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Committee on Energy and Commerce,
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Changes to Funding Formula Could Improve Allocation of Funds to States

Statement of Carolyn L. Yocom
Director, Health Care

GAO Highlights

Highlights of [GAO-16-377T](#), a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Medicaid, a joint federal-state health care program for low income and medically needy individuals, is a significant component of federal and state budgets, with estimated outlays of \$529 billion in fiscal year 2015. States and the federal government share in the financing of the Medicaid program, with the federal government matching state expenditures for Medicaid services on the basis of the FMAP formula. The FMAP is the percentage of expenditures for most Medicaid services that the federal government pays. In prior reports, GAO has examined multiple concerns regarding how the FMAP formula allocates funds among states, including during times of economic downturn, and has suggested possible improvements.

This statement highlights (1) alternative measures for allocating Medicaid funds across states, and (2) better allocating financial assistance to state Medicaid programs during economic downturns. This testimony is based on GAO reports issued between 2003 and 2015 on federal financing of the Medicaid program.

What GAO Recommends

To ensure that federal funding efficiently and effectively responds to Medicaid's countercyclical nature, GAO recommended that Congress could consider enacting an FMAP formula that targets variable state Medicaid needs and provides automatic, timely, and temporary assistance in response to national economic downturns.

View [GAO-16-377T](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

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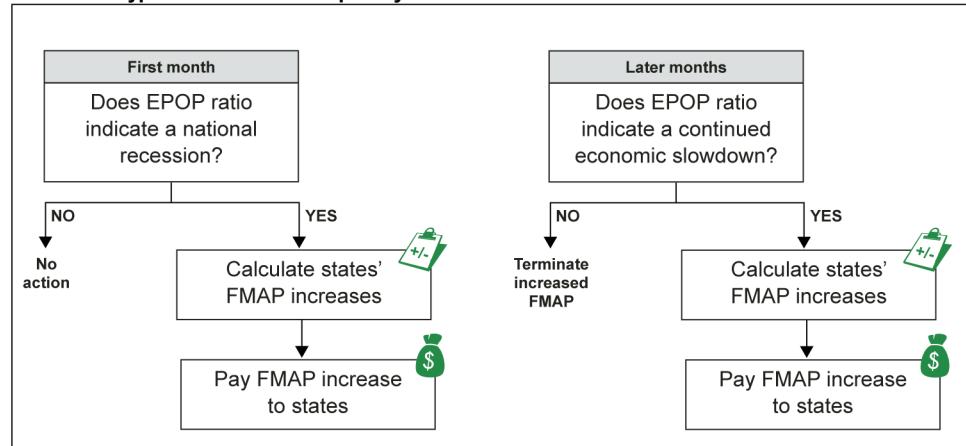
Changes to Funding Formula Could Improve Allocation of Funds to States

What GAO Found

In prior work, GAO identified alternative measures that could be used to allocate Medicaid funding to states more equitably than the current Federal Medical Assistance Percentage (FMAP) formula, which uses per capita income (PCI) to calculate each state's federal matching rate. GAO found that PCI is a poor proxy for both the size of a state's population in need of Medicaid services and the ability of a state to fund Medicaid. GAO identified data sources, such as nationally representative federal surveys, which could be used to develop measures of the demand for Medicaid services, geographic cost differences, and state resources. These measures could be combined to provide a basis for allocating funds more equitably among states than the current FMAP.

GAO has found that, during economic downturns—when Medicaid enrollment can rise and state economies weaken—the FMAP formula does not reflect current state economic conditions, and that past efforts to provide states with temporary increases in the FMAP were not as timely or responsive as they could have been. To be effective at stabilizing states' funding of Medicaid programs during such periods, assistance should be provided—or at least authorized—close to the beginning of a downturn. Additionally, to be efficient, funds should be targeted to states commensurate with their level of need due to the downturn. To help ensure that federal funding efficiently and effectively responds to states' needs during economic downturns, GAO developed a prototype formula that offers an option for providing temporary automatic, timely, and targeted assistance during a national economic downturn through an increased FMAP. The formula's automatic trigger would use readily available economic data (e.g., the monthly employment-to-population ratio or EPOP) to begin assistance. Targeted state assistance would be calculated based on (1) increases in state unemployment and (2) reductions in total wages and salaries.

GAO Prototype Formula for Temporary Increased FMAP Assistance to States



Source: GAO. | GAO-16-377T

Improving the responsiveness of federal assistance to states during economic downturns would facilitate state budget planning, provide states with greater fiscal stability, and better align federal assistance with the magnitude of the economic downturn's effects on individual states.

