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August 2016

MEDICAID

Key Policy and Data Considerations for Designing a Per Capita Cap on Federal Funding

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GAO-16-726

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GAO Highlights

Highlights of GAO-16-726, a report to congressional requesters

Why GAO Did This Study

Medicaid, a joint-federal state program that finances health care coverage for millions of low-income and medically-needy individuals, is an open-ended entitlement program. Federal and state Medicaid expenditures totaled $494.5 billion in fiscal year 2014 based on the most recent CMS actuarial report, which projected that spending will grow to about $920.5 billion by fiscal year 2024. Medicaid has been the focus of proposals to limit the federal expenditure commitment. One such approach, referred to as a per capita cap, would limit the amount of federal Medicaid funding states could receive per enrollee, adjusting the federal expenditure commitment based on the population covered. Whether to change the financing of the Medicaid program is a decision requiring congressional action. GAO was asked to examine considerations for designing a method to reimburse states on a per capita basis for individuals enrolled in Medicaid.

This report examines key (1) policy and (2) data considerations for designing a per capita cap on federal Medicaid funding. GAO reviewed its prior reports on Medicaid and a range of federal financing topics; conducted a literature review on Medicaid per capita caps; interviewed officials from 10 state Medicaid programs selected to vary in current per-enrollee spending, service delivery methods, and other program characteristics; and held interviews to obtain perspectives of subject matter experts selected on the basis of the literature review.

View GAO-16-726. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

What GAO Found

Through review of its prior reports, the literature and interviews with state Medicaid officials and subject matter experts, GAO identified several key interrelated policy considerations that could be useful should policymakers elect to pursue a per capita cap—a per-enrollee limit on federal Medicaid funding for states.

- **Coverage and flexibility**. Coverage entails decisions about whether all or a subset of Medicaid populations and spending categories would be financed under a per capita cap. Flexibility would entail balancing the ability of the federal government to prescribe program features—such as coverage of a set of services—with states' ability to choose program design features.
- **Allocation of funds across states and over time**. Considerations for allocating funds across states would include the extent to which a cap accounts for variation in the health care needs of states' Medicaid populations, geographic cost differences, state fiscal resources, and program design. Mechanisms to address change over time due to inflation or other changes in circumstances could also be considered.
- **Accountability**. Efforts to ensure accountability for the receipt of federal funds could include determining what existing, modified, or new mechanisms to use to verify the number and eligibility of enrollees covered by the cap. Additionally, accountability mechanisms could include measures aimed at achieving health care goals or tracking the effectiveness of the per capita cap policy in achieving federal objectives.
- **Broader effects**. Considerations would also include the potential effects that changes to Medicaid financing could have on other federally financed sources of health care, broader health care costs, states, and Medicaid enrollees. Such effects would be difficult to predict and would depend on the design features, as well as states' responses to a per capita cap.

Key data considerations for designing a per capita cap would include identifying appropriate data on enrollees and expenditures to help develop per capita cap amounts and allocate funds.

- **Centers for Medicare & Medicaid Services (CMS) enrollee and expenditure data.** CMS data could be used to develop estimates of per enrollee Medicaid expenditures, but the data have limitations; for example, not all CMS expenditure data can be easily linked to enrollees and doing so may require complex adjustments.
- **Other available federal data sources**. Data sources such as nationally representative population surveys could provide estimates of Medicaid enrollee characteristics or other aspects of state funding needs. However, these data sources would need to be combined with information on expenditures for services to identify the funding amounts needed to support particular program goals.

GAO provided a draft of this report to the Department of Health and Human Services for comment. The department had no comments on the draft.

Contents

Abbreviations

CHIP	State Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CPI	consumer price index
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FMAP	Federal Medical Assistance Percentage
FPL	federal poverty level
HHS	Department of Health and Human Services
MCO	managed care organization
MSIS	Medicaid Statistical Information System
MEI	Medicare economic index
PCI	per capita income
PPACA	Patient Protection and Affordable Care Act
T-MSIS	Transformed Medicaid Statistical Information System

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August 10, 2016

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives

Medicaid—a joint federal-state health care financing program for certain low-income and medically needy individuals—is a significant and growing component of federal and state budgets. Federal and state Medicaid expenditures totaled $494.5 billion in fiscal year 2014, with the federal share ($299.1 billion) comprising 61 percent of total spending, and the state share ($195.3 billion) comprising 39 percent.[1] The Centers for Medicare & Medicaid Services (CMS) projected an average annual spending growth rate of 6.4 percent over the next 10 years, with projected expenditures reaching $920.5 billion by fiscal year 2024. This projected growth in expenditures reflects both expected increases in levels of Medicaid enrollment and expected increases in costs per enrollee. On a per-enrollee basis, CMS projected that Medicaid benefit expenditures would increase by an average annual rate of 4.1 percent over the next 10 years. Medicaid is an open-ended entitlement program; states are generally obligated to pay for covered services provided to eligible individuals, and the federal government is obligated to pay its share of a state's expenditures under a federally approved state Medicaid plan.[2]

[1]Data are from the most recently issued Centers for Medicare & Medicaid Services (CMS) actuarial report. See Centers for Medicare & Medicaid Services, Office of the Actuary, *2015 Actuarial Report on the Financial Outlook for Medicaid* (Washington, D.C.: 2015).

[2]In contrast to the 50 states and District of Columbia, total federal Medicaid expenditures for each of five territories of the United States are subject to an overall cap, so that Medicaid expenditures are matched by federal funds, but only until the cap—a maximum federal contribution that is not dependent upon number of enrollees—is reached.

Given the continued expected growth in Medicaid spending as a component of the federal budget, deficit reduction and budget proposals have included various options intended to contain these expenditures, including proposals to restructure Medicaid financing with a goal of controlling increases in Medicaid spending. Legislative and other proposals have included implementing an overall limit on federal Medicaid spending—often referred to as a block grant—or implementing a limit on average federal Medicaid spending per enrollee—referred to in this report as a per capita cap. A per capita cap would not necessarily limit federal spending for any specific enrollee, but could instead limit the total federal funding to an amount equal to the dollar amount of the per capita cap multiplied by the number of enrollees covered by that cap. A key difference between a block grant and a per capita cap is that federal funding provided through a block grant would generally not change in response to program enrollment, whereas federal funding provided through a per capita cap would increase or decrease in accordance with changes in Medicaid enrollment levels. As with establishing a block grant for Medicaid, a Medicaid per capita cap would require legislative action to be established and could be designed and implemented in different ways, depending, in part, on Medicaid program and funding objectives.

Whether to change the financing of the Medicaid program is a decision requiring congressional action. You asked us to examine considerations for policymakers in developing a per capita cap for federal financing of the Medicaid program. This report examines

1. key policy considerations for designing a per capita cap method for financing Medicaid; and
2. key data considerations for designing a per capita cap method for financing Medicaid.

To identify key policy and data considerations for designing a per capita cap financing method for Medicaid, we examined information from a variety of sources. We reviewed prior GAO reports on Medicaid, federal grant financing and accountability issues, and other relevant topics, as well as relevant federal laws and regulations. We also conducted a review of literature related to Medicaid per capita cap proposals, and identified

and reviewed relevant publications.[3] In addition, we interviewed representatives of the American Academy of Actuaries and officials of 10 state Medicaid programs that we selected to ensure inclusion of states that represented variations in Medicaid program characteristics.[4] These characteristics included overall per enrollee spending levels, number of enrollees, extent of use of managed care systems for delivering Medicaid services, whether or not the state chose to expand Medicaid eligibility under the Patient Protection and Affordable Care Act (PPACA), and geographic region.[5] We used these sources of information to initially identify key policy and data considerations. We then obtained perspectives on these considerations through six interviews with authors of publications or representatives of organizations that issued one or more publications that we identified through our literature review. Specifically, we used relevant publications identified through our literature review that were issued from January 2005 through August 2015 by national public policy organizations, government entities, and other researchers to identify expert interviewees. See appendix I for a list of the publications we used to select interviewees. We also obtained perspectives from representatives of CMS and the Congressional Research Service.

[3]We conducted the literature review using the search terms “Medicaid” and “per capita cap*.” Additional search terms we tested for certain databases were “Medicaid” and “spending limit,” “Medicaid” and “per capita,” and “Medicaid” and “per capita limit.”

