

Report to Congress on Medicaid and CHIP

JUNE 2016



MACPAC

Medicaid and CHIP Payment
and Access Commission

About MACPAC

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). The U.S. Comptroller General appoints MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

MACPAC serves as an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability. The Commission's authorizing statute, 42 U.S.C. 1396, outlines a number of areas for analysis, including:

- payment;
- eligibility;
- enrollment and retention;
- coverage;
- access to care;
- quality of care; and
- the programs' interaction with Medicare and the health care system generally.

MACPAC's authorizing statute also requires the Commission to submit reports to Congress by March 15 and June 15 of each year. In carrying out its work, the Commission holds public meetings and regularly consults with state officials, congressional and executive branch staff, beneficiaries, health care providers, researchers, and policy experts.

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Commissioners

Sara Rosenbaum, JD, *Chair*
Marsha Gold, ScD, *Vice Chair*
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Stacey Lampkin, FSA, MAAA, MPA
Norma Martínez Rogers, PhD, RN,
FAAN
Charles Milligan, JD, MPH
Sheldon Retchin, MD, MSPH
Peter Szilagyi, MD, MPH
Penny Thompson, MPA
Alan Weil, JD, MPP

Anne L. Schwartz, PhD,
Executive Director

June 15, 2016

The Honorable Joseph R. Biden, Jr.
President of the Senate
U.S. Capitol
Washington, DC 20510

The Honorable Paul Ryan
Speaker of the House
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Vice President and Mr. Speaker:

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am pleased to submit the June 2016 *Report to Congress on Medicaid and CHIP*, fulfilling our statutory mandate to report each year by June 15.

Much of this report focuses on Medicaid spending and financing, reflecting concerns among some policymakers about the growth and sustainability of the program as it becomes a larger share of both federal and state budgets. The Commission's attention to these issues responds to a direct request from chairs of the congressional committees with interest in Medicaid to develop a long-term work plan focused on Medicaid spending, sustainability, and financing reform. At the request of these committees' ranking members, the June report also considers the implications of spending trends and changes to financing on access to care, provider rates and participation, and enrollment.

Chapter 1 examines Medicaid spending through a variety of lenses, considering how the program has grown over its history and the drivers of this growth. Our analyses point to the many different factors that affect Medicaid spending growth, including medical price inflation, the aging of the population, economic shifts affecting the rate of poverty and both job growth and loss, innovations in medical practice and technology, and changes in the mix and health status of the covered population, as well as changes in Medicaid policy.

Medicaid is growing as a share of federal and state budgets, and as a share of national health expenditures and gross domestic product. At the same time, Medicaid spending overall is expected to grow at a slower rate than Medicare and private insurance; growth in spending per enrollee has been lower than or comparable to Medicare and private insurance since the early 1990s. In fact, more than two-thirds of expenditure growth since the mid-1970s has been due to enrollment growth, reflecting the program's



important role in providing coverage for millions of low-income individuals and families who otherwise would have no source of health insurance.

Chapter 2 focuses on state policy choices. Although federal policy sets broad rules for allowable state expenditures and imposes requirements to ensure accountability, state decisions also affect the program's spending trajectory. Mindful of the need to balance state budgets, states have strong interests in holding down spending as well as multiple tools to limit growth in per-person spending and the overall rate of cost growth in Medicaid. These tools include selective use of eligibility pathways, widespread use of managed care, imposition of tight limits on provider payment, and strict management of coverage and utilization.

In Chapter 3, the Commission considers how Medicaid is financed and examines major alternatives that have been suggested as mechanisms to hold down future expenditure growth. In this chapter, we describe the current financing structure, commenting on its origins and noting that it permits the program to respond to secular events such as recessions, natural disasters, and public health emergencies. We then outline several major approaches to financing reforms—block grants, capped allotments, per capita caps, and shared savings—and consider how different approaches to the design of these policies might result in federal savings and affect state decision making, as well as how such constraints might affect beneficiaries, providers, and others.

The final chapter in the June report addresses functional assessment tools that Medicaid programs use to determine functional eligibility for long-term services and supports (LTSS) and to create specific care plans for eligible individuals. The federal government does not require states to use a particular functional assessment tool; MACPAC's analysis shows that there are at least 124 tools currently in use.

Use of a single national tool to assess functional status would facilitate analyses of LTSS use across states. However, moving to a single, national tool could be problematic at this time and particularly burdensome for states that have recently invested in new tools. Moreover, currently there is no clear empirical or operational reason to pick one existing tool over another. Given work at the Centers for Medicare & Medicaid Services to develop and validate standardized questions, the Commission will continue to monitor developments in this area.

A key part of the Commission's statutory charge is to bring rigor and evidence to discussion of core issues in Medicaid policy, and we trust that you will find this information useful as Congress considers legislation affecting the program's future. We anticipate continuing our work in these areas to advise Congress and others as more detailed Medicaid reform proposals are discussed.