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee:

I am pleased to be here today to discuss our work on the Medicaid program, more specifically our work examining the Federal Medical Assistance Percentage—the FMAP. The federal government and states share in the financing of the Medicaid program, with the federal government matching most state expenditures for Medicaid services on the basis of the FMAP formula.¹ The FMAP is the percentage of expenditures for most Medicaid services that the federal government pays; the remainder is referred to as the state share. Under the FMAP, the federal government pays a larger portion of Medicaid expenditures in states with low per capita incomes (PCI) relative to the national average, and a smaller portion for states with higher PCIs. PCI is used in the formula as a proxy for both state funding ability and the low-income population in need of Medicaid services in each state.² The FMAP formula uses a 3-year average of PCI, the effect of which is to smooth out fluctuations in state PCI so that it reflects longer-term trends rather than short-term fluctuations of the business cycle. This smoothing effect helps minimize year-to-year changes in federal matching funds, which could be disruptive to states' budget planning. However, states can struggle to

¹The FMAP is calculated annually using the following formula: $FMAP = 1.00 - 0.45 \times (\text{state per capita income (PCI)} / \text{U.S. PCI})^2$. PCI is calculated by the U.S. Bureau of Economic Analysis. Federal law specifies that the FMAP will be no lower than 50 percent and no higher than 83 percent. See 42 U.S.C. § 1396d(b). The Department of Health and Human Services is required to publish FMAPs for states between October 1 and November 30 of each fiscal year. 42 U.S.C. §§ 1301(a)(8)(B). For fiscal year 2016, states' FMAPs range from 50.00 percent to 74.17 percent. Under the Patient Protection and Affordable Care Act (PPACA), state Medicaid expenditures for certain Medicaid enrollees, newly eligible under PPACA, are subject to a separately calculated FMAP, which is higher than the regular FMAP—the “PPACA-expansion FMAP.” Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (2010). States also receive an FMAP above the state's regular FMAP, but below the PPACA-expansion FMAP, for their Medicaid expenditures for the state-expansion enrollees—those who would not have been eligible for Medicaid prior to PPACA except that they were covered under a state's pre-PPACA “expansion” of eligibility through, for example, a Medicaid demonstration. The formula used to calculate the state-expansion FMAP rates is based on a state's regular FMAP rate. In this statement, we use the term FMAP to refer to the regular FMAP rate. We use the term increased FMAP to refer to temporary FMAP increases above the regular FMAP, as authorized under federal law, that provided states with additional Medicaid funding during national recessions.

²Squaring PCI has the effect of making PCI appear in the formula twice as an attempt to reflect both state resources and the population in need of Medicaid services.

finance their Medicaid programs during economic downturns, when program enrollment increases and available state revenues decline.

My remarks today focus on the FMAP and options for (1) more equitably allocating Medicaid funds across states, and (2) better targeting assistance to states to address increased Medicaid expenditures during economic downturns.

My remarks are based on GAO's body of work on this issue since 2003, including our July 2015 report on key issues facing the Medicaid program, our May 2013 report on alternative measures for allocating Medicaid funds across states, and our November 2011 report on financial assistance to state Medicaid programs during economic downturns.³ Those reports provide further details on our scope and methodology. We conducted all of the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicaid is designed as a federal-state partnership, and both the federal government and the states play important roles in working to finance the program and meet the health care needs of the low-income and medically needy populations it serves. Medicaid is financed jointly by the federal government and states, administered at the state level, and overseen at the federal level by the Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services. Medicaid is the

³See GAO, *Medicaid Formula: Differences in Funding Ability among States Often Are Widened*, GAO-03-620 (Washington, D.C.: July 10, 2003); *Federal Assistance: Temporary State Fiscal Relief*, GAO-04-736R (Washington, D.C.: May 7, 2004); *Medicaid: Improving Responsiveness of Federal Assistance to States during Economic Downturns*, GAO-11-395 (Washington, D.C.: March 31, 2011); *State and Local Governments: Knowledge of Past Recessions Can Inform Future Federal Fiscal Assistance*, GAO-11-401 (Washington, D.C.: March 31, 2011); *Medicaid: Prototype Formula Would Provide Automatic, Targeted Assistance to States during Economic Downturns*, GAO-12-38 (Washington, D.C. Nov. 10, 2011); *Medicaid: Alternative Measures Could Be Used to Allocate Funding More Equitably*, GAO-13-434 (Washington, D.C.: May 10, 2013); and *Medicaid: Key Issues Facing the Program*, GAO-15-677 (Washington, D.C.: July 30, 2015).