[4]The selected states were Alabama, Alaska, California, Illinois, Maine, Massachusetts, Michigan, Oregon, Tennessee, and Virginia. We held interviews with officials from 9 of the 10 states and obtained written responses to our interview questions from one of the 10 states. We refer to all the states as interviewees. We cannot generalize our observations from these 10 states to other states.

[5]Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010). For purposes of this report, references to PPACA include the amendments made by HCERA. PPACA authorized states to expand Medicaid coverage under their state plans to include nearly all adults with incomes at or below 133 percent of the federal poverty level (FPL). The law also provides for a 5 percent income disregard when calculating an individual’s income to determine Medicaid eligibility, which effectively raises the eligibility limit for these individuals to 138 percent of the FPL.

In a managed care delivery system, enrollees obtain some portion of their Medicaid services from a managed care organization (MCO) under contract with the state, and capitation payments to MCOs are typically made on a predetermined, per person per month basis.

The policy and data considerations identified through these methods are not exhaustive. In this report, we are not recommending a Medicaid per capita cap financing method or particular design choices for such a method. Rather, our goal was to identify key policy and data considerations for designing a Medicaid per capita cap that could be useful should policymakers elect to pursue a Medicaid per capita cap financing strategy or related approaches to restructuring Medicaid financing in the future.

We conducted this performance audit from March 2015 to August 2016 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

During fiscal year 2014, Medicaid was the source of health care coverage and financing for an estimated 77.6 million low income and medically needy individuals—nearly one-quarter of the U.S. population.[6] Medicaid's diverse enrollee population includes children, adults, individuals who are disabled, and individuals age 65 and over. Medicaid covers a comprehensive set of services, some of which are not generally covered by private health insurance—including services to meet the long-term care needs of individuals who are elderly or disabled. At the federal level, CMS, within the Department of Health and Human Services (HHS), is responsible for overseeing the design and operation of states' Medicaid programs, while states administer their respective Medicaid programs' day-to-day operations.

Medicaid Financing

The federal government and states share in the financing of the Medicaid program, with the federal government matching most state expenditures

[6]This figure represents the estimated total number of individuals ever enrolled in the program during fiscal year 2014. There were an estimated 63.8 million individuals enrolled in the program at any one point in time. See Medicaid and CHIP Payment and Access Commission, *MACSTATS: Medicaid and CHIP Data Book* (Washington, D.C.: December 2015).

for Medicaid services on the basis of a statutory formula known as the Federal Medical Assistance Percentage (FMAP). The FMAP calculates the federal matching rate for each state on the basis of the state's per capita income (PCI) in relation to the national PCI.[7] Under the FMAP, the federal government pays a larger portion of Medicaid expenditures in states with low 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 resources and the state's low-income population in need of Medicaid services.

There are exceptions to the FMAP formula for certain services and certain populations, as illustrated in the following examples.

- States that chose to expand their Medicaid programs under PPACA receive a FMAP of 100 percent beginning in 2014 for expenditures for newly eligible low-income adults, gradually diminishing to 90 percent by 2020.[8]
- The costs of administration are generally matched at 50 percent, although some administrative activities (such as designing, developing, and installing claims processing and information retrieval systems) receive a higher federal matching rate.
- The FMAP for the cost of services furnished to Medicaid-eligible Native Americans and Alaska Natives through the Indian Health Service and tribal facilities is 100 percent.

States finance their share of Medicaid—often called the nonfederal or state share—though various means, including through state general funds appropriated by state legislatures. States have increasingly relied on funds from sources other than state general funds to finance the non-federal share of their programs, sources such as health care provider taxes and funds transferred from local governments and government

[7]The FMAP is calculated annually using the following formula: FMAP = 1.00 – 0.45 (state per capita income (PCI) / 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). For fiscal year 2016, states' FMAPs ranged from 50.00 percent to 74.17 percent.

[8]42 U.S.C. § 1396d(y). Certain states that expanded Medicaid coverage for low-income adults prior to the enactment of PPACA in 2010 may also receive an enhanced FMAP for Medicaid expenditures for this expansion population. 42 U.S.C. § 1396d(z).

health care providers.[9] States' financing of the nonfederal share is subject to federal requirements. For example, states must use state general funds to finance at least 40 percent of the nonfederal share of total Medicaid expenditures each year.

Current Medicaid Program Requirements and State Flexibility

The Social Security Act, which Congress amended in 1965 to establish the Medicaid program, provides the statutory framework for the program, setting broad parameters for states that choose to participate. As a comprehensive health benefit program for vulnerable populations, each state Medicaid program must, under current law, cover certain categories of individuals and a broad array of benefits. Within these requirements, however, the Medicaid program allows for substantial flexibility for states to design and implement their programs, resulting in more than 50 distinct state-based programs.[10] In addition, the Secretary of HHS may waive certain federal Medicaid requirements and approve costs not otherwise eligible for federal matching funds for experimental, pilot, or demonstration projects that are likely to promote Medicaid objectives.[11] For example, states may receive approval for demonstrations to extend Medicaid coverage to populations that would not otherwise be eligible under Medicaid rules, or to alter the state's benefit package for certain covered populations. HHS has also approved demonstrations for a variety of other purposes.[12] The flexibility afforded to states has implications for

[9]See GAO, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, GAO-14-627 (Washington, D.C.: July 29, 2014).

[10]Medicaid programs are administered by the 50 states, the District of Columbia, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

[11]42 U.S.C. § 1315(a). These waivers are authorized by section 1115 of the Social Security Act and are known as section 1115 demonstrations. HHS policy requires section 1115 demonstrations to be budget neutral to the federal government; that is, the federal government should spend no more under a state's demonstration than it would have spent on its Medicaid program without the demonstration.

[12]In fiscal year 2014, almost one third of federal Medicaid spending was governed by the terms and conditions of Medicaid 1115 demonstrations. In addition to these section 1115 demonstrations, waivers authorized under sections 1915(b) and 1915(c) of the Social Security Act allow states to provide services through managed care delivery systems or otherwise limit beneficiaries' choice of providers, and to provide long-term care services in home and community based settings, rather than in institutional settings.

program eligibility and services offered, as well as how services are delivered and expenditures are reported.

In administering their programs, states make decisions regarding populations or health services to cover beyond the minimum coverage and benefits standards mandated by federal law. For example, states must cover certain groups of individuals, such as pregnant women with incomes at or below 133 percent of the federal poverty level (FPL), but may elect to cover them above this required minimum income level. In addition, under PPACA, some states expanded Medicaid coverage to previously ineligible populations, such as childless adults with incomes at or below 133 percent of the FPL. Similarly, while states' Medicaid programs generally must cover certain mandatory services, states may also elect to cover certain optional benefits and services. (See table 1.)

Table 1: Examples of Mandatory and Optional Medicaid Services

Examples of mandatory services	Examples of optional services
Inpatient hospital	Prescription drugs
Outpatient hospital	Dental care
Physician	Hospice
Federally qualified health centers	Home- and community-based services[a]
Laboratory and X-ray	Primary care case management
Nursing facility (for ages 21 and over)	Optometry
Freestanding birth centers	Personal care
Early and periodic screening, diagnostic, and treatment (EPSDT)[b]	Prosthetic devices
Family planning services and supplies	Physical therapy
Non-emergency transportation to medical care	Occupational therapy

Source: Social Security Act, Centers for Medicare & Medicaid Services, and Medicaid and CHIP Payment and Access Commission. | GAO-16-726

[a]Home and community-based services are a type of long-term support services that Medicaid beneficiaries can receive in their own homes or communities. As examples, home and community-based services might include adult day care or in-home skilled nursing services.

[b]EPSDT services provided to children (defined as under age 21) in Medicaid include comprehensive screenings, preventive health care services, and other services medically necessary to correct illnesses or conditions identified by the screenings.

Although states are required to cover mandatory services, they generally have flexibility to set certain limits on these services based on criteria such as medical necessity (e.g., the criteria for determining functional eligibility for nursing home services) or utilization control procedures (e.g., prior authorization for certain services). States have additional flexibility to design coverage of optional services. For example, some states limit

coverage of adult dental services to emergency coverage of treatment for pain relief and infection, while others also cover preventive services such as oral examinations and teeth cleanings.

