

Setting Per Capita Caps:

Significant differences between current methods and those anticipated under financing reforms

Congress and the new Administration are considering substantial changes to Medicaid that include replacing the current federal financing mechanism with per capita caps, which would establish per enrollee limits on federal payments to states and give states responsibility for financing spending above the fixed per capita payments. Although national per capita caps represent a major departure from current law—under which states receive federal matching funds towards allowable state expenses on an open-ended basis—some have noted similarities between this new financing approach and two existing Medicaid practices, managed care rate setting and budget neutrality for Section 1115 demonstrations.

In this issue brief, we explore the extent to which rate setting and the process for establishing budget neutrality limits are useful analogues in considering how per capita caps might work at the national level. Both follow standard process steps that have evolved over time as states and the Centers for Medicare & Medicaid Services (CMS) have gained experience developing and operating within these models.

While experience with rate setting and budget neutrality may help inform policymakers as they consider changes in Medicaid financing, mechanisms developed to address the challenges in constructing valid state-level per capita payments do not necessarily translate to a national per capita model. In translating these approaches to broader federal policy, important considerations include:

- the limitations of using existing federal data to set state and eligibility group caps and project future spending and cost savings;
- managing the transfer of risk from one entity to another (state to plan, or federal government to states); and
- mechanisms for course correction and negotiation among parties.

Below, we describe the elements of rate setting and budget neutrality for 1115 waivers and then review technical requirements and challenges in operationalizing these methods. Finally, we discuss the policy considerations raised by these technical requirements and challenges, particularly as they might be applied at the national level.

Capitation Rate Setting

As of July 1, 2014, almost 60 percent of Medicaid beneficiaries were enrolled in comprehensive managed care (MACPAC 2016). Under comprehensive managed care, state Medicaid managed care programs contract with managed care plans to provide acute, primary, and specialty care services to Medicaid



enrollees; states use rate setting to establish capitation payments to plans that are sufficient to cover comprehensive services for the enrolled population while incentivizing efficiency. Plans are paid on a capitated basis each month for all Medicaid services and plans are at financial risk if spending on benefits and administration exceeds payments.

Since 1981, federal Medicaid law has required managed care capitation rates to be set on an actuarially sound basis (§1903(m)(2)(A)(iii) of the Social Security Act (the Act)). Federal rules issued by CMS in 2002 clarified that rates be developed in accordance with generally accepted actuarial principles and practices and certified by qualified actuaries (42 CFR 438.6). The Actuarial Standards Board, a non-governmental entity that sets standards for actuarial practice, issued an initial practice note for Medicaid managed care capitation rate development and certification in 2005 and has updated it periodically (ASB 2015). Federal rate setting regulations were updated in 2016, adding to the existing standard and specified standards and procedures for developing and documenting capitation rates (42 CFR 438.4).

To be considered actuarially sound, capitation payments must cover reasonable, appropriate and attainable costs in providing covered services to enrollees in Medicaid managed care programs. Capitation payments must be sufficiently high to induce managed care organizations (MCOs) to contract with the state and allow them to pay providers sufficiently, maintain solvency, and ensure beneficiary access to care. At the same time, as fiscal stewards of taxpayer dollars, states often implement managed care to save costs relative to fee for service (FFS). To help ensure that total MCO payments are neither too low nor too high, states can use a variety of additional payment mechanisms such as medical loss ratios, risk adjustment, and incentives or withholds.

To develop actuarially sound rates, state Medicaid agencies follow accepted actuarial methods and the specific requirements described in federal regulations and guidance. These include the following steps:

- **Baseline costs.** Using baseline FFS claims and health plan financial and encounter data, state actuaries examine historical costs and utilization of services to be covered by the capitation rate for the populations enrolled. States may use multiple years of data to improve credibility and smooth out variability, but may not use baseline data that is more than three years old. The actuaries make adjustments for missing data, claim lags, non-claims payments or recoupments such as pharmacy rebates, and the effects of differences in the expected covered population or services compared to the baseline.
- **Future costs.** State actuaries project future costs for the coverage period, taking into account medical cost inflation rates developed primarily from actual experience of the Medicaid population or from a similar population, changes in utilization patterns, and Medicaid program changes (i.e. changes in eligibility, benefits, or cost-sharing). Trends may vary by service or subset of services (e.g., primary care and specialist physician) and by population. State actuaries can take into account the effect of initiatives that are supported by corresponding cost savings policies (e.g., payment changes) but cannot set rates to achieve an arbitrary savings amount.



