

# Design Issues in Medicaid Per Capita Caps: An Update

Concerns about the level and rate of growth in federal Medicaid spending have prompted policymakers to consider changes that would alter its trajectory, including alternatives to the existing financing structure. Congress is considering substantial changes to Medicaid that include replacing the current 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 these fixed amounts.

Proponents of capping the federal share of Medicaid argue that such a change would lead to both federal savings and more predictable spending in the future. Additionally, caps 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 the use of provider taxes or intergovernmental transfers. Unlike some other mechanisms for limiting federal funding, a per capita cap approach would provide states with additional funding when enrollment increases, for example, during economic downturns when states face decreased revenues but higher Medicaid enrollment, as individuals lose jobs and health coverage.

Medicaid spending growth is driven both by increases in enrollment (about two-thirds of historical program growth) and increases in spending per person (about one third of historical program growth) (MACPAC 2016a). Because states are held harmless for enrollment growth in a per capita cap approach, spending per person must be constrained in order to realize federal savings. That is, the permitted rates of annual growth for per person spending must be below projected growth in the program under current law to achieve federal budget savings over time. This would create additional pressure on states to implement program efficiencies or other cost-saving innovations. However, it may be difficult for states, especially in a short time frame, to find enough savings to offset the reductions in federal funds. States would then have to weigh whether to cut eligibility, benefits, or provider payment rates or to increase state spending to maintain their existing programs.

This issue brief revisits the design considerations first described in MACPAC's June 2016 report chapter, *Alternative Approaches to Federal Medicaid Financing*, and subsequently discussed by MACPAC at its January, March, and April 2017 public meetings. We also describe the design choices made under the American Health Care Act (AHCA, H.R.1628) as passed in the House of Representatives on May 4, 2017, and the Senate discussion draft, the Better Care Reconciliation Act of 2017 (BCRA), as made public on June 22, 2017. Note that under both bills, a block grant option is available to states for certain populations; both bills would also make multiple other changes to Medicaid. These provisions are not discussed here.



## Overview of Per Capita Caps

A per capita cap creates per enrollee limits on federal Medicaid 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 constructed at the aggregate level or set individually 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).

Some advocates of per capita caps have noted similarities between this alternative financing approach and two existing Medicaid practices, managed care rate setting and budget neutrality for Section 1115 demonstrations. However, as discussed in *Setting Per Capita Caps: Differences between Current Methods and Financing Proposals*, 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 for risk-based managed care or the budget for a federal waiver do not necessarily translate to a national per capita cap model.

## Design Considerations

In establishing caps, several design considerations must be addressed. 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.

Below, we discuss four key 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. Within each of these sections, we present MACPAC's analysis of the implications of these various choices and the decisions reflected in the AHCA and the BCRA.

### Establishing spending limits

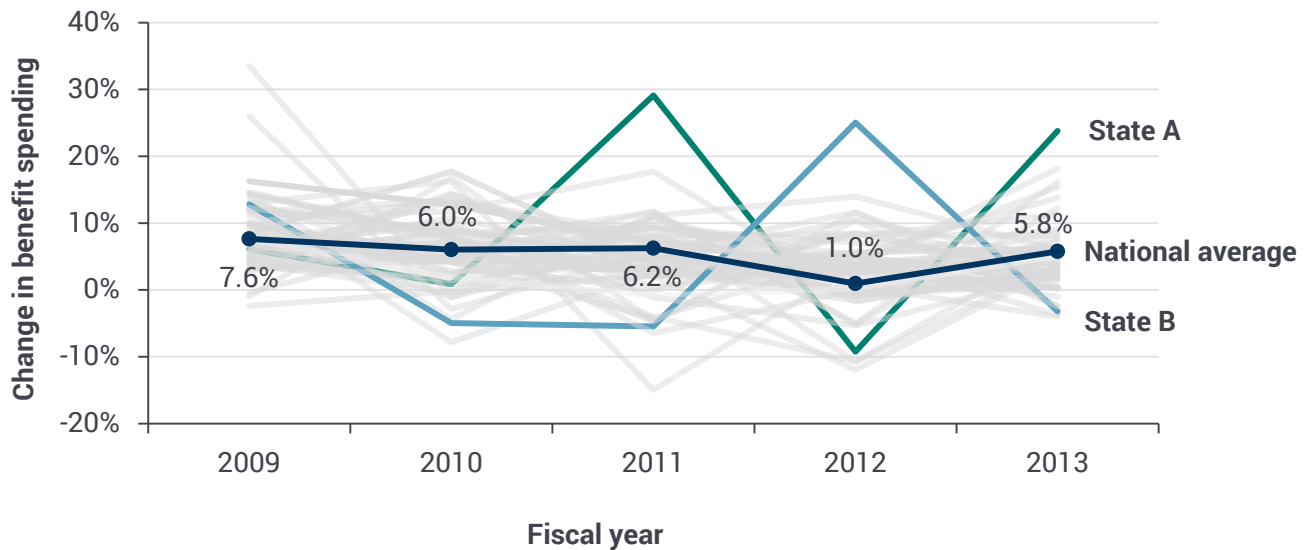
Under a proposal to limit federal Medicaid spending, policymakers need to determine how to define the overall spending level, how to establish a growth trend, and, in some cases, how to set state-specific or eligibility group-specific limits.

