualified health centers (FQHCs), or for certain services, such as primary care, could also be exempt from a cap; however, this may be administratively complex. As was seen in the primary care payment increase authorized under the ACA, some states reported difficulty in identifying eligible providers and needed more time than had been anticipated to implement the system modifications necessary to increase the payments. Additionally, to ensure that the increase was passed through to physicians in managed care situations, contracts had to be amended and capitation payments had to be adjusted (MACPAC 2013). Policymakers could also consider establishing separate caps for certain expenses, for instance, administrative costs, IT system builds, or targeted payments to providers, such as DSH or other supplemental payments. Under the capped allotment approach in CHIP, for example, states can spend up to 10 percent of their allotment on administrative costs.

Determining the level of state flexibility and accountability

Under the existing financing structure, states are required to follow certain program rules for drawing down federal funds. These federal requirements—such as coverage of mandatory eligibility groups, specified benefits, and limits on cost sharing—reflect federal policy decisions about the purpose of the program and how states should meet these objectives. Furthermore, existing standards on managed care and IT contracts, for example, place limits on federal financing if states do not meet certain benchmarks and are based on the assumption that states will economize.

The flexibility afforded states to design their own programs (within these federal constraints) recognizes the diversity of economies, health care systems, demographics, and policy preferences across the country. Proponents of increasing state flexibility believe that state officials are best qualified to design a program to meet the state's needs. They believe that states do not have sufficient discretion to manage their programs within the current framework and suggest that fewer federal requirements would allow states to be more innovative, would diminish the burden states feel to implement new federal requirements, and would reduce both state and federal spending.

For example, Medicaid is currently an entitlement program and states are required to provide coverage to any eligible individual. However, under a block grant or capped allotment approach, if federal funds were insufficient to support the number of beneficiaries, policymakers could allow states the flexibility to restrict enrollment, as they are allowed to do in CHIP.¹³ Additionally, policymakers could consider whether it is desirable to give states more flexibility in determining who should be covered and which benefits must be offered. Conversely, Congress could constrain state choices by imposing a maintenance-of-effort provision that requires states to preserve existing levels of financial contribution as discussed above

or by establishing a requirement to maintain existing eligibility thresholds, methodologies, and procedures, as has been done under the ACA and ARRA. To the extent that states are granted greater flexibility under a restructured system, the rationale for an ongoing role for Section 1115 and other waiver authorities could change.

Although state flexibility can be used as a tool for efficiency and innovation, there are concerns that a system with greater flexibility would lessen state accountability. Given that the Medicaid program is funded with federal dollars, it is important for federal authorities to maintain some level of oversight into how states are spending federal funds and to evaluate whether these funds are being used effectively. Under any alternative approach, policymakers will need to decide what level of federal accountability and oversight (e.g., data reporting and quality measures) they want in exchange for the federal dollars that continue to flow to state Medicaid programs.

The current match-based system, which requires states to send CMS a quarterly report of actual expenditures broken down into major benefit and administrative categories, provides the federal government with a great deal of information about state spending. MACPAC and others have documented the insufficiency of particular data sources for certain types of analyses, but the requirement that states provide data to support claims for federal matching funds provides the federal government with a timely and comprehensive source of information on Medicaid spending (MACPAC 2011). Under a revised approach to financing, policymakers will need to consider what degree of reporting and accounting for expenditures is required to maintain appropriate federal oversight.

The question remains as to how states will respond to any reductions in federal funds—whether they will curtail spending or whether they will be driven toward greater efficiency, quality, and value. If the larger goal of policymakers is to improve quality

and pay for value, then they may want to consider whether to tie funding to performance measures. On the other hand, implementing meaningful and consistent quality benchmarks may be difficult given the wide variation in the type and use of Medicaid quality measures. For example, in FY 2014, 34 states reported at least one of the optional adult quality measures in Medicaid (HHS 2016a). Furthermore, as discussed above, there are a number of ongoing initiatives in states to transform the delivery system. Policymakers may want to consider what role these programs will have under restructured financing and whether the changes may motivate states to accelerate innovations, continue them, or abandon them.