Compared with the FMAP Formula, Alternative Funding Measures Exist that Could More Equitably Allocate Medicaid Funds across States

nation's largest health program as measured by enrollment and the second largest health program, after Medicare, as measured by expenditures. It is a significant component of federal and state budgets, with estimated outlays of \$529 billion in fiscal year 2015, of which \$320 billion was expected to be financed by the federal government and \$209 billion by the states.⁴ By 2023, the CMS Office of the Actuary projects that Medicaid expenditures will total \$835 billion, with federal expenditures alone totaling \$497.4 billion.

In our May 2013 report, we identified alternative measures that could be used to allocate Medicaid funding to states more equitably than the current FMAP formula, which is based solely on PCI. In our July 2003 report, we found that PCI is a poor proxy for the size of a state's population in need of Medicaid services, as two states with similar PCIs can have substantially different numbers of low-income residents.⁵ Moreover, we found that PCI does not take into account differences across states in the health care service needs of this population, nor does it include any measure of geographic differences in the costs of providing health care services, which can vary widely. Finally, we found that although PCI measures the income received by state residents—such as wages, rents, and interest income—it does not include other components of a state's resources that affect its ability to finance Medicaid, such as corporate income produced within the state, but not received by state residents.

To be equitable from the perspective of beneficiaries and allow states to provide a comparable level of services to each person in need, we have reported that a funding allocation mechanism should take into account the demand for services in each state and geographic cost differences among states. To be equitable from the perspective of taxpayers, we have reported that an allocation mechanism should ensure that taxpayers

⁴Centers for Medicare & Medicaid Services, Office of the Actuary, *2014 Actuarial Report on the Financial Outlook for Medicaid* (Washington, D.C.: 2015).

⁵For example, we reported in 2003 that the District of Columbia and Connecticut had similar per capita incomes, but the share of the District's population in poverty was more than twice Connecticut's. The District of Columbia is one of two states that receive special federal matching rates set in statute that give them higher matching rates than they would have received solely on the basis of PCI. See [GAO-03-620](#).

in poorer states are not more heavily burdened than those in wealthier ones, by taking into account state resources.

We reported that revisions to the current FMAP formula could more equitably allocate Medicaid funds to states. We identified multiple data sources that could be used to develop measures of the demand for Medicaid services, geographic cost differences, and state resources.⁶ We reported that these measures could be combined in various ways to provide a basis for allocating Medicaid funds more equitably among states than the current FMAP.

- **Demand for services.** A measure of the demand for Medicaid services should account for both the size of the target population in need of services and the health service needs of that population. Nationally representative federal surveys, such as the U.S. Census Bureau's American Community Survey and Current Population Survey, are available data sources that can be used to directly estimate the number of persons residing in each state with incomes low enough to qualify them as potentially in need of Medicaid services. These estimates can then be adjusted to reflect variation in health service needs within the identified population, using available information from the surveys or from data sources external to the surveys, such as Medicaid data on enrollment or spending.
- **Geographic cost differences.** A measure of geographic cost differences should account for all components of health care costs, including the cost of the personnel who provide services, the cost of medical equipment and supplies, and the rental cost of facilities in which the services are provided. Of these three components, personnel costs represent the greatest share of total costs. National data that can be used to estimate average wages for health care personnel by state include the Occupational Employment Statistics survey conducted by the Bureau of Labor Statistics.
- **State resources.** A measure of state resources should account for all income—regardless of whether the state taxes the income or not. While PCI includes the personal income of state residents, it excludes other taxable income, such as undistributed corporate profits. In contrast, the Total Taxable Resources (TTR) measure, as generated

⁶See GAO-13-434.

by the Department of the Treasury from multiple data sources, comprises not only the income included in PCI, but also other significant sources of taxable income. As a result, nationwide, the TTR measure of income was 42 percent larger on a per capita basis than PCI in 2010, and provided a more comprehensive measure of state resources.

Measures of the demand for services, geographic cost differences, and state resources could be combined in various ways to provide a basis for allocating Medicaid funds equitably among states. For example, when determining states' ability to fund Medicaid services, rather than simply considering total state resources or state resources per capita, a funding formula could reflect state resources in relation to the population in need of Medicaid services—that is, in relation to demand for services. This would result in a more equitable allocation of funding, because two states with similar resources and populations may have very different numbers of residents in need of Medicaid services.