**Base year.** The first step policymakers are likely to take in setting a national spending threshold under a per capita cap is choosing a base year. Using administrative data from a prior year allows for a set level of funding based on actual program spending. However, given the considerable lag in the availability of Medicaid data, data from a prior year may not provide an accurate reflection of current spending given the speed with which changes in medical spending may occur (e.g., due to the introduction of new high-cost specialty drugs). Selecting a more recent base year for which partial data are available would require projecting current spending forward based on assumptions about growth, which could introduce other errors. Choosing a future base year also might allow states to inflate spending, for example, by making additional one-time supplemental payments to increase base year spending.



When choosing a base year, it is important to note that state spending can fluctuate substantially from year to year (Figure 1). However, some of this variation in spending could be smoothed out through the use of multi-year averages or periodic rebasing.

**Figure 1.** Annual Increases in Medicaid Benefit Spending, FYs 2009–2013



**Note:** FY is fiscal year.

**Source:** MACPAC analysis, 2017, of FYs 2008–2013 CMS-64 Financial Management Report net expenditure data from the Centers for Medicare & Medicaid Services, as of June 2016.

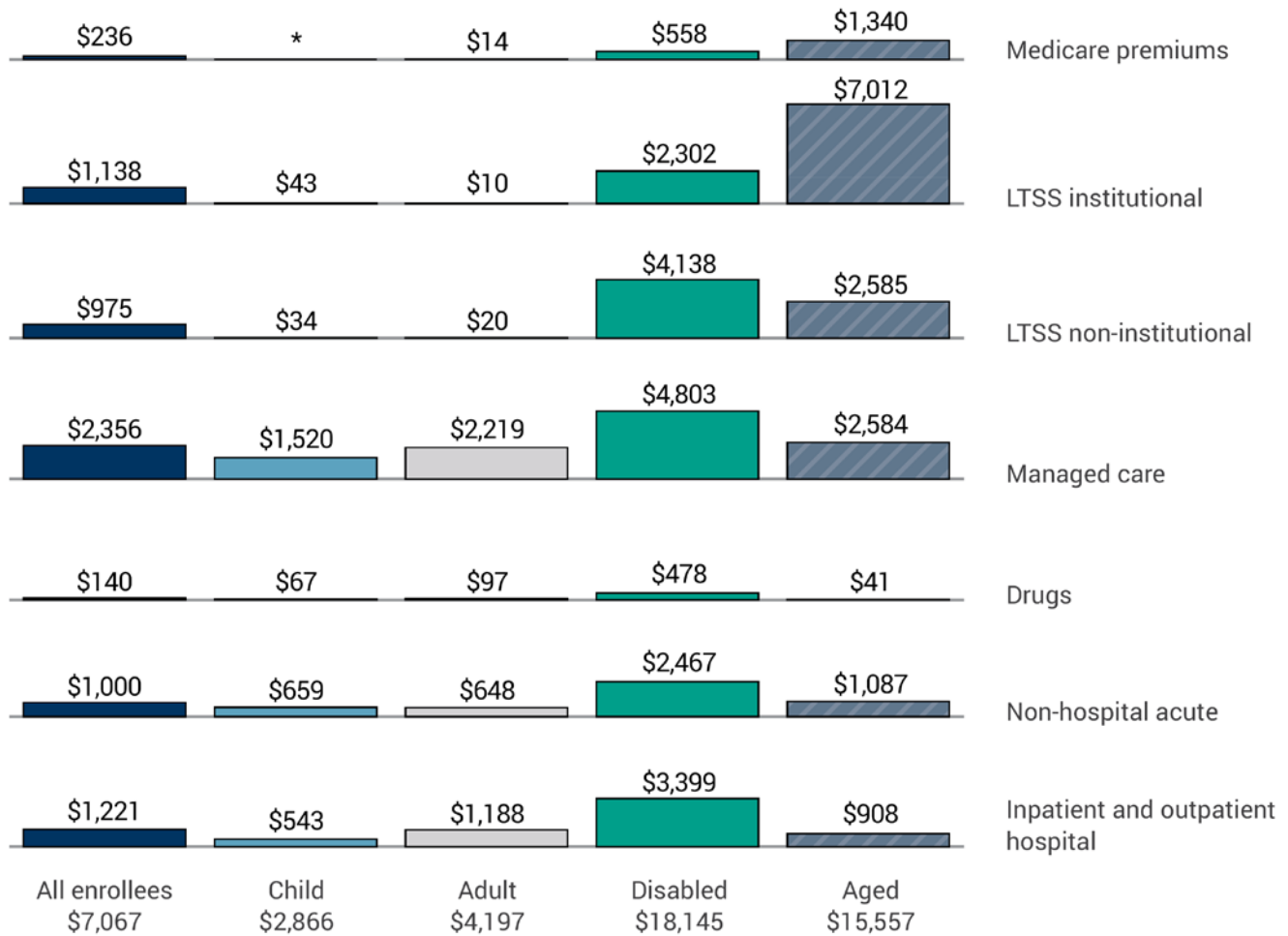
Basing future state spending on current spending would also lock in existing differences across states that reflect policy preferences (e.g., willingness to cover optional eligibility groups or benefits), the availability of resources (e.g., differences in revenues reflecting state economies and tax structures), and delivery system approaches (e.g., differences in the extent to which states have rebalanced their long-term care systems). States that have historically spent more on their programs, whether because of the generosity of their benefits or eligibility thresholds, local costs of health care exceeding the national average, or having a high proportion of aged and disabled residents in their state, would continue to receive higher levels of federal dollars, perpetuating the inequities in federal spending between states. On the other hand, low-spending states may find it difficult to achieve additional savings through program efficiencies. Policymakers could consider adjusting state-level caps to approach the national average, reallocating funds from high-spending states to lower-spending states.