Potential Effect on States and Enrollees

Given the federal-state partnership in funding Medicaid, changes to the federal financing approach will inevitably affect state budgets and the more than 70 million people who rely on Medicaid for coverage of acute care and LTSS. While the specific effects will depend on the level of ongoing federal spending and how states respond, recent proposals to alter financing have been designed to rein in federal financing either initially or over time. For example, the 2016 concurrent budget resolution that was passed in the House proposed a capped allotment, saving more than \$900 billion over 10 years, while the 2015 budget resolution proposed converting Medicaid to a block grant and assumed savings of \$732 billion over 10 years (Committee on the Budget 2015, 2014; H.Con.Res. 27, H.Con.Res. 96). Few details regarding how these savings would be achieved were included in committee documents, but previous analysis by the Congressional Budget Office (CBO) suggests that the majority of savings would come from holding the rate of growth for the block grant below the historic rate of growth of Medicaid spending (CBO 2012).

It is important to note that savings to the federal government would be lost revenue to the states. As discussed in Chapter 2 of this report, given the changes that states have already made to operate their programs more efficiently, it may be difficult for them to offset the decline in federal dollars, especially as the federal savings suggested in prior proposals are substantial. Instead, states may raise revenues, cut other programs to provide additional funding to Medicaid, or reduce spending in Medicaid (CBO 2013).

Furthermore, depending on how the proposals are structured, there may be questions of state equity. To the extent that historic spending levels are used when establishing limits, existing program variation and spending differences across states would persist. States that have historically spent more on their programs, either because of the generosity of their benefits or eligibility thresholds or because the costs of health care exceed the national average, would continue to receive higher levels of federal dollars, perpetuating the inequities in coverage between states. On the other hand, high-cost states may continue to receive higher levels of funding, but may have less of an incentive to reduce spending.

The effect on beneficiaries of any financing change depends greatly on the level of funding provided to states, how states react to the funding level, and the amount of flexibility afforded them. Theoretically, states could maintain their existing programs in response to decreased federal financing by raising revenues and enrollees would see little change. However experience shows that states have struggled to raise the revenue needed to close budget gaps in their Medicaid programs and have instead turned to reductions within the program (Smith et al. 2011). After years of cuts, a number of states have begun to increase payments to providers, as the overall budget climate has improved (NASBO 2015, Smith et al. 2015). However, should states face a decrease in federal funding, they may turn to provider rate cuts, which could discourage provider participation and

possibly diminish access to services. Additionally, some providers, such as FQHCs and rural health centers, rely on Medicaid for a substantial share of their revenue and may face issues of sustainability if Medicaid funds are diminished. If states were to eliminate optional benefits, individuals might forgo necessary treatment. If states were given the additional flexibility of reducing mandatory eligibility thresholds or limiting enrollment, fewer individuals would be covered in Medicaid (CBO 2013).

Changes to Medicaid would also likely have spillover effects because of its interaction and relationship with other programs serving low-income individuals and families. The design of many of these programs assumes the availability of Medicaid to cover certain health care needs. For example, children receiving Title IV-E services (foster care, guardianship assistance, and adoption assistance) are automatically eligible for Medicaid. Medicaid also provides financial assistance for Medicare premiums or cost sharing for some low-income individuals who are dually eligible for Medicare and Medicaid. Schools must provide a broad range of educational, social, and medical services to students with disabilities and Medicaid can help cover the cost of some of these services (CMS 2003). Furthermore, state eligibility and enrollment systems are integrated across Medicaid, CHIP, premium tax credits for exchange coverage, and, in some cases, other human services programs, such as the Supplemental Nutrition Assistance Program (SNAP, formerly referred to as food stamps) and TANF. As a result, major changes to Medicaid could affect the ability of beneficiaries to access other needed services, could limit funds available to states or agencies, and could increase demand for services provided by other programs. Because states have established coordinated systems and administrative processes, programs not connected to Medicaid could face operational changes merely because they serve the same individuals.