- **Managed care adjustments.** State actuaries adjust rates to account for expected savings through managed care efficiency factors, which include assumptions regarding the potentially lower rates of emergency room use and hospital re-admissions due to improved care coordination and provision of timely preventive care.
- **Administrative costs.** State actuaries calculate an allowance for administrative costs, including costs associated with MCO operations, taxes and allowances for profit and risk or contingency margin, sufficient to ensure that the medical loss ratio is neither too high nor too low.
- **Rate cells.** State actuaries develop different rates for population subgroups, separated by age, gender, geographic residence, eligibility category, institutional status, dual eligibility for Medicare and Medicaid, and other factors associated with differences in health care use. States can develop as many rate cells as needed to segment the population into groups with similar costs.
- **Risk adjustment and high-cost differentials.** State actuaries may apply risk adjustment techniques to better reflect the health status and expected costs of the populations actually enrolled in each managed care plan, to reduce the incentive for plans to enroll healthier members and avoid sick members. For some high-cost services that are difficult to predict, such as transplants, or highly predictable service costs, such as maternity care, state actuaries may make adjustments to the capitation rates so that these services will be paid as supplemental payments to the base rate.

As part of the official rate certification that must be submitted to CMS for review and approval, state actuaries must demonstrate compliance with actuarial soundness requirements. For example, state actuaries must document the rate-setting methodology, data used to set rates, trend factors, adjustments, and the development of non-benefit costs. States must also provide CMS with validated encounter data, fee-for-service data (as appropriate), and audited financial reports for the three most recent years. Finally, states must provide a copy of the contract between the state and MCO that details the services, populations, and administrative responsibilities that will be covered by the capitation payments.

CMS verifies compliance with these requirements and reviews the rates for adequacy and appropriateness. For example, CMS or an actuary applying generally accepted actuarial principles and practices evaluates each trend factor to determine its reasonableness for the enrolled population and reviews non-benefit cost documentation to evaluate the reasonableness of the assumptions underlying each expense. CMS also reviews the baseline data to verify that it includes the services and populations that will be covered by the contract between the MCO and state or that reasonable assumptions and adjustments have been made. After a 2010 U.S. Government Accountability Office (GAO) report found inconsistent review of capitation rate by CMS, CMS made an effort to strengthen its oversight (GAO 2010).

Federal rules require that rates be certified for a 12-month rating period, with a few exceptions for special circumstances. States must update the capitation rates and rate certification each year, including supporting data and documentation, and obtain new approval from CMS before the new rates become effective. Once rates are approved, a state can adjust a rate cell by 1.5 percent up or down without requiring a new approval, allowing some flexibility for small programmatic changes. However, if there are



significant developments affecting actuarial soundness, states must obtain federal approval before changing the capitation rates by more than 1.5 percent.

Budget Neutrality for Section 1115 Demonstrations

Section 1115 of the Act provides authority to the Secretary of the U.S. Department of Health and Human Services (HHS) to approve any demonstration that is likely to assist in promoting the objectives of the Medicaid program.¹ Currently, 39 states have approved Section 1115 demonstrations; in fiscal year (FY) 2015, more than half of Medicaid benefit spending was under Section 1115 demonstrations in 15 states.

Although not defined by federal statute or regulations, since the late 1970s CMS has used budget neutrality limits to provide an upper limit on federal spending in a Section 1115 demonstration and a benchmark for ensuring that any additional costs do not exceed what the expected federal costs would have been without the demonstration (Lambrew 2001). Section 1115 demonstrations are required to be budget neutral, meaning that federal spending under the demonstration (referred to as with-waiver costs) cannot exceed projected costs in absence of the demonstration (referred to as without-waiver costs). CMS provides states with instructions for calculating budget neutrality and updated its budget neutrality guidance most recently in 2016 (CMS 2016; CMS 2017).