**Per enrollee caps.** In setting per capita caps, 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 for each group because per enrollee spending varies considerably among eligibility groups. In FY 2013, average spending per enrollee was \$7,067, but ranged from \$2,866 per child to \$18,145 per individual with disabilities (Figure 2) (MACPAC 2016b). As a result of these spending differences, the average Medicaid



spending per enrollee in a given state is heavily influenced by the enrollment mix across eligibility groups (Figure 3). An average cap across all enrollees could affect a state positively or negatively over time if the distribution of enrollees among eligibility groups shifted compared to the distribution in the initial year.

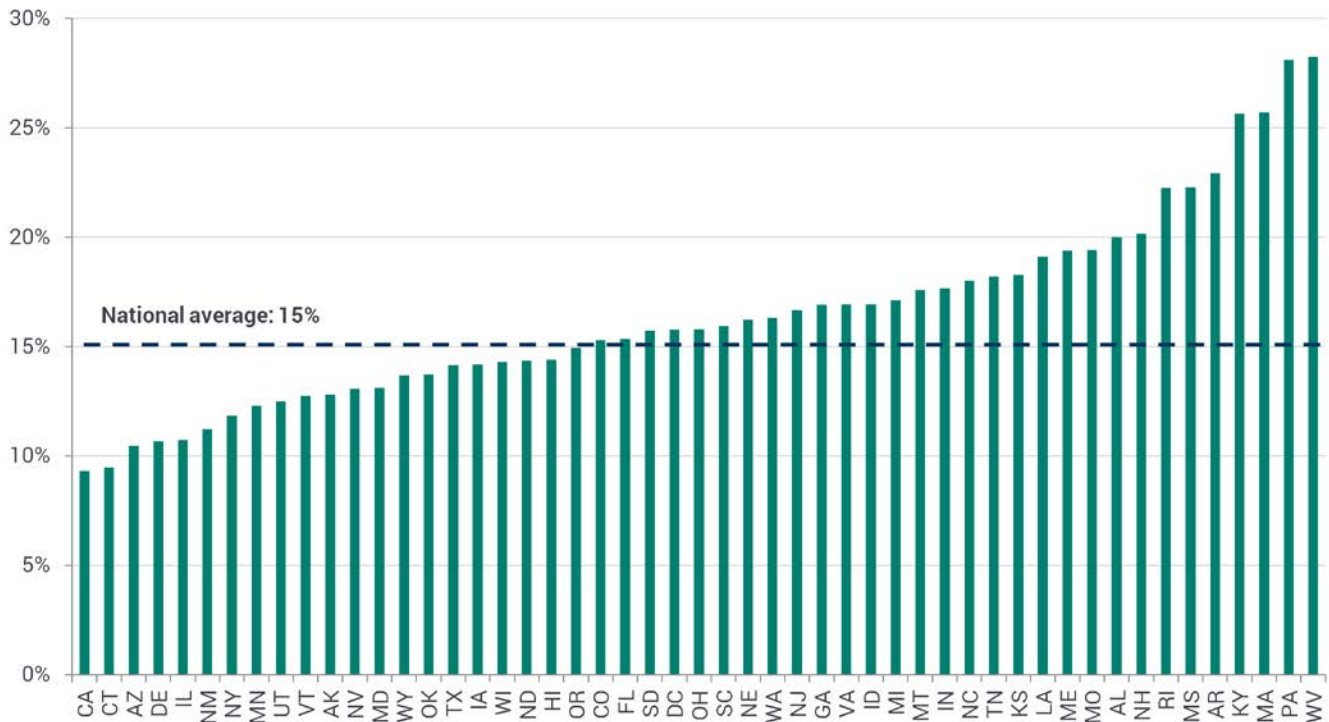
**Figure 2.** Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by Eligibility Group and Service Category, FY 2013



**Notes:** FY is fiscal year. LTSS is long-term services and supports. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Excludes Idaho, Louisiana, and Rhode Island due to data reliability concerns regarding completeness of monthly claims and enrollment data.

\* Values less than \$1 are not shown.

**Source:** MACPAC 2016b.

**Figure 3.** Percent of Medicaid Enrollees in the Disabled Category by State, FY 2013

**Notes:** Enrollment numbers generally include individuals ever enrolled in Medicaid-financed coverage during the year, even if for a single month. However, in the event individuals were also enrolled in CHIP-financed Medicaid coverage (i.e., Medicaid-expansion CHIP) during the year, they are excluded if their most recent enrollment month was in Medicaid-expansion CHIP. Numbers exclude individuals enrolled only in Medicaid-expansion CHIP during the year and enrollees in the territories. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. About 746,000 enrollees age 65 and older are identified in the data as disabled. Given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged.

**Source:** MACPAC analysis, 2017, of Medicaid Statistical Information System data as of December 2015.

In addition to the variation across eligibility groups, average spending within an eligibility group could be affected by a number of factors beyond a state's control, such as the age mix. For example, newborns are more than three times as costly as older children (Table 1) and enrollees who use long-term services and supports (LTSS) are ten times more expensive than enrollees who do not use LTSS (Table 2). Demographic changes within an eligibility group (e.g., an increasing share of aged enrollees using LTSS) could put external pressure on average spending within an eligibility group. Furthermore, there are approximately 7 million enrollees that receive only limited Medicaid benefits (MACPAC 2016c).<sup>1</sup> Spending on these groups differs from the larger categorical groups discussed above, and significant enrollment of these individuals could skew the calculation of the caps.