Conclusion

This chapter provides an overview of the current system of Medicaid financing and some of the proposed alternatives. Although the specific effects of any reform will depend on the ongoing level of federal funding, limiting federal (and possibly state) spending on the program may affect beneficiary eligibility and benefits as well as payments to providers, and the prospect raises concerns about whether Medicaid can fulfill its current role. On the other hand, states may find ways to operate their programs more efficiently within new constraints, and reduced federal and state outlays may improve long-term budget projections. The specific impact of any given proposal requires additional information on the design considerations described above.

As proposals to change financing are discussed and further specified, the Commission will continue to explore the implications of restructuring federal Medicaid financing and will conduct more in-depth analyses on the design and technical considerations of particular approaches, including the availability of data to inform policy decisions and the federal statutory and regulatory changes required. We will assess the potential outcomes of different alternatives, including the effects on federal and state spending, beneficiaries, and providers, and will explore the trade-offs associated with each. We will also examine the opportunities within the existing financing structure to address some of the concerns raised regarding program inefficiencies and state incentives to draw down federal funds. We will further explore the existing areas of state flexibility, as well as where additional flexibility has been requested. Finally, we will examine in greater detail the policy considerations with regard to Medicaid's relationship to other federal programs. These additional analyses will help inform future debate on redesigning Medicaid's financing structure.

Endnotes

¹ Certain administrative functions have a higher federal match, including activities that require medically trained personnel, the operation of information systems, fraud control activities, and administration of services that themselves have higher medical assistance match rates (MACPAC 2016c).

² Federal statute permits the use of funds transferred from or certified by units of government within a state as the non-federal share of Medicaid expenditures regardless of whether the unit of government is also a health care provider (§ 1903(w)(6)(A) of the Act). “Unit of local government” is defined as “a city, county, special purpose district, or other governmental unit in the state” (§ 1903(w)(7)(G) of the Act).

³ Health care-related taxes are defined by federal statute as taxes of which at least 85 percent of the burden falls on health care providers, and are permitted by federal rule for 18 separate provider classes (§ 1903(w)(3)(A) of the Act and 42 CFR 433.56). Provider donations are also permitted as a source of the non-federal share, but the stringent conditions placed on donations have effectively prohibited their use.

⁴ The behavioral health services were integrated into the state plan early in the Systems of Care initiative, but the initiative was implemented at a county level over a five-year period.

⁵ An additional \$150 million in grant funds are available for healthy marriage and responsible fatherhood grants and \$583 million is available in a contingency fund, as well as grants to the territories and tribes.

⁶ CHIP provides a higher federal match to states with lower per capita incomes relative to the national average, and rates are updated annually. This is similar to the manner in which federal Medicaid matching rates are assigned, although the CHIP matching rates are higher.

⁷ Under the original CHIP legislation, the annual state-specific allotments were determined by a formula based on a combination of the number of low-income children, the number of low-income uninsured in the state, and a cost factor representing the average health service industry wage in the state compared to the national average. The initial

state-specific allotments in CHIPRA were 110 percent of the highest of the state’s FY 2008 spending (adjusted for health care inflation and child population growth), the state’s FY 2008 allotment (with the same adjustments), or the state’s projected spending of federal dollars in FY 2009. In the years after 2009, the CHIP allotments were adjusted annually for health care inflation and child population growth, and every two years the allotments were rebased (or recalculated) based on the state’s actual use of CHIP funds in the preceding year.

⁸ In FY 2015, Michigan was poised to exhaust its federal CHIP allotments. As a result, the state requested and qualified for federal CHIP contingency funds totaling \$52.6 million, but because the contingency fund payment was insufficient to eliminate the state’s shortfall, Michigan also qualified for \$61.5 million in redistribution funds. The combination of contingency and redistribution funds eliminated the state’s shortfall. The only other state to ever qualify for contingency funds was Iowa, in FY 2011, which did not then require redistribution funds.