Demonstrations that generate federal savings relative to their without-waiver baselines can spend savings on costs not otherwise matchable (CNOM), such as delivery system reform incentive payments (DSRIP) to providers or expansions of eligibility to individuals that cannot otherwise be covered under the state plan. However, states cannot spend budget neutrality savings without CMS approval of the CNOM expenditures.

Twenty-six states currently demonstrate budget neutrality using a per capita method. Under this method, the state is at risk for the costs of individuals served by the demonstration but not for the number of individuals enrolled. CMS typically establishes different per capita limits for different eligibility groups, such as children, adults, and people with disabilities. (See Appendix A for information about which states currently use the per capita method and which populations are included in their demonstration.) States can also demonstrate budget neutrality using an aggregate method, in which the state is at risk for both per capita costs and for the number of enrollees in the demonstration.² Vermont and Rhode Island have used this budget neutrality method in the past but have since switched to the per capita method.³

CMS develops per capita budget neutrality limits in consultation with states and the Office of Management and Budget (OMB). The following factors are considered:

- **Baseline costs.** Baseline per capita costs for each eligibility group are determined based on the most recent year of historical spending provided by the state. Due to data lags, the most recent year with complete data is often trended forward to the start date of the demonstration.
- **Hypothetical costs.** For populations or services that states could have covered without a demonstration but are not included in the historical baseline, CMS has permitted states to add hypothetical costs to the budget neutrality limits. For example, low-income adults with incomes at or



below 138 percent of the federal poverty level (FPL) are treated as hypothetical costs because there are no historical data for this population.⁴ The budget neutrality limit for hypothetical populations is based on state estimates of the costs of covering these populations. Because it is more difficult to measure federal savings from hypothetical populations, states are not permitted to spend savings from these populations on other CNOM expenditures under the waiver.

- **Future costs.** Per capita costs are projected to grow based on a trend rate calculated by CMS, in consultation with states and OMB. CMS's general policy is to use the lower of the President's budget trend rate or the state's historical growth in spending during the five years prior to the demonstration. The President's budget trend rate derives from CMS Office of the Actuary (OACT) projections, but OACT is not directly involved in approving budget neutrality trend rates.
- **Administrative costs.** State administrative costs are typically excluded from budget neutrality calculations. Many states exclude certain Medicaid payments, such as prescription drug rebates.
- **Policy exclusions.** States with Section 1115 demonstrations are required to comply with future changes in federal law, and in some circumstances, the costs of complying with these changes, are excluded from budget neutrality calculations. For example, the federal costs of increasing physician payments for primary care services delivered by primary care providers in 2013 and 2014 were excluded from budget neutrality calculations.

As part of the waiver application process, states must submit historical Medicaid expenditure data for all populations that will be affected by the proposed demonstration and cost projections showing that the proposed demonstration will not cost the federal government more than the state's program could have cost in the demonstration's absence. The special terms and conditions for the approved demonstration detail the populations and services to be covered, as well as the performance reports and other information that must be provided to CMS to demonstrate compliance with the operational and financial terms and conditions of the waiver.

Budget neutrality is enforced over the entire period of the demonstration, typically five years. This means that if a state exceeds its limit in one year, it can maintain budget neutrality by achieving savings in a future year. States can also exceed spending limits for one eligibility group as long as the demonstration overall is budget neutral. Historically, states have been able to carry over savings from prior years at renewal. However, in 2016, CMS revised its policy and has begun to phase-down accumulated savings and rebase per capita spending limits based on actual spending at the time of renewal (CMS 2016).

Common Elements

Although managed care rate setting and budget neutrality have different goals, both processes have similar elements, including requiring data on historical spending, making assumptions about future cost growth, and allowing renegotiation between CMS, states, and—as applicable—managed care plans during or at the end of each certification period (Table 1).