Finally, as is done in Section 1115 waivers, policymakers could also allow states to exceed the caps for a particular group as long as overall spending remained under an aggregate cap. This approach would allow states to cross-subsidize categories of enrollees—for example, allowing savings accrued for children to be used for people with disabilities—while constraining spending overall.



**TABLE 1.** Average Benefit Spending Per FYE for Children by Eligibility and Age Group, FY 2013

| Age group        | Eligible on basis other than disability | Eligible on basis of disability |
|------------------|---|---------------------------------|
| Less than 1 year | \$9,172                                 | \$95,428                        |
| 1–5 years        | 2,709                                   | 24,622                          |
| 6–14 years       | 2,232                                   | 15,223                          |
| 15–20 years      | 3,143                                   | 17,307                          |
| <b>Total</b>     | <b>\$2,863</b>                          | <b>\$17,950</b>                 |

**Notes:** FYE is full year equivalent. FY is fiscal year. Includes federal and state funds. Excludes spending for administration. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Excludes Idaho, Louisiana, and Rhode Island due to data reliability concerns regarding the completeness of monthly claims and enrollment data.

**Sources:** MACPAC analysis, 2017, of Medicaid Statistical Information System data as of December 2015 and CMS-64 Financial Management Report net expenditure data from the Centers for Medicare & Medicaid Services as of June 2016.

**TABLE 2.** Average Benefit Spending Per FYE by Use of Long-Term Services and Supports, FY 2013

| Use of LTSS    | Total           | Child          | Adult          | Disabled        | Aged            |
|----------------|-----------------|----------------|----------------|-----------------|-----------------|
| Using LTSS     | <b>\$44,936</b> | \$26,481       | \$27,410       | \$54,293        | \$39,275        |
| Not using LTSS | <b>4,403</b>    | 2,674          | 4,068          | 10,403          | 5,429           |
| <b>Total</b>   | <b>\$7,067</b>  | <b>\$2,866</b> | <b>\$4,197</b> | <b>\$18,145</b> | <b>\$15,557</b> |

**Notes:** FYE is full year equivalent. FY is fiscal year. LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Excludes Idaho, Louisiana, and Rhode Island due to data reliability concerns regarding the completeness of monthly claims and enrollment data.

**Sources:** MACPAC analysis, 2017, of Medicaid Statistical Information System data as of December 2015 and CMS-64 Financial Management Report net expenditure data from the Centers for Medicare & Medicaid Services as of June 2016.

**Growth factors.** Decisions regarding growth factors reflect the policy goal of reform, for example, aligning growth rates across health programs or pegging growth to national income or different measures of inflation (Table 3). Additionally, policymakers could consider including additional factors that take into account changes in enrollment mix (such as the aging of the population). The growth factor could also be adjusted to incorporate increases in costs that are not captured in the inflationary measure (such as accounting for the increased Medicaid costs in response to the opioid crisis). The current congressional debate has focused on limiting spending growth; both houses of Congress have selected factors that are



lower than the expected growth under current law. For more information on growth rates, see [Medicaid per Person Spending: Historical and Projected Trends Compared to Growth Factors in Per Capita Cap Proposals](#).

**AHCA spending limits.** The AHCA would shift federal Medicaid financing from an open-ended match to a per capita cap. Aggregate spending would be capped based on per-enrollee spending caps for each Medicaid eligibility group, trended forward to the applicable year, and multiplied by the number of enrollees in each eligibility group. Beginning in 2020, if a state spends over its cap, its federal reimbursement is reduced in the subsequent year.

The House-passed bill uses both fiscal years (FYs) 2016 and 2019 in establishing base-year spending. Specifically, FY 2019 spending (excluding non-disproportionate share hospital (DSH) supplemental payments) for each eligibility group is adjusted by the proportion of non-DSH supplemental payments in FY 2016. FY 2019 is then further adjusted by comparing FY 2019 actual spending to FY 2016 spending that has been trended forward using the medical care component of the consumer price index (CPI-M).

A number of populations are excluded from the per capita cap, such as individuals covered using State Children’s Health Insurance Program (CHIP) funding, individuals who receive health care from the Indian Health Service, individuals who receive services under the Breast and Cervical Cancer Treatment program, partial benefit enrollees (e.g., emergency services, family planning, and dually eligible only receiving Medicare cost-sharing assistance, often referred to as partial duals), individuals enrolled in premium assistance, and enrollees covered under the block grant option.

Separate per capita amounts are calculated for five eligibility groups—aged, blind and disabled, children under age 19, non-expansion adults, and the new adult group that became eligible under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). However, no further adjustments, for example, age or health status, are made to the caps, with the exception, as discussed above, that non-DSH supplemental payments are distributed across the eligibility groups based on their use in FY 2016. Beginning in 2020, spending is capped at the aggregate level, meaning that spending for any particular individual or eligibility group may exceed the cap, as long as total spending across all eligibility groups is below the aggregate cap.