Sincerely,



Sara Rosenbaum, JD
Chair



Commission Members and Terms

Sara Rosenbaum, JD, Chair
Washington, DC

Marsha Gold, ScD, Vice Chair
Washington, DC

Term Expires April 2017

Sharon Carte, MHS
West Virginia Children's Health Insurance Program
South Charleston, WV

Norma Martínez Rogers, PhD, RN, FAAN
The University of Texas Health Science Center at San Antonio
San Antonio, TX

Andrea Cohen, JD
United Hospital Fund
New York, NY

Sara Rosenbaum, JD
The George Washington University
Washington, DC

Herman Gray, MD, MBA
United Way for Southeastern Michigan
Detroit, MI

Term Expires April 2018

Gustavo Cruz, DMD, MPH
Health Equity Initiative
New York, NY

Charles Milligan, JD, MPH
UnitedHealthcare Community Plan of New Mexico
Albuquerque, NM

Leanna George
Beneficiary Representative
Benson, NC

Sheldon Retchin, MD, MSPH
The Ohio State University Wexner Medical Center
Columbus, OH

Marsha Gold, ScD
Independent Consultant
Washington, DC

Peter Szilagyi, MD, MPH
University of California, Los Angeles
Los Angeles, CA

Term Expires April 2019

Brian Burwell
Truven Health Analytics
Cambridge, MA

Stacey Lampkin, FSA, MAAA, MPA
Mercer Government Human Services Consulting
Tallahassee, FL

Toby Douglas, MPP, MPH
Centene Corporation
Davis, CA

Penny Thompson, MPA
Penny Thompson Consulting, LLC
Ellicott City, MD

Christopher Gorton, MD, MHSA
Tufts Health Plan
Watertown, MA

Alan Weil, JD, MPP
Health Affairs
Bethesda, MD

Commission Staff

Anne L. Schwartz, PhD, Executive Director

Office of the Executive Director

Annie Andrianasolo, MBA, Executive Assistant to the Executive Director

Kathryn Ceja, Director of Communications

Policy Directors

**Amy Bernstein, ScD, MHSA
Policy Director and Contracting Officer**

Moira Forbes, MBA, Policy Director

Principal Analysts

Kirstin Blom, MIPA

Chris Park, MS

Martha Heberlein, MA

Chris Peterson, MPP

Joanne Jee, MPH

Kristal Vardaman, MSPH

Jessica Morris, MPA

Senior Analysts

Veronica Daher, JD

Robert Nelb, MPH

Benjamin Finder, MPH

Katie Weider, MPH

Sarah Melecki, MPAff

Analysts

Kacey Buder, MPA

Kayla Holgash, MPH

Research Assistant

Madeline Britvec

Operations and Finance

Ricardo Villeta, MBA, Deputy Director of Operations, Finance, and Management

Kevin Ochieng, IT Specialist

James Boissonnault, MA, Chief Information Officer

Ken Pezzella, Chief Financial Officer

Allissa Jones, Administrative Assistant

Brian Robinson, Financial Analyst

Eileen Wilkie, Administrative Officer

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Table of Contents

Commission Members and Terms	vii
Commission Staff	viii
Acknowledgements	ix
Executive Summary	xiii
Introduction to Medicaid Spending and Financing Analyses	xvii
Chapter 1: Trends in Medicaid Spending	1
Medicaid Share of U.S. Health Care Spending	3
Medicaid as Share of Federal Spending	4
Medicaid’s Share of State Budgets	5
Growth in Spending per Enrollee	8
Components of Spending Growth	9
Medicaid Spending in 2014 and Beyond	14
Endnotes	18
References	19
Chapter 2: Addressing Growth in Medicaid Spending: State Options	23
Eligibility	26
Benefits	28
Provider Payments	31
Delivery Systems	32
Program Integrity	33
Conclusion	34
Endnotes	34
References	35
Chapter 3: Alternative Approaches to Federal Medicaid Financing	39
Medicaid’s Current Financing Structure	42
Alternative Financing Proposals	46
Design Considerations	52
Potential Effect on States and Enrollees	57
Conclusion	58
Endnotes	59
References	60
APPENDIX 3A: Medicaid Financing Alternatives	64

Chapter 4: Functional Assessments for Long-Term Services and Supports 67

- Functional Eligibility Criteria: Variation by Eligibility Pathway 70
- Functional Assessment Process: Eligibility Determination and Care Planning 70
- Federal Role in Functional Assessment 72
- State Variation in Functional Assessment Tools 74
- Factors Influencing States’ Choice of Tools 76
- Issues in Moving Toward a National Functional Assessment Tool 78
- Next Steps 80
- Endnotes 81
- References 81

Appendix 85

- Authorizing Language from the Social Security Act (42 USC 1396) 87
- Biographies of Commissioners 94
- Biographies of Staff 98