TABLE 1. Summary of Goals and Methods for Managed Care Rate Setting and Budget Neutrality

	Managed care rate setting	Budget neutrality limit calculations
Goals	<ul style="list-style-type: none"> To establish a capitation payment to managed care plans sufficient to cover comprehensive services for the enrolled population while incentivizing efficiency 	<ul style="list-style-type: none"> To provide a benchmark for ensuring that any additional costs authorized under a Section 1115 demonstration do not exceed the expected costs without the demonstration
Data sources	<ul style="list-style-type: none"> State FFS claims data and health plan financial and encounter data for historical costs and use for populations enrolled 	<ul style="list-style-type: none"> State aggregate spending data for historical costs for the populations included in the demonstrations
Future spending	<ul style="list-style-type: none"> Actuaries project future spending by applying trend rates based on actual experience to specific population subgroups associated with differences in use of health care services (e.g., age, gender, geography) 	<ul style="list-style-type: none"> CMS projects future spending by applying a trend rate to historical spending for broad Medicaid eligibility groups (e.g., children, adults, etc.)
Future savings	<ul style="list-style-type: none"> Managed care plans can retain savings if costs are less than the capitation payment, but actuaries adjust rates to account for expected savings 	<ul style="list-style-type: none"> States can spend budget neutrality savings on additional Medicaid expenditures with CMS approval
Administrative expenses	<ul style="list-style-type: none"> Actuaries project allowances for reasonable administrative expenses 	<ul style="list-style-type: none"> Administrative expenses are typically excluded from estimates of future spending
Certification period	<ul style="list-style-type: none"> One year 	<ul style="list-style-type: none"> Five years
Treatment of changes during certification period	<ul style="list-style-type: none"> Actuaries can adjust capitation rates within 1.5 percentage points to account for minor programmatic changes or unanticipated events without federal reapproval 	<ul style="list-style-type: none"> The cost of complying with changes in federal law is generally excluded from budget neutrality calculations States can request amendments to make other changes to budget neutrality agreements during the demonstration period



	Managed care rate setting	Budget neutrality limit calculations
Carryover and aggregate spending	<ul style="list-style-type: none"> Rate certification periods and MCO contracts are annual (although individual managed care plans can use profits in one year to offset losses in another year) Managed care plans use the entire amount of capitation payments from the state to cover the entire enrolled population; there are no spending requirements or limits by population subgroup 	<ul style="list-style-type: none"> Budget neutrality is enforced over the entire period of the demonstration and states can offset an excess one year with savings in a future year of the waiver period States can exceed spending limits for one eligibility group as long as the demonstration overall is budget neutral

Note: FFS is fee for service. MCO is managed care organization. CMS is the Centers for Medicare & Medicaid Services.

Below we review common challenges with collecting accurate data and accounting for future spending and savings. We also discuss the different processes that are part of rate setting, establishing budget neutrality, and operating within a capitated financing approach.

Adequate data are needed to develop per capita amounts but there are limits on what is available.

Both managed care rate setting and budget neutrality primarily rely on state Medicaid data to establish per capita amounts for different types of Medicaid enrollees. Section 1115 demonstrations identify population sub-groups based on broad eligibility categories that are easily identified in state administrative data (e.g., children), while managed care rate setting involves more specific rate cells based on characteristics like age, gender, and geography and can require more sophisticated analyses. However, utilization and eligibility data are often incomplete and can be subject to a substantial data lag, particularly when more detailed data are needed to support a complex analysis. For example, while CMS receives spending information from states on a quarterly basis, detailed state statistics on enrollment and utilization often lags several years. The 2016 managed care rule includes requirements for states to improve the reliability of managed care encounter data, which are used to support rate setting; these will take effect in 2018. GAO has criticized CMS’s oversight of the data used to develop managed care rates and budget neutrality and called upon the agency to provide more transparency about the data used and the processes used to validate this data (GAO 2013; GAO 2017).