The AHCA uses CPI-M in calculating per capita caps. To calculate the provisional target in FY 2019, an adjustment is made to FY 2019 spending by comparing it to FY 2016 spending that has been trended forward to FY 2019 by CPI-M. In establishing the caps from 2020 on, the growth factors are specified for each eligibility group. The growth factor for children, non-expansion adults, and new adults is CPI-M. The growth factor for individuals over age 65 and people with disabilities, it is CPI-M plus one percentage point (Table 4). The growth factors under the AHCA exceed projected growth in spending for individuals over age 65 and people with disabilities in most years; however, the growth factors are below projected spending increases for children, non-expansion adults, and expansion adults. Because of these higher growth rates, states with a higher proportion of enrollees over age 65 and enrollees with disabilities would have a higher aggregate cap (Figure 3).



**TABLE 3.** Historical and Projected Average Annual Growth in Medicaid Spending per Enrollee and Various Benchmarks, by Calendar Year

|   | 2010  | 2011 | 2012  | 2013 | 2014  | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|-------|------|-------|------|-------|------|------|------|------|------|------|------|------|------|------|------|
| <b>Average annual percent growth in spending per enrollee by source of coverage</b> |       |      |       |      |       |      |      |      |      |      |      |      |      |      |      |      |
| Medicaid <sup>1</sup>   | -1.0% | 3.0% | -3.6% | 4.1% | -0.3% | 3.8% | 1.1% | 1.6% | 4.5% | 4.5% | 4.6% | 4.6% | 4.7% | 4.8% | 5.1% | 5.2% |
| Medicare  | 1.7   | 2.6  | 0.3   | 0.0  | 1.9   | 2.2  | 1.4  | 3.2  | 4.7  | 5.2  | 5.2  | 4.7  | 4.8  | 5.0  | 4.7  | 4.0  |
| Private health insurance <sup>2</sup>   | 5.9   | 4.1  | 1.8   | 2.3  | 3.3   | 4.5  | 5.0  | 5.9  | 5.2  | 5.1  | 4.2  | 4.6  | 4.7  | 4.7  | 4.7  | 4.6  |
| <b>Average annual percent growth in prices and economic output</b>                  |       |      |       |      |       |      |      |      |      |      |      |      |      |      |      |      |
| CPI-U   | 1.6%  | 3.2% | 2.1%  | 1.5% | 1.6%  | 0.1% | 1.2% | 2.4% | 2.3% | 2.3% | 2.4% | 2.4% | 2.4% | 2.4% | 2.4% | 2.4% |
| CPI-M <sup>3</sup>  | 3.4   | 3.0  | 3.7   | 2.5  | 2.4   | 2.6  | 3.8  | 3.8  | 4.3  | 4.2  | 4.2  | 4.2  | 4.2  | 4.2  | 4.2  | 4.2  |
| GDP   | 3.8   | 3.7  | 4.1   | 3.3  | 4.2   | 3.7  | 2.9  | 4.2  | 3.9  | 3.6  | 3.5  | 3.8  | 3.9  | 4.0  | 4.0  | 4.0  |

**Notes:** Figures represent growth over the prior year. CPI-U is consumer price index for all urban consumers. CPI-M is the medical care component of the CPI-U. GDP is gross domestic product.

<sup>1</sup> Medicaid per person spending growth includes federal and state spending on Medicaid benefits and administration.

<sup>2</sup> Private health insurance includes employer-sponsored coverage and direct purchase coverage and medical spending and corresponding net costs of property and casualty insurance. Direct purchase coverage includes Medicare supplemental and individually-purchased plans, including plans purchased on the exchanges.

<sup>3</sup> CPI-M are from the Office of the Actuary (OACT), Centers for Medicare & Medicaid Services. In their scoring of the American Health Care Act, the Congressional Budget Office (CBO) projected that CPI-U medical care would grow at an average annual rate of 3.7 percent from 2017–2026.

**Sources:** MACPAC compilation of CPI data from the Bureau of Labor Statistics; CBO, 2017, *Budget and economic data*, <https://www.cbo.gov/about/products/budget-economic-data#3>; and OACT, 2017, *National health expenditure amounts by type of service and source of funds, CY 1960–2015* and *National health expenditure amounts by type of expenditure and source of funds: CY 1960–2025 in projections format*, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html>.





**TABLE 4.** Projected Growth in Medicaid Spending per Enrollee by Eligibility Group under Current Law Compared to AHCA and BCRA Growth Factors, FYs 2020–2025

|  | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 + |
|--|------|------|------|------|------|--------|
| <b>Aged and disabled</b>                           |      |      |      |      |      |        |
| AHCA growth factor (CPI-M +1)                      | 5.2% | 5.2% | 5.2% | 5.2% | 5.2% | 5.2%   |
| BCRA growth factor (CPI-M +1/CPI-U) <sup>1</sup>   | 5.2  | 5.2  | 5.2  | 5.2  | 5.2  | 2.4    |
| Projected spending - aged                          | 4.1  | 3.9  | 4.0  | 4.1  | 4.3  | 4.4    |
| Projected spending - disabled                      | 4.8  | 5.0  | 5.1  | 5.2  | 5.3  | 5.3    |
| <b>Child, non-expansion adult, expansion adult</b> |      |      |      |      |      |        |
| AHCA growth factor (CPI-M)                         | 4.2% | 4.2% | 4.2% | 4.2% | 4.2% | 4.2%   |
| BCRA growth factor (CPI-M/CPI-U) <sup>1</sup>      | 4.2  | 4.2  | 4.2  | 4.2  | 4.2  | 2.4    |
| Projected spending - child                         | 4.8  | 4.8  | 4.9  | 4.9  | 5.0  | 5.0    |
| Projected spending - non-expansion adult           | 5.2  | 5.1  | 5.2  | 5.2  | 5.3  | 5.3    |
| Projected spending - expansion adult               | 5.6  | 5.5  | 5.5  | 5.5  | 5.6  | 5.6    |