States also have flexibility to determine how the services they cover will be delivered to Medicaid enrollees—whether on a fee-for-service basis, through managed care arrangements, or a combination of both. For example, under some managed care arrangements, the state pays managed care organizations a fixed amount, known as a capitation payment, to provide a package of services. States vary in terms of the types of managed care arrangements used and the populations enrolled.[13] For example, as of July 2013, about 55 percent of total Medicaid enrollment was in comprehensive risk-based managed care. CMS data indicated that 14 of 37 states with managed care as of July 2013 enrolled individuals requiring long-term services and supports.

States also have flexibility, within broad federal requirements, in setting payment rates for fee- for-service providers. States establish provider payment rates for certain mandatory and optional services they may cover; however, the federal government will only provide matching funds for certain services, such as inpatient hospital services, for amounts up to what Medicare would pay for comparable services.[14] The payment rates established by states for Medicaid services have typically been lower than for other programs, including Medicare. In addition to claims-based payments—which are made in response to the provision of a covered service to a particular patient—states may make supplemental payments to certain providers. Supplemental payments are lump sum payments that are generally not linked to specific enrollees for specific services, and the federal government shares in the costs of these payments. There are various types of supplemental payments, including, for example, those that states are required to make, such as disproportionate share hospital payments; those that states receive approval to provide under their state

[13]States may contract with managed care organizations to provide the full range of covered Medicaid services or a subset of covered services, such as dental care or behavioral health care. States may also use primary care case management programs, in which enrollees are assigned a primary care provider who is responsible for providing primary care services and for coordinating other needed health care services.

[14]Medicare is the federally financed health insurance program for persons aged 65 and over, certain individuals with disabilities, and individuals with end-stage renal disease.

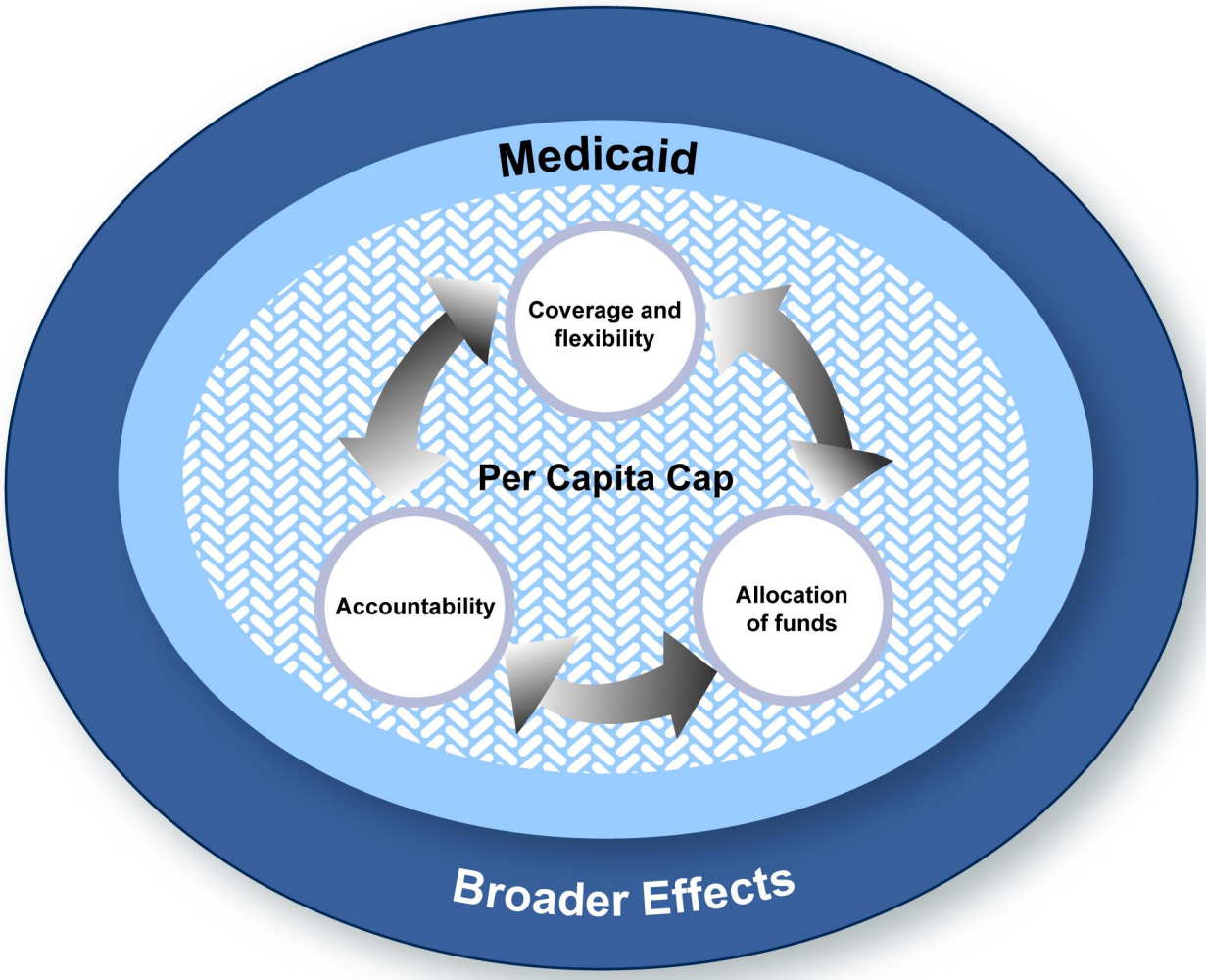
plans for Medicaid covered services; and those that are authorized under demonstrations for delivery system improvements and for uncompensated care costs.[15]

Key Policy Considerations for Designing a Medicaid Per Capita Cap

We identified several policy considerations that could inform congressional policymakers regarding the design of a Medicaid per capita cap. As shown in figure 1, policy considerations within the Medicaid program include decisions related to coverage and flexibility, allocation of funds across states and over time, and mechanisms to promote accountability for program requirements, goals, and outcomes. Additionally, a change from the current funding paradigm for Medicaid could have broader effects on other health care programs, states, and enrollees. These policy considerations are interrelated.

[15]States are required to make disproportionate share hospital payments to hospitals that care for a disproportionate share of Medicaid and low-income uninsured patients. 42 U.S.C. §§ 1396a(13)(A), 1396r-4.

Figure 1: Key Policy Considerations for a Per Capita Cap on Federal Medicaid Funding



Source: GAO. | GAO-16-726

Coverage and Flexibility

Our review of the literature and our interviews with state officials and experts indicate that key policy choices would include determining the populations and services to be covered by the cap, and what, if any, flexibility states would have in their Medicaid programs.

Populations Covered

Our review of literature and interviews indicates that one key set of choices for policymakers to consider would be which enrollee populations to include under per capita caps–specifically, whether to finance all

eligibility groups under a per capita cap or a subset of eligibility groups. Because spending for the four broad eligibility groups (children, adults, individuals with disabilities, and individuals age 65 and over) varies, with spending for seniors and those who are disabled being higher and more variable than for children and adults, decisions about which populations to include under a per capita cap could affect the degree of expenditure containment.[16] Such decisions could also affect whether states would have incentives to reclassify enrollees to either be included or excluded from the cap. For example, if a certain category of individuals—such as those with disabilities—were excluded from the cap, there could be incentives for states to maximize the number of enrollees who are classified as disabled to potentially increase the population not subject to the cap and thus increase federal matching funds.

Service and Spending Categories Covered

Our review of the literature and our interviews also suggest that policymakers would need to consider which categories of services to include under a per capita cap. As with populations, all Medicaid services could be financed under a per capita cap, or only a subset could be covered by the cap, with other services treated differently—either uncapped, as in the current Medicaid program, or excluded from coverage altogether. In addition to deciding which services that are currently offered to Medicaid enrollees to include in a per capita cap (such as hospital care, physician care, or nursing facility services), policymakers would also need to consider how to treat spending categories that are not linked to specific enrollees, such as administrative costs and supplemental payments to hospitals and other providers.

Decisions about which services or other spending categories to include or exclude from a cap are likely to affect states differently, as shown in the following examples.