A Revised Medicaid Financing Formula Could Better Target Assistance to States during Economic Downturns

We reported in 2011 that the FMAP formula does not reflect states' current economic conditions, and that efforts to provide states with temporary increases in the FMAP during economic downturns were not as timely or responsive to states' unique economic conditions as they could have been.⁷

During periods of national recessions, Medicaid enrollment and the state funding needed to support the program increase when the number of people with incomes low enough to qualify for Medicaid coverage rises as states' economies weaken.⁸ Moreover, as the economy weakens, states

⁷See GAO-11-395.

⁸States have some flexibility in the design of their Medicaid programs within broad federal parameters. For example, under federal law, states generally must enroll certain mandatory categories of individuals, which include pregnant women and children up to 6 years of age with family income at or below 133 percent of the federal poverty level (FPL), and children ages 6 to 19 with a family income at 100 percent or less of the FPL. States may choose to cover additional categories of individuals, such as pregnant women and infants between 133 and 185 percent of the FPL. Under federal law, states generally are required to cover a specified set of benefits for their mandatory and optional Medicaid populations, such as inpatient and outpatient hospital services. In addition, states may choose to cover optional benefits, such as dental and physical therapy services, for these populations. See 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a).

have reduced revenues with which to fund their share of the Medicaid programs in place prior to the recession. To help states meet additional Medicaid program needs, and to provide fiscal relief, Congress established temporary FMAP increases for states in 2003, 2009, and 2010.⁹ Increased FMAPs help states maintain their Medicaid programs during downturns. They may also free up funds states would otherwise have used for Medicaid and make them available to address other state budget needs. The FMAP is a readily available mechanism for providing temporary assistance to states because assistance can be distributed quickly, with states obtaining funds on a quarterly basis through Medicaid's existing payment system.

However, we have reported that each state can experience different economic circumstances—and thus different levels of change in Medicaid enrollment and state revenues during a downturn.¹⁰ As a result, we found that efforts to provide states with temporary increases in the FMAP were not as responsive to states' unique economic conditions as they could have been.¹¹ We reported that states that experience greater stress in their Medicaid programs—due to increased enrollment or decreased revenues—should receive a larger share of aid than states less severely affected by the economic downturn.

To be effective at stabilizing states' funding of Medicaid programs during times of economic stress, we have found that assistance should be provided—or at least authorized—close to the beginning of a downturn.¹² Additionally, to be efficient, funds should be targeted to states

⁹Congress provided for increases in the regular FMAPs for states through the Jobs and Growth Tax Relief Reconciliation Act of 2003 and the American Recovery and Reinvestment Act of 2009 (Recovery Act). Jobs and Growth Tax Relief Reconciliation Act of 2003, Pub. L. No. 108-27, § 401, 117 Stat. 752, 764 (2003); Recovery Act, Pub. L. No. 111-5, Div. B. Tit.V, § 5001, 123 Stat. 115, 496 (2009). The increased FMAP authorized under the Recovery Act was subsequently extended, subject to certain modifications, by the Education, Jobs, and Medicaid Assistance Act. Pub. L. No. 111-126, Tit. II, Subtit. A, § 201, 124. Stat. 2389, 2393 (2010).

¹⁰See [GAO-11-395](#).

¹¹See [GAO-04-736R](#), [GAO-11-395](#), and [GAO-11-401](#).

¹²As we noted in [GAO-11-395](#), starting assistance closer to the onset of an economic downturn could help states avoid Medicaid program cuts. If states can anticipate assistance, the funds do not need to be received or "in the pipeline" in order to produce the desired effect on state fiscal behavior.

commensurate with their level of need due to the downturn. Automatically providing increased federal financial assistance to states affected by national economic downturns—through an increased FMAP—could help provide timely and targeted assistance that is more responsive to states’ economic conditions than what has been provided through legislation in the past. In addition, economists at the Federal Reserve Bank of Chicago have described the ideal countercyclical assistance program as one having an automatically activated, prearranged triggering mechanism that could remove some of the political considerations from the program’s design and eliminate delays inherent in the legislative process.¹³