**Notes:** Figures represent growth over the prior year. AHCA is American Health Care Act. BCRA is Better Care Reconciliation Act. FY is fiscal year. CPI-M is the medical care component of the consumer price index for all urban consumers. CPI-U is the consumer price index for all urban consumers. Annual change in spending per enrollee calculated using Centers for Medicare & Medicaid Services Office of the Actuary (OACT) projections for benefit spending per enrollee. These figures include some spending (e.g., DSH, Medicare cost-sharing) and populations (e.g., partial benefit enrollees) that would not be included under the AHCA per capita cap. <sup>1</sup> Beginning in fiscal year 2025, the BCRA reduces the growth factor from CPI-M plus one percentage point for the aged and disabled, and CPI-M for children and adults to CPI-U.

**Sources:** MACPAC analysis of OACT, 2017, *2016 Actuarial Report on the Financial Outlook for Medicaid* and CBO, 2017, *Budget and economic data*, <https://www.cbo.gov/about/products/budget-economic-data#3>.

**BCRA spending limits.** The spending limits established in the Senate discussion draft are similar to those in the House bill, with a few key differences.

Under the Senate bill, states may choose a period of eight consecutive fiscal quarters between the first quarter of FY 2014 and the third quarter of FY 2017. Spending in this two-year period is divided by two to make it an annual number. The ability to select a two-year spending window to serve as a base period may address some of the concerns regarding year-to-year variation. It also potentially allows states to select a period with higher per capita spending than the base period (FY 2016) used in the AHCA.



The per capita allotments in the Senate bill apply to the same five eligibility groups as the House bill, except that the Senate bill excludes children under age 19 who qualify on the basis of disability from the caps.

The Senate bill uses the same growth factors as the House bill in establishing the initial 2019 targets and inflating the caps through FY 2024; however, beginning in FY 2025, the consumer price index for all urban consumers (CPI-U) is used as the trend rate going forward for all eligibility groups (Table 4). As discussed above, the growth factors under the BCRA typically exceed projected growth in spending for the aged and disabled categories, but are below projected spending growth for children, non-expansion adults, and expansion adults through FY 2024. Beginning in FY 2025, when the growth rate changes to CPI-U, the projected spending growth for all groups exceeds the CPI-U factor used in the Senate bill.

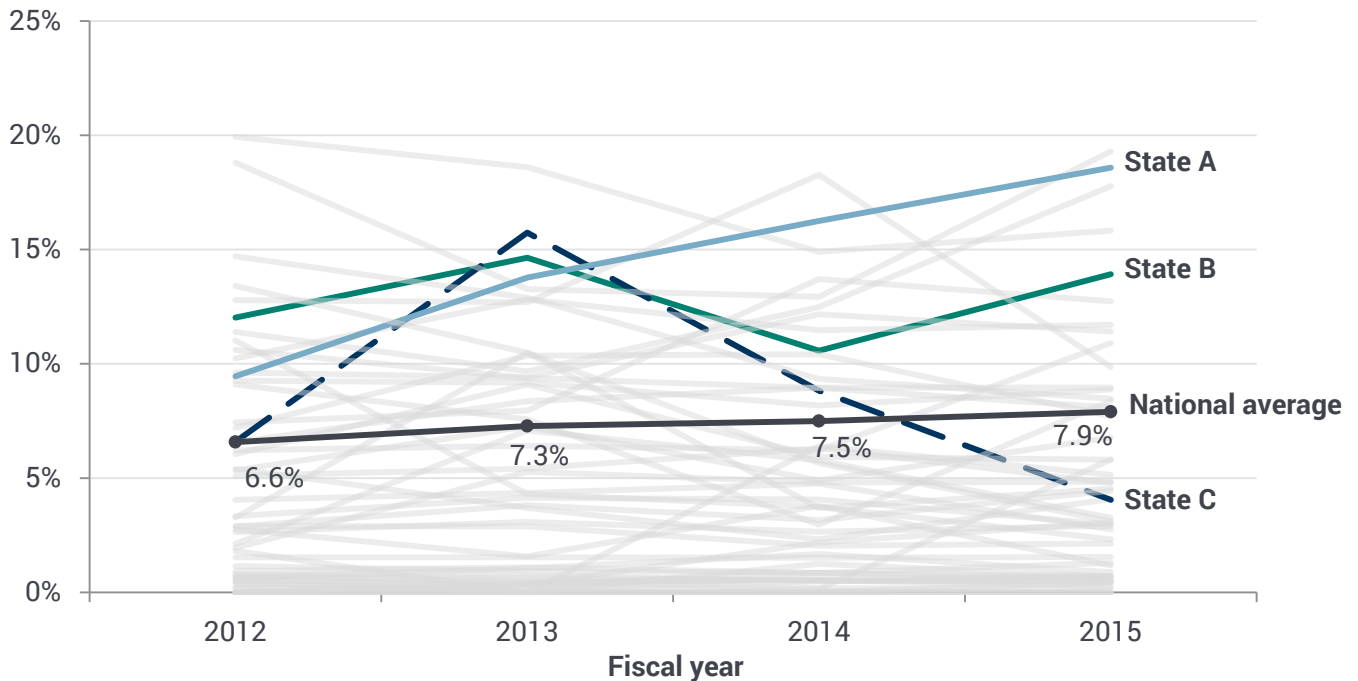
Finally, the Senate bill adds a provision beginning in FY 2020 that adjusts the target per capita cap for states with spending 25 percent above or below the national average based on the prior year of spending. The caps will be adjusted upward for states with lower spending or downward for states with higher spending by an amount determined by the Secretary of the U.S. Department of Health and Human Services that ranges between 0.5 and 2 percent. In FYs 2020 and 2021, the comparison will be at the overall level, and in subsequent years, the comparison will be made at the enrollee group level.<sup>2</sup>