⁹ The calculations of budget neutrality have been controversial in some cases. Over the years, for example, GAO has repeatedly questioned CMS approval of some waivers, expressing concern regarding inappropriate setting of baselines and trend rates (GAO 2012).

¹⁰ In 2014, MSSP and Pioneer ACOs (another type of Medicare ACO) had a combined net program savings of \$411 million. The MSSP ACOs that reported data in both 2013 and 2014 saw improvement on 27 of the 33 quality measures, such as patient ratings and screening for high blood pressure (HHS 2016b).

¹¹ MSIS data includes information on individuals receiving coverage only for the following services: family planning services, assistance with Medicare premiums and cost sharing, or emergency services.

¹² For example, without the minimum FMAP of 50 percent, Connecticut would have a matching rate of 17 percent (Tatum 2015).

¹³ Although states have the flexibility to establish enrollment caps or freezes in their separate CHIP programs, under the ACA maintenance-of-effort provision that expires October 1, 2019, states are currently unable to implement them. An exception to this is Arizona, which had an enrollment freeze in its program prior to the passage of the ACA.

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APPENDIX 3A: Medicaid Financing Alternatives

TABLE 3A-1. Comparison of Medicaid Financing Approaches

Point of comparison	Current financing	Block grant	Capped allotment	Per capita cap	Shared savings
Overview of approach	Each state receives federal matching funds for eligible Medicaid spending. The FMAP, or matching rate, is determined by a formula that compares each state's per capita income to the U.S. per capita income.	There is an overall cap on the total annual federal contribution, with state-specific federal grants.	There is an overall cap on the total annual federal contribution, with state-specific federal grants. States must spend matching dollars to draw down the allotment and are not guaranteed to receive the entire allotment amount—the amount they receive depends on their level of spending.	Per enrollee limits on federal payments to a state are established, with spending rising based on the number of enrollees. Per capita caps could be designed on an aggregate level or on a more targeted basis for each eligibility group.	Maintains existing FMAP. States that lower their per capita cost trends below a certain level while improving quality and outcomes would keep a higher share of savings. Those that spend above their cost trend would pay a higher share of the costs.
How does it control federal spending?	Federal definitions of allowable expenses and appropriate state share. Policy decisions regarding mandatory and optional requirements.	Establishes an overall spending limit. Often projects cost growth at lower than historic rates. May also include constraints similar to current financing, such as definitions of allowable expenses.	Same as block grant, although states must spend in order to draw down federal matching funds.	Establishes per enrollee spending limits. Often projects cost growth at lower than historic rates. May also include constraints similar to current financing.	Adjusts the state share depending upon the level of savings achieved. Spending levels for savings could be set below current spending levels.
How does it account for inflation and medical cost growth?	Federal spending is tied to state spending, so matching amount increases accordingly.	Annual changes in federal and state limits are typically tied to specific economic indicators, which may include general inflation or medical cost growth, and are often lower than historical rates.	Same as block grant.	Per capita limits may include growth factors based on general inflation or medical cost growth. These growth rates are typically lower than historic growth rates.	Same as per capita cap.
How does it account for the enrollee mix?	Federal match is a percentage of each state's spending, and therefore accounts for changes in spending as the health of enrollees changes.	It depends. A block grant would likely be based on historic spending, which might reflect the current case mix in the state. A case-mix adjustment could also be made to account for changes in the health of enrollees.	Same as block grant.	It depends. Per capita caps determined by eligibility category will likely account for state case mix. A case-mix adjustment could also be made to account for changes in the health of enrollees.	Same as per capita cap.