- States with higher need for particular services—such as states with a higher need for transportation services due to a large number of

[16]Moreover, within the four broad groups, there are multiple subcategories for which spending also varies; for example, among seniors, the chances of needing long term care services—some of the most costly services covered by Medicaid—are higher for older enrollees, and among children, those in foster care have higher average expenses than others. For more information about factors affecting spending for Medicaid enrollees, see GAO, *Medicaid: Assessment of Variation among States in Per-Enrollee Spending*, GAO-14-456 (Washington, D.C.: June 16, 2014).

enrollees in rural or remote regions— could be differently affected by a decision to include or exclude such services within a cap.

- States with different types or amounts of supplemental payments relative to enrollment levels could be differently affected by a decision to include such payments in or exclude such payments from a per capita cap. Supplemental payments are generally paid on a lump sum basis and are not linked to services provided to particular Medicaid enrollees and, in some cases, are made for items and services not covered by Medicaid, such as delivery system improvements and uncompensated costs of treating uninsured individuals.[17]

Decisions about which services to include could also influence states' incentives for providing particular services. For example, including both Medicaid nursing facility services (which are currently mandatory) and home- and community-based care services (which are currently optional) under the cap could affect states' decisions about the extent to which both types of services are provided, as well as the functional eligibility criteria they set for these services.[18]

Flexibilities Offered to States

Another theme that emerged from our literature review and interviews involves what, if any, additional flexibility states would be provided with regard to the populations and services financed under a cap. Decisions regarding possible flexibilities to include with a per capita cap involve a complex set of interactions, some of which are related to choices regarding covered populations and services. Determining levels of flexibility to provide states would involve striking a balance between the

[17]Supplemental payments are a significant component of Medicaid spending, totaling at least $43 billion in fiscal year 2011. See GAO, *Medicaid: States Reported Billions More in Supplemental Payments in Recent Years*, GAO-12-694 (Washington, D.C.: July 20, 2012); *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed*, GAO-13-48 (Washington, D.C.: Nov. 26, 2012); and *Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments*, GAO-16-108 (Washington, D.C.: Feb. 5, 2016).

[18]Interviewees noted that some states have more restrictive eligibility criteria than others for certain populations or services, and states with more restrictive eligibility criteria may experience higher per enrollee needs and costs. For example, interviewees noted that some states require enrollees to demonstrate more limitations to activities of daily living to qualify for long term care services than other states, and as a result, the health needs of this population can differ across states. Depending on the flexibilities afforded with regard to eligibility criteria, such states may have incentives to change to less restrictive eligibility criteria to lower the average per enrollee costs for such groups.

ability of the federal government to prescribe specific program features—such as coverage of a particular set of services—and the ability of states to design program features as they deem appropriate. For example, policymakers could decide to allow each state to determine the populations and services it will cover, rather than specifying that certain populations or services are mandatory for all states, or allow states to place limits on the number of enrollees. Alternatively, policymakers could follow the current approach in the Medicaid program, which requires some populations and services to be covered, and offers flexibility for states regarding other populations and services. Additional areas of potential flexibility identified in the literature we reviewed and interviews we conducted include the extent and nature of flexibility provided with regard to standards for access and quality; managed care rate setting methods; service delivery methods, such as using funds to help enrollees purchase private insurance; and the extent to which waivers or other avenues for innovation would be available to states.

Allocation of Funds across States and Over Time

Another key set of considerations for policymakers that emerged from our prior work, review of the literature, and our interviews involves the approaches that would be used to allocate federal funds across states, both initially and over time.

Allocation of Funds across States

A per capita cap, which allocates funds on a per enrollee basis, inherently uses the size of states' Medicaid populations as a factor in allocating federal funds. While any per capita cap funding mechanism would link funding to enrollment levels, our prior work, review of the literature and interviews we conducted suggest that there are a variety of considerations that could inform additional allocation decisions. For example, our prior work on Medicaid and other programs emphasizes that equitable funding allocations consider variation in the state population

needs and costs of providing services, as well as state fiscal resources.[19] In addition, our literature review and interviews identified other equity-related considerations, such as differences across states in program design and cost efficiencies. Key considerations include the following.

- **Variation in enrollee health needs.** The health care needs of Medicaid enrollees can vary substantially. An enrollee's eligibility group is one key predictor of expected health needs, and substantial variation in health needs exists within eligibility groups as well. While accounting for average differences across eligibility groups would partially recognize differences in enrollee health needs, focusing on eligibility groups alone may not fully capture differences across states in need for services. Additionally, the average level of health service needs for eligibility groups in a single state are likely to change over time.[20]
- **Geographic variation in the costs of providing health services.** The costs to states of providing needed health services vary due to geographic differences in factors that include the wages of personnel who provide services, the cost of medical equipment and supplies, and the rental cost of facilities in which the services are provided.
- **Variation in state fiscal resources.** States differ with respect to the extent of resources—such as income produced within a state or

[19]For example, we have reported that one equity standard for allocating federal funds—referred to as beneficiary equity—stipulates that funds are distributed to states according to the needs of their respective populations so that each state, with its federal allocation, can provide a comparable level of services to each person in need. A second equity standard—referred to as taxpayer equity—applies to programs in which states contribute funding, and stipulates that funds are distributed to states according to a state's ability to finance a program from its own resources, so states can offer comparable levels of service to individuals, with each state contributing about the same proportion of their resources to the program. For more information see GAO, *Vocational Rehabilitation Funding Formula: Options for Improving Equity in State Grants and Considerations for Performance Incentives*, GAO-09-798 (Washington, D.C.: Sept. 30, 2009); *Older Americans Act: Options to Better Target Need and Improve Equity*, GAO-13-74 (Washington, D.C.: Nov. 30, 2012); *Medicaid: Alternative Measures Could Be Used to Allocate Funding More Equitably*, GAO-13-434 (Washington, D.C.: May 10, 2013); and *Medicaid Formula: Differences in Funding Ability among States Often Are Widened*, GAO-03-620 (Washington, D.C.: July 10, 2003).

[20]For example, the age mix within the senior eligibility group may change over time and states with greater proportions of older individuals within the senior eligibility category would likely experience higher need for services.

received by state residents—that are potentially available for state taxation for state financing of a share of program costs.

- **Variation in state program design and efficiency.** State per enrollee costs are shaped, in part, by program design elements such as the level of benefits states offer, service delivery and payment approaches, and cost-efficiency initiatives.

Our review of the literature and our interviews identified potential approaches to funding allocation decisions that would have varying implications for addressing the above considerations of state health care needs, costs, fiscal resources, and program design.

With regard to addressing these considerations, our work suggests that cap amounts could be designed to allocate funds based, in part, on state health care needs and costs, with varying degrees of complexity. One approach to calculating cap amounts would divide a specified amount of money (for example, an amount based on historical Medicaid funding in each state) by the number of enrollees, an approach analogous to a block grant indexed to enrollment. The simplest version of this approach—setting one cap for all enrollees—would address state Medicaid population size, but not health needs or costs. Establishing separate payment caps for different Medicaid eligibility groups would be a way of accounting for the different health care needs—and resulting costs—of such groups, on average.[21] While multiple caps would be more complex, as an interviewee noted, setting a single cap for multiple eligibility categories with distinct costs could create incentives for states to limit eligibility for higher cost categories to the extent allowable. Increasingly complex approaches could address factors beyond eligibility group that affect enrollee health needs. For example, caps could be divided into more detailed groups (for example, age groups within eligibility groups), and cap amounts for each group could be further adjusted based on geographic, diagnostic, or demographic data.

[21]In addition, in some cases, not all Medicaid enrollees are eligible for all covered services. For example, some enrollees are only eligible to receive family planning benefits. States may elect to provide only family planning benefits for certain women who are not otherwise eligible for Medicaid. If such enrollees were included under a per capita cap, separate caps could be considered for full benefit and limited benefit enrollees. Separate caps could be designed to allow states to use unspent amounts from one eligibility group to offset costs for another eligibility group, or they could be designed to prohibit such offsets.

A different approach from dividing a pre-determined amount of money by enrollment would be to estimate expected per enrollee costs—tied to the specific services to be covered and enrollee characteristics that are predictive of service utilization—and allocate funds to cover a specified amount of the expected costs. This approach could vary in complexity depending on the number and level of detail of factors considered.[22] While somewhat analogous to Medicaid MCO capitation rate setting methods, a key difference between per capita payments to states and state payments to managed care plans involves the outcomes that may occur when estimates of the cost of care differ from the actual costs. Depending on various design features, a per capita cap could shift the risk for increased spending to the state, whereas managed care plans generally assume some or all risk for overspending under the current Medicaid program.