This adjustment does not apply to states that have a population density of less than 15 people per square mile. Five states—Alaska, Montana, North Dakota, South Dakota, and Wyoming—meet this criteria based on 2010 census data. This approach would decrease the caps in the high-spending states and could potentially increase the caps in low-spending states (if they are able to increase their own spending to draw down the higher cap), compressing variation in state-level spending toward the mean. However, given the lag in reporting spending information, states will not know how their prior year of spending compares to other states until the second quarter of the current fiscal year, at which point it may be impossible (due to legislative and budget cycles) for the state to respond to the changes in federal financing amounts. States typically set their budgets in the spring prior to the start of their fiscal year, which unlike the federal fiscal year begins July 1 in most states.

## Deciding which programmatic pieces to include

In designing per capita caps, 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 affect the level of federal savings. Policymakers could also consider establishing separate caps for certain expenses, for instance, administrative costs, IT system development, or targeted payments to providers, such as DSH or other supplemental payments. If lump-sum payments are included, states would need to make decisions about how to allocate them across eligibility groups. Furthermore, there is a great deal of state variation in the use of supplemental payments, as well as fluctuation year-to-year in their use, reflecting different state policy choices and economic conditions (Figure 4). Whether and how these payments are included in the calculation of a per capita cap could affect the amount of federal funds states receive.



**Figure 4.** Non-DSH Supplemental Payments as a Percent of Total Spending, FYs 2012–2015

**Notes:** FY is fiscal year. Non-DSH supplemental payments include supplemental payments made under the upper payment limit and uncompensated care pool, delivery system reform incentive payments, designated state health programs, and other supplemental payments made under Section 1115 wavier authority. Total spending excludes disproportionate share hospital payments and Medicare premiums and coinsurance.

**Source:** MACPAC analysis, 2017, of FYs 2008–2013 CMS-64 Financial Management Report net expenditure data from the Centers for Medicare & Medicaid Services, as of June 2016.

**AHCA-excluded expenditures.** Under the House-passed bill, certain expenditures are excluded from the caps. These include DSH payments, Medicare cost sharing, payments made under the Vaccines for Children program, and administrative costs. In addition, safety net provider payment adjustments that are included in the AHCA for non-expansion states are also excluded when calculating the caps. (For more on the changes to DSH allotments under the AHCA, see MACPAC’s issue brief, *Medicaid DSH Allotments: How Could Funding for Safety-Net Hospitals Change in 2018?*). It is assumed that all other funds not mentioned in the bill language (such as graduate medical education) would continue to be funded using the current matching structure

As discussed above, non-DSH supplemental payments are included in the per capita caps, but are apportioned across eligibility groups and adjusted to reflect the same proportion of total spending that was in place in FY 2016. Their inclusion in the caps accounts for payments states may make to certain providers, such as hospitals, that would not otherwise be captured in per capita spending. However, benchmarking states’ use of supplemental payments to their FY 2016 levels may limit states’ options to



adjust payments to providers, other than through rate increases, and could also affect states' ability to raise the non-federal share of Medicaid funds.

**BCRA-excluded expenditures.** The Senate bill excludes the same expenditures and accounts for non-DSH supplemental payments in the same manner as the House bill but uses the state's selection for the base period instead of FY 2016.

## Defining the level of state contribution

Given the size of state and local contributions to Medicaid, policymakers will need to specify expectations regarding continued state financing as the federal portion of the program is restructured. For example, this could be done under an extension of the existing matching structure using the federal medical assistance percentage (FMAP) or take the form of some type of maintenance-of-effort requirement. If the FMAP remains, 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 could reexamine the manner in which states can raise the non-federal share and what are considered allowable (i.e., matchable) state expenses. The Medicaid statute currently permits states to generate their share of Medicaid expenditures through multiple sources, and 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.<sup>3</sup>

**AHCA state contribution.** Under the House-passed bill, the existing matching structure remains in place; however, federal match would only be available up to the aggregate amount of spending as determined by the per capita caps. States would be responsible for financing any spending above the per capita caps. As discussed above, certain expenses are excluded from the caps and are assumed to continue to be matched at the existing rate. Furthermore, there is no change to the funds states can use as their non-federal share.<sup>4</sup>

**BCRA state contribution.** The Senate draft also maintains the existing matching structure, with federal match available up to the aggregate amount of spending as determined by the per capita caps. However, the bill limits the states' ability to finance Medicaid through provider taxes by phasing down the existing safe harbor threshold from the current 6 percent to 5 percent in 2025. All states, except Alaska, currently raise the non-federal share through an approach that includes provider taxes and the majority of them have provider taxes for multiple provider types above 5 percent (KFF 2017). If states exceed the revised safe harbor threshold, they may need to find additional sources of revenue to fund Medicaid.