Using state data also could be problematic when setting per capita caps nationally. State data vary reflecting a range of factors (e.g., type and level of benefits covered, payment methodologies, and geographic price differences). In 2012, overall Medicaid benefit spending per full-year equivalent enrollee ranged by state from \$5,679 to \$13,003 (MACPAC 2016). This variation also exists in state-level per capita payments. For example, a review of managed care rates in seven states found that managed care payments per enrollee ranged from \$2,784 to \$5,180 in 2014, and in 2017, per capita limits under Section



1115 demonstrations for non-disabled children ranged from \$2,463 to \$9,498 per year in 2017 (GAO 2016; MACPAC 2017).

There are no well-tested tools to risk adjust or normalize Medicaid spending on a national basis for payment purposes. States may adjust payment rates between health plans using diagnostic risk adjustment to account for differences in health status between enrollment populations, but these tools may not support risk adjustment between states as they do not account for all the differences among programs. Other methods to normalize differences, such as applying data from the Medicare acute inpatient prospective payment system, can account for some but not all differences across states.

Projections of future costs rely on assumptions about trends and policy effects. Both managed care rate setting and budget neutrality estimate future costs by applying trend rates to baseline per capita spending levels. For budget neutrality, a single trend rate is applied to all costs for individuals in an eligibility group, while in managed care rate setting, more sophisticated assumptions are made about future costs for populations in specific rate cells. Many managed care and Section 1115 demonstrations exclude high-cost, high-need populations, such as people over age 65 and people with disabilities. The high variability in costs and utilization make it more difficult to accurately project average per enrollee costs for these groups and make future costs more difficult to predict.

In developing the best estimates of future costs, states must make several subjective judgments (e.g., how to deal with variability and outliers in the underlying data, what potential changes in utilization or prices can be achieved, and how to account for differences between the baseline data and the actual enrolled population). Decisions about trend rates also involve several assumptions for which there may be a range of appropriate responses, such as whether to assume that Medicaid costs will increase at the same rate as overall health care inflation, whether the trend rate for certain covered services such as specialty drugs will be higher than the overall trend, or whether the trend rate will be lower than general health care inflation if managed care plans can negotiate lower unit costs for health care services.

While actuaries have established professional guidelines for making assumptions about future costs for purposes of capitation rate setting, fewer standards apply to Section 1115 budget neutrality. Although the final trend rates are included in each demonstration's special terms and conditions, CMS does not document the method for developing these trend rates publicly and the CMS Office of the Actuary does not review them. GAO has recommended that CMS provide more transparency about its assumptions, particularly for states that include hypothetical costs in their budget neutrality limit (GAO 2013).

Projections of future savings can influence decisions to accept per capita payments. In managed care, savings relative to the capitation rate are retained by managed care plans, which provide an incentive for plans to reduce costs. However, this only motivates plans to participate if they expect that the payment rates and program design create a reasonable opportunity to achieve savings. In addition, because previously attained managed care savings become part of the trend used in rate setting going forward, health plans often protest that they are effectively penalized for becoming more efficient.



In Section 1115 demonstrations, states can apply savings to additional Medicaid expenditures, which raises concerns about whether these demonstrations ultimately increase federal costs. However, because CMS must approve any additional CNOM expenditures, states often cannot spend the full amount of budget neutrality savings that they have accumulated. GAO has recommended that CMS provide more guidance on the types of additional spending that can be authorized through Section 1115 demonstrations, and CMS has begun to take steps to phase-down accumulated budget neutrality savings to better align per capita limits with actual Medicaid spending (GAO 2015; CMS 2016).

Calculating accurate per capita amounts is only one aspect of managing the transfer of risk.

Capitation rates and budget neutrality calculations are the payment components of broader agreements between the state and CMS or the state and an MCO that involve the transfer of risk from one entity to the other.⁵ These agreements, which are voluntary and negotiated between the parties, include several safeguards to bound the risks taken under these alternative payment and financing approaches. All parties rely on clear guidelines as demonstration waivers and managed care contracts include both downside risk as well as upside risk—states and MCOs are on the hook if program costs exceed total per capita payments but can retain or redirect any savings if program costs are held below total per capita payments. The goal of all parties is to settle on adequate per capita payments that provide for reasonable upside and downside risk. Several mechanisms are used to help achieve this goal.