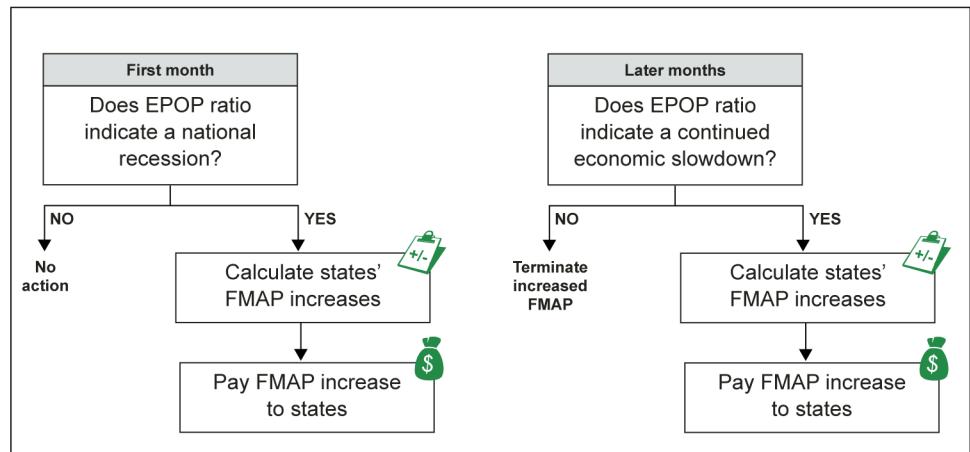
To ensure that federal funding efficiently and effectively responds to the countercyclical nature of the Medicaid program, we have recommended that Congress could consider enacting an FMAP formula that is targeted for variable state Medicaid needs and provides automatic, timely, and temporary increased FMAP assistance in response to national economic downturns.¹⁴ In our November 2011 report, the prototype formula we presented offers such an option. (See fig. 1.) Our prototype formula uses the monthly employment-to-population (EPOP) ratio and a threshold number of states to identify the start of a national economic downturn, and to automatically trigger the start of the increased FMAP assistance.¹⁵ The automatic trigger would use readily available economic data to begin assistance rather than rely on legislative action at the time of a future national economic downturn. Once the increased FMAP is triggered, targeted state assistance would be calculated based on (1) increases in state unemployment, as a proxy for increased Medicaid enrollment; and (2) reductions in total wages and salaries, as a proxy for decreased revenues for maintaining state Medicaid programs. The increased FMAP would end when the EPOP ratio indicated that less than the threshold number of states was in an economic downturn.

¹³Countercyclical aid, such as the Recovery Act’s increased FMAP, is intended to assist states experiencing revenue declines and expenditure increases that are associated with economic downturns. R. Mattoon, V. Haleco-Meyer, and T. Foster, “Improving the impact of federal aid to the states,” *Economic Perspectives*, vol. 34, no. 3 (2010).

¹⁴See GAO-12-38.

¹⁵The employment-to-population ratio is the ratio of the number of jobs in a state to the working age population aged 16 and older. Our prototype formula identifies the start of a national recession and triggers assistance when 26 states show a decrease in their 3-month average EPOP ratio, compared to the same 3-month period in the previous year, over 2 consecutive months.

Figure 1: GAO Prototype Formula for Temporary Increased FMAP Assistance to States



Source: GAO. | GAO-16-377T

Note: The employment-to-population (EPOP) ratio is the ratio of the number of jobs in a state to the working age population aged 16 and older. The Federal Medical Assistance Percentage (FMAP) is used to determine the percentage of federal assistance for most state Medicaid expenditures.

Our prototype formula improves the starting and ending of assistance, accounts for variations in state economic conditions, and responds to state Medicaid needs by providing a baseline for full funding of state Medicaid needs during a downturn. However, the level of funding and other design elements—such as the choice of thresholds for starting, ending, and targeting assistance—are variables that policymakers could adjust depending on circumstances such as competing budget demands, macroeconomic conditions, and other state fiscal needs beyond Medicaid. Improving the responsiveness of federal assistance to states during economic downturns would facilitate state budget planning, provide states with greater fiscal stability, and better align federal assistance with the magnitude of the economic downturn's effects on individual states.

In summary, our past work has found that alternatives to the current FMAP could more equitably allocate funds to states and provide additional support during economic downturns. We also have ongoing work examining Medicaid financing and other aspects of the program, and we look forward to continuing to work with the Congress to further identify improvements.

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions you may have.

GAO Contact and Staff Acknowledgments

For questions about this statement, please contact Carolyn L. Yocom, (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement.

Individuals who made key contributions to this statement include Robert Copeland, Assistant Director; Emily Beller; Robin Burke; Sandra George; and Drew Long.

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