## 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.



Constraints in the growth in federal Medicaid funding typically have been discussed in connection with increases in state flexibility. 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, diminish burdens associated with meeting federal requirements, and reduce both state and federal spending.

Others have raised concerns that a system with greater flexibility would lessen state accountability. Given that Medicaid is funded with federal dollars, they note the importance of retaining strong federal oversight of how states are spending federal funds and evaluating whether funds are being used effectively. The current 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. Under any alternative approach, policymakers will need to decide what level of 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.

**AHCA state flexibility and accountability.** Overall, there is relatively little change to the level of state flexibility under a per capita cap approach (although states are provided significant flexibility if they adopt the block grant option). States have the option of extending a work requirement to non-disabled, non-elderly, non-pregnant adults. It is also important to note that the AHCA adds requirements for states, for example with regard to counting certain assets related to eligibility for LTSS and conducting eligibility redeterminations every six months for the new adult group.

The House-passed bill also adds a requirement for states to report expenditures by enrollment category on the existing CMS-64 form, which states must submit quarterly to claim reimbursement for expenses. Currently, states only report this information at the aggregate level.

States are given an increase in the administrative match rate associated with the implementation of a work requirement, six-month renewal periods, and data reporting on the CMS-64.

**BCRA state flexibility and accountability.** Similar to the House bill, the Senate bill does not offer states considerable new flexibility under a per capita cap approach. Like the House bill, the Senate bill includes a block grant option, but the requirements associated with it are more extensive than in the House bill.

Under the Senate bill, states also have the option of extending a work requirement to non-disabled, non-elderly, non-pregnant adults, but the bill does not include specific income and asset counting requirements as the House bill does. The Senate bill also gives states the ability to conduct redeterminations every six months for individuals eligible under the Medicaid expansion (a requirement in the House bill).

In addition to the changes to the CMS-64 in the House bill, the Senate bill also adds reporting requirements related to expenditures associated with inpatient psychiatric hospital services, and data related to children with complex medical conditions.

Under the Senate bill, states receive the enhanced match for data reporting requirements only if they select the most recent eight quarters to serve as their base period. The other increases in the administrative match rate are the same as in the House bill.



## Potential Effect on States and Enrollees

Changes to the federal financing approach will inevitably affect state budgets and the more than 70 million people who are now covered by Medicaid. While the specific effects will depend on the level of federal funding and how states respond, the AHCA and the BCRA were designed to constrain the growth in federal spending. The Congressional Budget Office (CBO) estimates that the House bill would reduce federal outlays for Medicaid by \$834 billion and that the Senate bill would reduce outlays by \$772 billion over the 2017-2026 period. CBO also estimates that both bills would also result in lower Medicaid enrollment (14 million under the House bill and 15 million under the Senate bill by 2026), although such reductions also reflect the effects of other provisions such as eliminating the enhanced matching rate for the new adult group (CBO 2017a, CBO 2017b).

States currently have incentives both to be prudent with state dollars and to maximize the federal contribution. Some critics suggest that the open-ended match does not promote efficiency, because the more states spend, the more federal dollars they receive. As a result, the current financing structure may encourage states to substitute federal funds for state funds, for example, by converting formerly state-funded programs or services to Medicaid in order to draw down federal match. 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 prudent with their own spending, as evidenced by state legislative debates on Medicaid policy changes as part of their annual or biennial budgets and the many actions states have taken to find savings and efficiency in their Medicaid programs.

Under the existing financing arrangement, the risks of increased costs due to the costs of medical care and enrollment growth are shared between the states and the federal government. Under a restructured program, the balance could shift and may lead states to different responses in terms of benefits, eligibility, and the delivery of services. 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 are substantial. States may raise revenues, cut other programs to provide additional funding to Medicaid, or reduce spending in Medicaid.

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 state revenues and enrollees would see little change. However, the experience of the last recession showed that as states struggled to raise the revenue needed to close budget gaps in their Medicaid programs they 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 again turn to provider rate cuts, which could discourage provider participation and possibly diminish access to services.

Additionally, some providers, such as federally qualified health centers 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 2017a).



Changes to Medicaid also would be likely to have spillover effects due to statutory relationships 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 (i.e., 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 helps cover the cost of some of these services for eligible students (CMS 2003). As a result, major changes to Medicaid could affect the ability of beneficiaries to access other needed services, limit funds available to states or agencies, and increase demand for services provided by other programs.

## Endnotes

<sup>1</sup> Individuals receiving limited benefits include those receiving only emergency services or family planning services, and dually eligible beneficiaries only receiving Medicare cost-sharing assistance (often referred to as partial duals).

<sup>2</sup> These adjustments must be budget neutral in that it does not result in a net increase in federal spending. In addition, the adjustment is disregarded when determining the target amount for the succeeding year.

<sup>3</sup> For more on the use of provider taxes, see MACPAC's fact sheet: *Health Care Related Taxes in Medicaid*.

<sup>4</sup> The AHCA decreases the target total expenditures calculated under the per capita cap for required expenditures for certain political subdivisions. This provision applies to states that had a DSH allotment for FY 2016 more than six times the national average DSH allotment (only New York qualifies) and requires political subdivisions to contribute funds towards medical assistance for a fiscal year (beginning with FY 2020). The target total expenditures will be decreased by the amount that political subdivisions are required to contribute without reimbursement from the state. Exceptions include contributions from political subdivisions with populations of more than 5 million (i.e., New York City) and contributions required from administrative expenses. This provision was unchanged in the Senate bill.

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