Our work also suggests that per capita cap allocations could be designed to account for differences in states' fiscal resources. For example, the federal payment could be structured in different ways, and for each approach policymakers could consider designing the state contribution to vary across states depending on fiscal resources. Potential approaches noted in the literature we reviewed and interviews we conducted include

- The federal government could match a percentage of the costs incurred by the state, but only up to the cap amount.
- The federal government could make fixed payments to states. The federal fixed payment could potentially be calculated as a federal matching percentage of a total expected amount of federal and state spending.[23]
- The federal government could discontinue state contribution requirements for capped expenditures entirely. For example, the federal per capita cap amount could be designed to fund a specific set of core benefits, with state discretion to cover other benefits with state funds at their option, or not provide such services.

[22]For example, we have reported that states account for a range of factors to predict costs for purposes of setting Medicaid managed care capitation rates. See GAO-14-456.

[23]This approach could be designed to allow states to retain a portion of federal funds if any were allocated in excess of actual per enrollee costs, as an incentive to contain costs or to help stabilize state budgets.

To the extent that federal matching of expenditures continues, the current FMAP could be used for this purpose, or a new FMAP could be developed.[24] Alternative approaches to state financial participation could also be considered. Maintenance-of-effort provisions, which set minimum state spending requirements based on previous spending levels, could be considered to discourage states from reducing their own spending on Medicaid under a per capita cap financing structure.[25]

Our prior work, literature review, and interviews also indicate that variations in state program design and efficiencies are a key consideration, and the use of historical levels of state spending as a baseline for allocating funds could affect states differently depending, in part, on program design. Historical spending levels reflect aspects of state variation in enrollee health needs and geographic cost, and they also reflect differences that are not due to these factors—such as choices regarding the extent of optional benefits offered to enrollees. Implicit within this variation is the question of whether policymakers intend to provide more funds to states that provide more benefits, or whether funding amounts would be intended to support a more uniform, targeted level of benefits in all states. Historical spending levels also reflect other differences in state program choices and efficiency, such as the extent of cost containment measures and choices regarding the use of supplemental payments. Interviewees noted that some states are farther along than others with respect to cost-efficiency initiatives, and that states that have previously achieved greater cost efficiencies would have less room to cut costs, if necessary, to manage programs within cap amounts than states that have not achieved cost efficiencies. In our previous work on federal allocations provided through grants in various program areas,

[24]We have reported that alternative measures—such as the Total Taxable Resources measure produced by the Department of Treasury—are available to more equitably address variation in state fiscal resources than the current FMAP, which is based solely on per capita income. See GAO-13-434.

[25]We have reported on various challenges and oversight functions related to maintenance-of-effort funding provisions. For example, maintenance–of-effort provisions can be difficult to monitor and can lock states into spending levels that are no longer warranted under changing circumstances. While such provisions are often difficult to administer and oversee, they can be important tools for helping ensure that federal spending achieves its intended effect. See GAO, *Temporary Assistance to Needy Families: State Maintenance of Effort Requirements and Trends*, GAO-12-713T (Washington, D.C.: May 17, 2012).

we have reported that state spending is a poor proxy for state needs and costs, and that basing federal allocations solely on prior state spending can have the effect of rewarding states that administered programs inefficiently or chose to do so more expensively.[26]

Allocation of Funds Over Time

Based on the literature we reviewed and our interviews, a related set of considerations for policymakers involves the extent to which the initial per capita cap amounts would change over time, and if so, the nature of any adjustments to be made. Changes to allocations over time could be made on a routine basis, in response to specific events that change the cost or utilization of health care in specific states or nationwide, or both. These changes could include specifying a growth index—an automatic rate of change for cap amounts based on relevant measures of economic growth or price inflation—or providing for additional funding adjustments in response to particular emergent events.

One type of adjustment over time would be to link changes in per capita cap amounts to a relevant measure of price inflation, health care expenditure growth, or economic growth.[27] In selecting such a measure, policymakers could consider the varying implications of each for potential policy goals, such as the extent of desired cost savings and the extent to which federal Medicaid funding could support the provision of coverage if health care costs increase. Potential measures we identified through our work include

- **Consumer price index (CPI).** CPI, produced by the U.S. Bureau of Labor Statistics, is a measure of price inflation. The broadest and most comprehensive CPI is the All Items Consumer Price Index for All Urban Consumers (referred to as the all items CPI). A medical-care specific index is one component of the all items CPI.[28]

[26]See GAO, *Federal Grants: Design Improvements Could Help Resources Go Further*, GAO/AIMD-97-7 (Washington, D.C.: Dec. 18, 1996); *Block Grants: Characteristics, Experience, and Lessons Learned*, HEHS-95-74 (Washington, D.C.: Feb. 9, 1995); and GAO-09-798.

[27]Changes in funding amounts could be set as equal to such a measure, which could be calculated on a per capita basis as applicable, or the change could be specified as a certain amount lower or higher than an underlying measure.

[28]The medical care component of CPI measures out-of-pocket medical expenses only. For example, it does not measure employer contributions to health insurance premiums.

- **National Health Expenditure Accounts.** The accounts, produced by CMS, measure annual U.S. expenditures for health care goods and services, public health activities, government administration, the net cost of health insurance, and investment related to health care.
- **Gross domestic product.** The gross domestic product, produced by the Bureau of Economic Analysis, is a measure of overall economic output and, therefore, could be considered an indicator of resources available to devote to Medicaid funding.
- **Medicare economic index (MEI).** MEI, produced by CMS, is a measure of inflation in the costs of operating a self-employed physician practice in the United States that reflects changes in practice costs and physician earning levels.[29]
- **Other.** Policymakers could also consider specifying the creation of a new index to be used for this purpose. For example, growth rates that are linked to indicators of population health needs in states—such as the age distribution—could be used alone or in combination with other indices.

In addition to linking funding allocations to growth or inflation measures, policymakers could consider whether funding allocations would be responsive to emergent circumstances that result in changes to relevant health care costs or result in changes in states' ability to fund such costs. Circumstances that could affect the costs of health care include the introduction of new prescription drugs or other treatments, new technologies, changing service utilization patterns, and epidemics. Emergent circumstances could also include changes to Medicaid costs, regardless of broader health care costs—costs such as those associated with economic downturns (which bring more people into Medicaid, thereby increasing state costs while state revenues are in decline); changes states make to their Medicaid programs, such as adding or reducing covered benefits or changing eligibility criteria; and

[29]The MEI is used to partly determine updates to Medicare payment rates for physician services. The potential use of MEI to adjust per capita funding amounts—which would generally consist of one amount regardless of the number of services received per enrollee—would differ from the current use of MEI to adjust payments for services. Specifically, the MEI includes a productivity adjustment to reduce the effects of estimated increases in physicians' ability to provide a greater number of services. For purposes of using MEI as an index for change in Medicaid funding rather than to adjust payments for services, the MEI could be calculated without the productivity adjustment.

circumstances in which states run out of funds to provide coverage. Our prior work, literature review, and interviews suggest various strategies that could address the potential for emergent circumstances.

- **Periodically recalculate cap amounts.** Recalculation of cap amounts based on updated spending data could reduce the extent to which states are "locked-in" to previous program decisions by the cap amounts, and could allow funding allocations to be responsive (if with a lag) to certain changes in state demographics and health care utilization patterns. As with growth indices, recalculation of cap amounts would have implications for cost savings and the extent to which cap amounts would keep up with trends in actual costs.
- **Specify federal responses to particular circumstances**. Per capita cap legislation could specify particular circumstances under which additional federal funds would be automatically provided, or alternatively, under which unspent federal funds could be recouped. For example, policymakers could specify particular national events that are associated with reduced state ability to fund Medicaid, increased Medicaid costs, or both—such as economic downturns—as automatic triggers for temporary increased federal funding assistance to states.[30] Conversely, policymakers may want to consider provisions to address circumstances in which state costs are lower than expected; for example, specifying a threshold after which states could be required to return funds if caps are established in a manner that allows states to retain some or all of the federal funds they receive in excess of actual costs.
- **Establish other contingency provisions.** Under the State Children's Health Insurance Program (CHIP), a joint federal-state program for children whose household incomes are too high for Medicaid eligibility, federal funding is capped and financing provisions include both a federal contingency fund and state redistribution funds that may be available to states that have exhausted their capped funding allotments. Depending on program design, a similar approach could be applied in a Medicaid per capita cap.