- **Transparency and negotiation during the development of capitation rates and budget neutrality limits.** Transparency is needed to evaluate estimates of future costs to ensure that both parties can agree that the per capita estimates are adequate and appropriate. For managed care, actuaries have developed professional guidelines around transparency and states are required to disclose their assumptions to CMS. For budget neutrality, CMS has established a process to discuss assumptions with states and come to agreement about appropriate per capita payments. However, there is room for improvement in transparency: MCOs have asked CMS to strengthen state requirements, and the GAO has suggested that CMS can improve its own transparency.
- **Opportunities for periodic review of per capita payments.** Periodic review allows the rate setting and budget neutrality processes to respond to changes in health care cost trends, unanticipated events, and policy developments. Actuaries must review the underlying assumptions and rate setting methodology each year and make updates to account for changes in the delivery system, payment rates, or other factors. Section 1115 budget neutrality calculations are developed for a five-year period and states can use savings from one or more years to offset costs in other years or submit waiver amendments during the demonstration period to make programmatic changes or changes to the budget neutrality agreement if needed. In addition, CMS must review state requests to spend savings, which provides a protection against exceeding the waiver limit.
- **Detailed agreements that spell out the responsibilities of each party.** Section 1115 demonstrations and managed care programs are supported by a waiver agreement between the state and CMS or a managed care contract between the MCO and the state. These state-specific waivers and contracts detail what is covered by the per capita payments: covered services, enrolled populations, performance standards, administrative requirements, and any other expectations. They also describe the data that



must be submitted to support payment, which can include detailed claims and encounter data and other reports demonstrating performance on required measures. The waiver and contract require federal approval along with the capitation rates and budget neutrality calculations to ensure that they support each other.

Policy Considerations in Setting Per Capita Caps

The Medicaid managed care rate setting process and Section 1115 waiver budget neutrality process are examples of methods that states and CMS have refined over time to ensure that payments are sufficient to cover care for populations while incentivizing efficiency. Experience with these methods may help inform policymakers as they consider changing the Medicaid financing structure from an open-ended approach to one with per capita or global caps, although some mechanisms developed to construct valid state-level per capita payments do not necessarily translate to a national per capita model.

Different goals may require different methods and different data sources. Mechanisms that have been developed to establish capitation rates and budget neutrality limits differ and neither may directly apply to the technical requirements for a per capita cap federal financing model. For example, when paying MCOs, states develop many specific rate cells to ensure that payments are as precise as possible, but to establish limits for federal contributions to state health care demonstrations, CMS uses broad eligibility categories that have much greater variation within each category. In addition, many state demonstration waivers and managed care programs aim to improve or reform health care delivery systems and the assumptions underlying the payment mechanisms anticipate the results of those system changes. For example, while Section 1115 waivers are the closest parallel to current proposals for per capita caps, many demonstrations are designed to test the long-term effects of upfront investments and do not anticipate cost savings in the early years of the demonstration. A per capita cap federal financing model will have its own spending and policy goals and policymakers will need to establish guidelines to support those goals.

State-specific processes do not need to account for different state policies. The process in each state is developed and adjusted to account for the unique characteristics of that state's program design, data availability, and program goals. Each state develops its rates or limits independently, without reference to other states, so these approaches do not tell us much about how to adjust for the significant differences among states, in terms of coverage and provider payment.⁶ In addition, while some state managed care programs and demonstrations are quite large, none enrolls the tens of millions of beneficiaries anticipated to be covered by a per capita cap federal financing model and none provides an analogue to the challenges and opportunities of implementing a per capita payment approach at that scale. A federal approach to developing per capita caps will need to account for greater variation and scope than are addressed by current rate-setting and budget neutrality processes.