TABLE 3A-1. (continued)

Point of comparison	Current financing	Block grant	Capped allotment	Per capita cap	Shared savings
How does it respond to economic downturns and other current events?	As enrollment or per enrollee costs increase, federal matching funds increase. To the extent a state's economy declines relative to the national average, the FMAP would increase.	Under most block grant proposals, grant amounts would not be affected by economic conditions. However, an adjustment could be made to the grant amount to reflect economic conditions and other events (such as natural disasters).	Same as block grant.	Increases in enrollment, such as might occur during an economic downturn, would result in an increase in a state's total amount. Unless specifically adjusted, per capita caps would not adjust for medical innovations or new diseases.	As enrollment or per enrollee costs increase, federal matching funds increase. To the extent a state's economy declines relative to the national average, the FMAP would increase.
How does it influence the variation across states?	Maintains existing variation.	To the extent that historic spending levels are used when establishing limits, existing program variation and spending differences across states would persist. However, adjustments could be made to the state grant amounts in an attempt to distribute funding more uniformly.	Same as block grant.	To the extent that historic spending levels are used, same as block grants. Growth factors or nationally based caps would diminish state variation.	To the extent that historic spending levels are used, same as block grants. However, the saving incentives would likely reduce spending variation between high- and low-cost states.
What types of spending would be exempt?	The territories and the District of Columbia have fixed FMAPs in statute; certain populations, providers and services, and spending on administration receive different FMAPs.	It depends. Administrative spending is typically included within block grants, although specific populations (such as those who are dually eligible for Medicaid and Medicare) could be excluded.	It depends. For example, under CHIP, administrative spending is included in the allotment and is subject to a 10 percent cap.	It depends. Per capita caps could exclude the territories, certain populations and services, and certain administrative expenses.	It depends. The shared savings requirements could exclude certain populations and services as well as certain administrative expenses.
How much flexibility would states be given?	Within federal requirements—such as coverage of mandatory eligibility groups—states have flexibility to design their programs.	It depends. Although details are sparse, block grants are generally combined with reduced federal requirements, including more flexibility in required state spending, mandatory eligibility groups, and covered services.	It depends. Under CHIP, states are still required to meet certain federal requirements, but are given greater flexibility, for example, in determining the benefits provided to low-income children.	It depends. Details are sparse, but states could be given broader flexibility (for example, in terms of benefits) to stay within their established caps.	It depends. Similar to per capita caps, states could be given additional flexibility to manage their programs within the caps and achieve desired savings.

TABLE 3A-1. (continued)

Point of comparison	Current financing	Block grant	Capped allotment	Per capita cap	Shared savings
What financial obligations would states be subject to?	Within federal requirements, states receive federal match for allowable state expenditures.	It depends. States may be subject to a maintenance of effort on existing spending.	State spending would be matched with federal funds up to the capped allotment amount.	The federal government would pay a fixed cost per enrollee; states would be responsible for any remaining costs.	States would receive federal matching funds for allowable state expenditures.
How would states be held accountable for the use of federal funds?	States currently must report quarterly expenses. Compliance with federal policies is monitored through several avenues, for example, State Plan Amendment approvals and Payment Error Rate Measurement reviews.	It depends. It is likely that states would minimally be required to report how they are spending their federal grant amount.	It depends. Under CHIP, states are subject to the same reporting requirements as in Medicaid.	It depends. It is likely that states would minimally be required to report per capita spending.	It depends. States would likely have to report per capita spending to be eligible for shared savings or be subject to shared losses. They would also need to report quality measures.
What data would be needed to establish the alternative financing structure?	Already in place.	It depends. Proposals typically use historical spending and an inflation factor to determine grant amounts. If desired, any data to account for changes in the economy or other growth factors.	Same as block grant.	It depends. Proposals typically use historical spending per enrollee, by eligibility category (and, if desired) risk-adjusted by state. Would also require a growth factor.	It depends. Proposals typically use historical spending and an inflation factor to determine benchmark amounts. Would also need consistent quality and outcome measures. The FMAP is used to determine matching rates.

Notes: FMAP is federal medical assistance percentage.

Source: MACPAC analysis.