[30]In prior work we identified a threshold that could be used to trigger additional funding for states at the onset of a national economic downturn. See GAO, *Medicaid: Prototype Formula Would Provide Automatic, Targeted Assistance to States during Economic Downturns*, GAO-12-38 (Washington, D.C.: Nov. 10, 2011).

Accountability

Our prior work and our review of the literature, and interviews with officials and experts suggests that another set of key considerations for policymakers would be whether to continue or modify existing accountability mechanisms, or implement new ones. Our prior work on other federal programs has noted that well-designed accountability mechanisms may be key to preserving state flexibility and levels of funding.[31] Interviewees also noted that in shifting to a per capita cap financing method, policymakers could consider combining increased accountability for program outcomes with providing more flexibility on specific process requirements. For example, interviewees noted that policymakers could link accountability mechanisms to particular goals and measures of performance.

Examples of the types of accountability mechanisms that could be considered include

- **Accountability for conditions attached to the receipt of federal Medicaid funds.** Depending on the specific features of a Medicaid per capita cap, policymakers could attach certain conditions to the receipt of federal funds, and if they do, they could consider establishing accountability mechanisms related to those conditions. Examples include mechanisms to verify the number and eligibility of enrollees covered by the cap, which could include establishing processes for reconciling any discrepancies and identifying the consequences if any specified criteria are not met. Other accountability mechanisms may address any possible perverse incentives created by the cap. For example, an interviewee noted that if cap amounts do not fully account for costs of higher need enrollees, there may be incentives to slowly process the applications of those who are likely to have more costly care needs. To prevent this from occurring, policymakers could consider maintaining or modifying requirements regarding the timely processing of applications.

[31]Our work notes that, in the past, Congress reduced state flexibility and funding allocations over time in the absence of sufficient information and assurances that federal funds were being well managed and used to support national objectives. See GAO, *Block Grants: Issues Designing Accountability Provisions*, GAO/AIMD-95-226 (Washington, D.C.: Sept. 1, 1995); and GAO/HEHS-95-74. See also GAO, *Grant Program Consolidations: Lessons Learned and Implications for Congressional Oversight*, GAO-15-125 (Washington, D.C.: Dec. 12, 2014).

- **Accountability for achievement of particular health care goals.** Depending on the specific features of a Medicaid per capita cap, policymakers may consider establishing goals aimed at achieving particular health care goals, such as meeting particular utilization, quality, access, or health outcomes. For example, thresholds for ensuring utilization of preventive health care services, such as immunizations or check-ups, could be established. If policymakers establish any such goals, they might also consider how to link outcomes to evidence of goal achievement. For example, activities such as publishing information about states' relative performance, providing financial or other performance incentives for meeting or exceeding goals, or increasing the degree of oversight for states with unmet goals could be considered.
- **Accountability for achieving federal objectives for the cap.** Policymakers might also consider establishing accountability mechanisms to evaluate whether a per capita cap is having the intended outcomes. For example, if one federal objective of implementing a per capita cap is to promote the cost-efficiency of Medicaid, policymakers could include provisions for evaluating cost-efficiencies after implementation of a cap. To undertake these evaluations, it would be necessary to obtain appropriate, accurate, and timely data over an established period of time.

Our prior work establishes the importance of federal programs having strong internal controls, meaningful performance information, and transparency.[32] We have reported that implementation of an internal control system to provide reasonable assurance that key objectives will be achieved is a key factor in ensuring accountability and includes reporting reliable information about relevant operations.[33] We have also reported that meaningful performance information is critical to performance management and accountability, and that data-driven performance reviews that ensure alignment between agency goals, program activities, and resources—and that are based on accurate,

[32]Internal control is a process involving an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. See GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 10, 2014).

[33]See GAO, *Financial Management: Effective Internal Control is Key to Accountability*, GAO-05-321T (Washington, D.C.: Feb. 16, 2005).

useful, and timely performance data—can contribute to effective management of government programs.[34] The Office of Management and Budget Circular A-136 notes that accountability is increased when performance information is transparent, and we have raised concerns regarding identified limits to the transparency and reliability of information critical to effective oversight of the Medicaid program.[35]

Broader Effects on Health Care, States, and Enrollees

Depending on the specific features of a Medicaid per capita cap, a change from the current funding paradigm could affect a number of health care programs and markets, as well as Medicaid enrollees and states. A per capita cap on federal Medicaid expenditures could also have a wider impact beyond Medicaid, either increasing or decreasing the demand for other federal health care programs. The effects of a per capita cap on these broader programs might, in some cases, be somewhat predictable, given the specific details of the cap, but in other cases, the effects might not be clearly identifiable in advance. Further, such changes could affect Medicaid enrollees and states.

Broader Health Care Effects

Our work for this review suggests that changes to Medicaid financing methods could interact with other federally financed sources of health care. For example, a cap that constrains populations, services, or both may shift health care needs to other federally financed sources of health care or, to the extent that a per capita cap results in improvements to cost-efficiency or improvements in beneficiaries' health, the effects on other sources of health care could be beneficial. Examples of federally financed sources of health care that could be affected include

- **Medicare and other federal health programs.** Certain individuals, such as the elderly or disabled individuals with low incomes, are eligible for both Medicaid and Medicare—both of which are open-

[34]See GAO, *Managing for Results: Agencies Report Positive Effects of Data-Driven Reviews on Performance but Some Should Strengthen Practices*, GAO-15-579 (Washington, D.C.: July 7, 2015).

[35]See GAO, *Medicaid: Key Issues Facing the Program,* GAO-15-677 (Washington, D.C.: July 20, 2015).

ended federal entitlement programs.[36] Services covered by both programs are first paid by Medicare to the extent of its liability, with Medicaid then paying up to the limit of its liability. While Medicare covers a broad range of health care services, beneficiaries may still have significant out-of-pocket expenditures, including copayments, coinsurance, deductibles, and the full cost of services not covered by Medicare. For those Medicare beneficiaries who are eligible for full Medicaid benefits, Medicaid provides supplemental coverage for such costs. If changes to Medicaid payment policies affect eligibility criteria or the benefits available to those who are currently eligible for both programs, then Medicare costs could be affected.[37] Likewise, changes in Medicaid eligibility criteria or Medicaid services could result in a shifting of individuals between Medicaid and other federal health care programs, such as health care provided through the Department of Veterans Affairs and the Department of Defense, and federally qualified health centers.

- **Health insurance premium tax credits and cost sharing subsidies.** Under PPACA, federal tax credits and cost-sharing subsidies are available to certain low-income individuals to help pay for health care coverage purchased through health insurance exchanges. If individuals were to lose Medicaid coverage as a result of the design of the cap, some of those individuals could become eligible for premium tax credits and cost-sharing subsidies instead,

[36]Most Medicaid enrollees who are seniors aged 65 and older or disabled are also eligible for Medicare. In calendar year 2011, these dually eligible enrollees accounted for 14 percent of Medicaid enrollees and 20 percent of Medicare enrollees. Although some are fairly healthy and have relatively low health care costs, as a group, they have more expensive health care needs than most enrollees in either program, and therefore account for a disproportionate share of expenditures for each program, specifically, 33 percent of Medicaid expenditures and 35 percent of Medicare expenditures in calendar year 2011.