Managed care programs and Section 1115 demonstration waivers are voluntary programs while per capita caps are typically not voluntary. Health plans can decide whether to contract with states and states can decide whether or not to pursue waivers, and there is negotiation of both performance requirements and payment terms and then periodic renegotiation or rebasing. Some national per capita cap models anticipate an automatic formula that would be applied to all payments going forward (similar



to the sustainable growth rate methodology previously used in Medicare) and do not include mechanisms for rebasing or making actuarial adjustments to per capita amounts. Similarly, both managed care and budget neutrality calculations have mechanisms for periodically updating base data and revalidating assumptions to ensure that the per capita amounts are still appropriate, but to date, legislative proposals have not discussed how or when per capita caps would be revisited.

Endnotes

¹ Section 1115 of the Social Security Act (the Act) provides HHS with two authorities that can be used to approve Medicaid demonstrations: (1) the ability to waive almost any Medicaid state plan requirement, and (2) the ability to provide federal matching funds for costs that would not otherwise be matchable under the state plan. HHS cannot waive federal matching rates and can only waive cost sharing requirements in certain circumstances (§1916(f) of the Act).

² For family planning and other targeted Section 1115 demonstrations, states have demonstrated budget neutrality by estimating the avoided costs of the demonstration. This methodology is not discussed in this issue brief.

³ Rhode Island switched from an aggregate budget neutrality method to the per capita method in 2014 and Vermont in 2016.

⁴ Coverage for individuals who would otherwise be Medicaid-eligible if they were receiving home and community based services under a Section 1915(c) waiver are also considered hypothetical populations for budget neutrality purposes.

⁵ While a small number of states have implemented programs that use population payments or global budgets, most managed care programs and Section 1115 demonstrations use a per capita methodology that does not put plans or states at risk for enrollment growth, a factor that is beyond plan or state control under current law.

⁶ State actuaries have developed methods for accounting for significant differences between MCOs when using health plan data to calculate a baseline for future period capitation rates. For example, an actuary can determine if an MCO is performing poorly relative to others in the state and remove the higher expenses and member months for that MCO from the baseline. These methods may or may not be illustrative for efforts to adjust for the significant differences among states.

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Appendix A

TABLE A-1. States with Per Capita Limits in Section 1115 Demonstrations, by Eligibility Group, 2017

State	Percent of Medicaid benefit spending under Section 1115 demonstrations (FY 2015)	Children	Adults		Aged, Blind, and Disabled
			Previously eligible before ACA	New adult group	
Total	32%	20	24	16	21
Alabama	1%*	✓	✓		✓
Arizona	100%	✓	✓	✓	✓
Arkansas	30%			✓	
California	52%	✓	✓	✓	✓
Delaware	87%	✓	✓	✓	✓
Florida	64%	✓	✓		✓
Hawaii	95%	✓	✓	✓	✓
Indiana	23%		✓	✓	
Iowa	3%			✓	
Kansas	94%	✓	✓		✓
Maryland	70%	✓	✓		✓
Massachusetts	62%	✓	✓	✓	✓
Michigan	26%			✓	
Minnesota	2%	✓	✓		✓
Mississippi	2%				✓
Montana	6%			✓	
Nevada	11%	✓	✓		✓
New Hampshire	—*	✓	✓	✓	✓
New Jersey	82%	✓	✓	✓	✓
New York	3%	✓	✓	✓	✓
Oklahoma	53%	✓	✓		✓
Oregon	66%	✓	✓	✓	✓
Rhode Island	76%	✓	✓	✓	✓
Tennessee	83%	✓	✓		✓
Texas	79%	✓	✓		✓
Utah	9%		✓		
Vermont	98%	✓	✓	✓	✓
Washington	—*		✓		
Wisconsin	12%		✓		

Notes: FY is fiscal year. ACA is the Patient Protection and Affordable Care Act (P.L. 111-148, as amended).

* Alabama, New Hampshire, and Washington received approval of new Section 1115 demonstrations after FY 2015, and so future benefit spending under Section 1115 demonstrations is expected to be higher than the benefit spending reported in FY 2015.

Source: MACPAC analysis of CMS financial management reports and approved Section 1115 demonstrations as of February 1, 2017.