[37]For example, we have previously noted that supplemental coverage may reduce the incentive for Medicare enrollees to be cost-conscious in making decisions about the use of health care services, leading them to use more services than they need. Reducing supplemental coverage could, however, create a risk that some individuals forgo necessary services, exacerbating their health care needs and perhaps the long-term cost of their care. See, for example, GAO, *Medicare Supplemental Coverage: Medigap and Other Factors Are Associated with Higher Estimated Health Care Expenditures*, GAO-13-811 (Washington, D.C.: Sept. 19, 2013). Note that changes to Medicare can also affect the costs incurred by Medicaid for these individuals. For example, Medicaid pays the cost of premiums for Part B Medicare coverage—coverage for physician services, lab and x-ray services, durable medical equipment, and outpatient and other services—for dually eligible enrollees, and so increases in those premiums are borne by Medicaid.

which could increase federal spending for these programs. One way in which some Medicaid enrollees could become eligible for premium tax credits and cost-sharing subsidies would be if some states discontinue the optional PPACA Medicaid expansion for low-income adults (or decline to adopt it in the future). The Congressional Budget Office estimated in 2013 that the cost increase resulting from individuals gaining coverage through exchanges should some states eliminate the optional PPACA Medicaid expansion would be outweighed by the savings from the overall reduction in Medicaid coverage, at least in part because many individuals who would lose Medicaid coverage would not qualify for premium tax credits and cost sharing subsidies.[38]

Interviewees told us that depending on the specific features of a Medicaid per capita cap, a change from the current funding paradigm could increase or decrease the demand for and costs of health care, whether nationally or in more limited markets.

- Health care costs, in both the short and long terms, could go up if specific features of the per capita cap result in changes to Medicaid that resulted in shifting the provision of care to higher cost alternatives, such as emergency rooms. Conversely, costs could go down if the result of these features were to shift the provision of care to more cost-efficient alternatives.
- Service-specific effects are also possible. For those services for which Medicaid is a dominant payer—such as nursing home care (Medicaid is the primary payer for more than 60 percent of nursing home residents in the United States) or child and maternal health (Medicaid finances 40 percent of births in the United States)—any changes in funding could have repercussions on the broader market for those services. For example, if a cap were to result in a change in overall Medicaid demand or expenditures for nursing home care or home health aides, there could be broader ramifications for supply or cost of these services.
- Depending on the details of a cap, specific hospitals and clinics that receive a portion of their funding from Medicaid, whether for services

[38]Individuals with incomes below 100 percent of the federal poverty level are ineligible for such credits and subsidies. See Congressional Budget Office, *Options for Reducing the Deficit: 2014 to 2023* (Washington, D.C.: November 2013).

rendered to enrollees or through supplemental payments, could be affected. For example, hospitals or clinics could end up receiving a different proportion of their funding from Medicaid or could experience a change in demand for services.

Effects on States and Enrollees

Another theme that emerged from our review of the literature and our interviews involves broader, interrelated implications of a Medicaid per capita cap for states and enrollees, which could vary depending on the state. On one hand, states could have additional incentives to set priorities and identify ways to increase program efficiencies to manage their Medicaid programs and provide effective care within the financial constraints of a per capita cap. On the other hand, interviewees noted that depending on the funding design, per capita caps could constrain avenues for state innovation that require up-front investment, and could limit the ability of states to make program changes, such as offering benefits that were not in place at the onset of the cap policy.

In addition, interviewees noted that states with relatively greater cost-efficiency prior to the change in financing policy may have more difficulty finding areas to further identify efficiencies and streamline program spending. Beyond efficiency, key levers for achieving savings that were raised in the literature we reviewed and our interviews include changes to eligibility, benefits, and provider payment rates. Ultimately, state responses and the resultant impact on enrollees may be difficult to predict and would depend on particular features of the cap and how states respond. For example, potential state responses that could affect enrollee access to services—such as changes to eligibility, benefits, or provider payments—would depend on features such as the amount of flexibility, the extent to which the cap amounts reflect potential changes in the health needs of states' enrollee populations, and the extent to which cap amounts increase over time in pace with health care costs.

Key Data Considerations for Designing a Medicaid Per Capita Cap

To design a per capita cap financing method for Medicaid, policymakers would need to identify appropriate data on enrollees and expenditures to help develop per capita cap amounts and allocate funds. CMS enrollment and expenditure data could be used to identify enrollees and develop estimates of per enrollee Medicaid expenditures. However, our past work has identified complexities and limitations in available CMS enrollment and expenditure data; for example, some CMS expenditure data may not be easily linked to enrollees or may require complex adjustments to establish such links at a sufficient level of accuracy. Other available federal data sources—such as nationally representative population

surveys—could provide estimates of Medicaid enrollee characteristics or other aspects of state funding needs, but would need to be combined with expenditures for services in order to identify funding amounts needed to support particular program goals.

CMS Data on Enrollee Populations

One consideration for policymakers in designing a Medicaid per capita cap would be how to measure enrollment, and at what level of detail. Interviewees noted that different methods of measuring Medicaid enrollment can produce different enrollment figures.[39] Beyond determining a consistent method of defining enrollment, an additional consideration would be the level of detail used to differentiate populations with materially different health care needs and costs; for example, policymakers could consider differences amongst eligibility groups, age groups, gender, region of residence, groups with varying benefit eligibility, or groups assigned to particular service delivery strategies (such as managed care or fee-for-service).

Based on the decisions made, policymakers would need reliable data on enrollee populations. The main federally centralized source of Medicaid enrollment data is the Medicaid Statistical Information System (MSIS), a national Medicaid eligibility and claims data set through which states are required to submit detailed enrollee information. We have reported on anomalies and timeliness concerns with MSIS enrollment data, which are not used to determine federal Medicaid funding to states and do not receive the same level of review as expenditure data used for

[39]For example, Medicaid enrollment could be measured by "ever enrolled" persons (i.e., the number of people covered by Medicaid for any period of time during the relevant timeframe); "point-in-time" (i.e., the number of Medicaid enrollees at a specified date); or "person-year equivalents" (i.e., the average enrollment over the course of the year). These measurement choices produce substantially different enrollment figures. For example, in 2014, there were an estimated 77.6 million ever-enrolled persons compared to an estimated 63.8 million persons enrolled at a point in time. See Medicaid and CHIP Payment and Access Commission, *MACSTATS: Medicaid and CHIP Data Book* (Washington, D.C.: December 2015).

reimbursement purposes.[40] To improve upon MSIS, CMS is implementing a new data system known as Transformed–MSIS, or T-MSIS. The goals of T-MSIS include improving the timeliness, quality, and level of detail of the MSIS data, and providing a link to expenditure data from other CMS systems to support improved program and financial management, evaluations, fraud identification, and program efficiency.

CMS Data on Medicaid Expenditures

Policymakers would also need reliable information on Medicaid expenditures per enrollee in order to design a per capita cap. As we have noted in prior work, the most reliable and complete federal source of information on Medicaid expenditures is the data drawn from the form CMS-64.[41] Because CMS reviews these data as part of its oversight of providing federal funds, CMS-64 expenditure data are believed to be reliable and comprehensive.[42] CMS-64 data are, however, available only in aggregate form and generally do not include enrollment or claims

[40]Our prior work noted that states have often been late reporting MSIS data, with some states delaying reporting of MSIS data for as long as 3 years. According to CMS officials, states that delay reporting can have issues with both the timeliness and quality of their submissions. If states submit poor quality data, CMS may reject the submission, resulting in further delays. See GAO, *Medicaid: Data Sets Provide Inconsistent Picture of Expenditures*, GAO-13-47 (Washington, D.C.: Oct. 29, 2012). In our past work examining enrollee-specific Medicaid spending, we have excluded certain state data from our analyses due to enrollment data reliability issues. See GAO-14-456 and GAO-15-460. Beginning in 2014, states also began submitting certain enrollment data through the Medicaid Budget and Expenditure System, but this data source does not differentiate all eligibility categories. States report the number of Medicaid enrollees, and, for states that have expanded Medicaid, provide specific counts for the number of individuals enrolled in the new adult eligibility group. See GAO-16-53.

[41]See GAO-13-47 and GAO-14-456. States also have data specific to their Medicaid programs, such as encounter data used by some states to develop managed care capitation rates. Such data would not be directly comparable across states and could vary with respect to level of detail and reliability. While this report focuses on considerations related to federally-designed per capita caps, another possibility would be that these types of state-specific data could be used to allow states to generate and propose their own estimates of expected per enrollee costs for their unique populations and benefit structures.

[42]We have reported on the different picture of expenditures obtained through MSIS data versus data drawn from the form CMS-64, which states use to claim federal matching funds for their Medicaid expenditures. Some of the differences in expenditures between the two data sets can be attributed to specific factors because they are the result of differences in the types of expenditures captured in the data, while the remainder cannot be attributed to specific factors. See GAO-13-47.

information that can be used to link spending to particular Medicaid enrollees. Estimates of overall per enrollee spending can be obtained by combining the aggregated CMS-64 spending data with information on the overall number of enrollees.[43]

As also illustrated in our prior work, estimates of per enrollee spending can be developed for each eligibility group through a more complex process in which CMS-64 expenditures are divided among eligibility groups based on eligibility group specific MSIS data on expenditures for parallel service categories.[44] Specifically, MSIS expenditures can be tabulated by service category and eligibility group, and CMS-64 expenditures can be tabulated by service category. Data from the two sources can be combined by matching the service categories in the CMS-64 to the more detailed MSIS service categories, and then distributing the spending reported in the CMS-64 across eligibility groups accordingly.[45] The accuracy of this strategy depends, in part, on the consistency of service category definitions between the MSIS and the CMS-64 data sets.[46] Key considerations related to such estimates include taking into account adjustments and linking expenditures and enrollees, each of which are described below.

- *Taking into account adjustments:* States may continue to adjust the expenditures they report using the CMS-64 for a period of years, so estimates of spending per enrollee for a recent reference period would not necessarily reflect the adjustments, which can be substantial. Detailed information about adjustments is available in the CMS-64 system and could potentially be used to ensure that the expenditures refer to the desired reference time period. According to CMS officials, states report most adjustments within two years, but may report some

[43]See GAO-14-456.

[44]See GAO-14-456.

[45]See GAO-14-456. In that report, we used tabulations obtained from the CMS Office of the Actuary to develop state-specific estimates of per enrollee spending by eligibility group.

[46]As an example, we previously reported that expenditures for inpatient services, as reported by a state in the CMS-64, cannot be assumed to be the same services reported by the state in MSIS, despite the service having the same name in both data sets. See GAO-13-47.

adjustments, including those resulting from federal audits, three or more years after the original spending occurred.[47] Decisions would need to be made about whether—and if so, how—to incorporate adjustments over time. As we have reported, some states make sizeable adjustments to expenditures—and their effect may be magnified when per enrollee spending is estimated at the eligibility group level—indicating that different decisions about incorporating adjustments could lead to very different spending estimates in some states.[48]

- *Linking expenditures and enrollees:* Approaches to including expenditures that are not directly linked to Medicaid enrollees also have varying implications for per enrollee spending estimates. For example, supplemental payments are generally not made for care provided to specific enrollees, and thus decisions would need to be made regarding whether—and if so, how—to include supplemental payments in estimates of spending per enrollee. We previously reported on two approaches for attributing certain supplemental payments to Medicaid eligibility groups. In particular, in three states, estimates of spending per enrollee for some eligibility groups differed by more than $1,000 depending on the approach used.[49] Excluding supplemental payments from such estimates poses a different set of considerations. States vary in their use of supplemental payments in general, and would therefore be differentially affected if these payments were excluded from per enrollee spending estimates. Complete and accurate information about all types of supplemental payments, as well as their purposes, would be important to allow consistent exclusion or inclusion of such payments in funding

[47]See GAO-14-456.

[48]See GAO-14-456.

[49]In the state for which the choice of distribution method made the greatest dollar difference, the difference in Medicaid spending per enrollee for adults was $2,123 (per enrollee spending was estimated to total $8,508 using the first method and $6,385 using the second method). See GAO-14-456.

amounts, and if included, to inform decisions about how to allocate such payments across eligibility groups as applicable.[50]

Other Data Sources

Beyond CMS Medicaid enrollment and expenditure data, other sources of data can provide additional context for understanding expected state per enrollee expenditures. In our prior work, for example, we have used the following data sources to estimate Medicaid-eligible populations and the variation in costs of providing services, and to measure states' financial resources.[51]

- Nationally representative federal surveys, such as the U.S. Census Bureau's American Community Survey and the Current Population Survey, are available data sources that can be used to estimate the age, disability status, and other characteristics of persons residing in each state with incomes low enough to qualify them as potentially eligible for Medicaid.[52] Estimates based on survey data, however, may not track actual Medicaid enrollment for many reasons, including variation in Medicaid participation rates among potentially eligible enrollees, variation in state eligibility criteria, and survey sampling or other sources of measurement error.
- 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. Such data can be used to create an index of health care personnel costs across states as an indicator of geographic differences in costs of providing services.

[50]We have previously reported that inconsistencies in state reporting of certain supplemental payments preclude the ability to fully differentiate such payments from other types of expenditures. See GAO-14-456. See also GAO, *Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy*, GAO-15-322 (Washington, D.C.: April 10, 2015).

[51]See GAO-13-434.

[52]For example, the American Community Survey contains information such as respondents' health insurance coverage—including self-reported enrollment in means-tested public coverage such as Medicaid or CHIP—as well as income, age, gender, disability status, and geographic area of residence (state and detailed location within a state).

- The Total Taxable Resources measure, as generated by the Department of the Treasury from multiple data sources, provides estimates of state fiscal resources.

These types of data could be used to develop a formula-based approach to setting per capita cap amounts or to transition to a formula-based approach over time.[53] Such an approach could allocate funds based on measures that indicate the extent to which states fall above or below the national average in each of these areas. Such measures provide a sense of relative need across the states, but do not provide information on the dollar amounts that would be associated with a particular level of service provision in the states. As such, these measures would need to be combined with additional information on service costs in order to establish a per capita cap amount that could be targeted to specific program goals, such as providing particular services to enrollees.

Agency Comments

We provided a draft of this report to the Department of Health and Human Services for comment. The department had no comments on the draft.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretary of HHS and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact Carolyn L. Yocom at (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 report. GAO staff who made major contributions to this report are listed in appendix II.

Carolyn L. Yocom
Director, Health Care

[53]See GAO-13-434.

Appendix I: List of Publications Identified to Select Subject Matter Expert Interviewees

To select individuals or organizations with subject matter expertise to interview with regard to our identified considerations for designing a per capita cap financing method for Medicaid, we used relevant publications identified through our literature review that were issued from January 2005 through August 2015 by national public policy organizations, government entities, and other authors. As applicable, we used our literature review to identify national public policy organizations or government entities to contact, rather than specific individuals. Accordingly, in some cases we interviewed representatives of identified organizations and not the specific individual or individuals who authored the publications.

- Congressional Budget Office, *Options for Reducing the Deficit: 2014-2023* (Washington, D.C.: November 2013).
- "Health Policy Brief: Per Capita Caps in Medicaid," *Health Affairs*, April 18, 2013.
- Emily Eagan, *Primer: Medicaid Per Capita Caps* (Washington, D.C.: American Action Forum, Aug. 5, 2013).[1]
- Edwin Park, *Medicaid Per Capita Cap Would Shift Costs to States and Undermine Key Part of Health Reform* (Washington, D.C.: Center on Budget and Policy Priorities, May 8, 2013).
- Edwin Park, Matt Broaddus, Jessica Schubel, and Jesse Cross-Call, *Frequently Asked Questions About Medicaid* (Washington, D.C.: Center on Budget and Policy Priorities, June 29, 2015).
- Edwin Park and Matt Broaddus, *Medicaid Per Capita Cap Would Shift Costs to States and Place Low-Income Beneficiaries at Risk* (Washington, D.C.: Center for Budget and Policy Priorities, Oct. 4, 2012).
- James C. Capretta, "End Medicaid's Crony Federalism," *National Review Online* (Washington, D.C.: American Enterprise Institute, March 25, 2013).
- James C. Capretta, "Reforming Medicaid," *The Economics of Medicaid: Assessing the Costs and Consequences*, edited by Jason

[1]We interviewed representatives of American Action Forum, and not the listed author of the publication.

J. Fichtner (Arlington, VA: Mercatus Center at George Mason University, 2014).

- Sara Rosenbaum, “Threading the Needle: Medicaid and the 113th Congress,” *New England Journal of Medicine*, vol. 367, no. 25 (Dec. 20, 2012).

We also reviewed publications issued prior to 2005, and publications issued by other types of entities—such as advocacy groups—but did not use these additional publications as a basis for selecting individuals or organizations for interviews.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, key contributors to this report were Robert Copeland, Assistant Director; Kristen Joan Anderson; Emily Beller; Sandra George; and Drew Long.