List of Boxes

BOX 1-1.	Prescription Drug Spending	15
BOX 2-1.	Mandatory Medicaid Eligibility Groups, 2016	27
BOX 2-2.	Mandatory Medicaid Benefits, 2016	29
BOX 3-1.	Aggregate Limits under Section 1115 Demonstrations	48
BOX 4-1.	Functional Assessments and Managed Long-Term Services and Supports	72
BOX 4-2.	Details Matter: Examples of Variation in Specific Assessment Questions	77

List of Figures

FIGURE 1-1.	Major Health Programs and Other Components of the Federal Budget as a Share of Federal Outlays, FYs 1965–2015	5
FIGURE 1-2.	Medicaid’s Share of State Budgets Including and Excluding Federal Funds, SFYs 1987–2014	6
FIGURE 1-3.	Distribution of Medicaid, Education, and All Other Spending from Total State Budgets versus State-Funded State Budgets, SFY 2014	7
FIGURE 1-4.	Growth in Real Medicaid Benefit Spending Due to Enrollment by Eligibility Group, FYs 1975–2012	9
FIGURE 1-5.	Annual Growth Rates in Medicaid Enrollment and Spending, FYs 1975–2014	10
FIGURE 1-6.	Growth in Real Medicaid Benefit Spending Due to Spending per Enrollee by Eligibility Group, FYs 1975–2012	11
FIGURE 1-7.	Medicaid Benefit Spending per Full-Year Equivalent Enrollee by Eligibility Group and Service Category, FY 2012	13
FIGURE 1-8.	Average Annual Growth in Projected Enrollment and Spending per Enrollee, FYs 2014–2023	16
FIGURE 1-9.	Growth in State Medicaid Spending (Excluding Federal Funds) in Expansion and Non-Expansion States, FY 2014	17

List of Tables

TABLE 1-1.	Average Annual Growth in Medicaid Spending per Enrollee Compared to Various Benchmarks, 1987–2023	8
TABLE 1-2.	Distribution and Annual Growth of Medicaid Benefit Spending by Type of Service, FYs 2006–2016	14
TABLE 3A-1.	Comparison of Medicaid Financing Approaches	64
TABLE 4-1.	Medicaid Eligibility Pathways for Long-Term Services and Supports	71
TABLE 4-2a.	Information on Bathing Needs Collected by the District of Columbia Long-Term Care Assessment Tool	77
TABLE 4-2b.	Information on Bathing Needs Collected by the Kentucky Medicaid Waiver Assessment Tool	77

Executive Summary: June 2016 Report to Congress on Medicaid and CHIP

In this June 2016 *Report to Congress on Medicaid and CHIP*, the second of two reports required annually by MACPAC's authorizing statute, the Commission addresses the issue of Medicaid spending and financing, reflecting concerns among some policymakers about the growth and sustainability of the program as it becomes a larger share of both federal and state budgets. The Commission's attention to these issues responds to a direct request from chairs of the congressional committees with interest in Medicaid to develop a long-term work plan to analyze and evaluate financing reforms that would reduce federal and state outlays. The ranking members of these committees further requested that MACPAC assess the effects that various financing reforms might have on states, enrollees, providers, and plans.

The first three chapters of the June 2016 report respond to those requests by examining trends in Medicaid spending, state actions to ensure the program's sustainability, and alternative approaches to change federal financing. The analyses contain new information on spending trends, consider how federal and state policy choices influence spending, and consider design issues in changing the current method of federal financing to other methods that cap the federal government's contribution in various ways. The chapters also discuss spending and financing issues in the context of Medicaid's multiple roles—providing access to medical care for low-income Americans, covering long-term services and supports (LTSS), and wrapping around other sources of coverage, as well as serving as a critical source of revenue for safety-net providers delivering care to both Medicaid beneficiaries and the uninsured.

The final chapter of the June report describes state use of functional assessment tools—sets of questions about health conditions and functional needs that help Medicaid programs determine applicants' LTSS eligibility and create care plans for them.

Chapter 1: Trends in Medicaid Spending

Chapter 1 examines national Medicaid spending trends through a variety of lenses, comparing the growth in Medicaid spending as a share of national health expenditures and federal and state budgets. The chapter also examines the drivers of spending growth. These include changes in enrollment due to eligibility expansions, economic shifts affecting the rate of poverty, demographic changes such as the aging of the population, and changes in the mix and health status of the covered population, as well as state policy decisions affecting payment rates, breadth of covered benefits, and design of delivery systems.

Medicaid is growing as a share of federal and state budgets and as a share of national health expenditures and gross domestic product. In fiscal year (FY) 1970 the program accounted for 1.4 percent of federal outlays; it had grown to 9.5 percent of outlays in FY 2015. The program also represents a growing share of state budgets, increasing from 6.9 percent of state-funded expenditures in 1990 to 15.3 percent in 2014.

At the same time, Medicaid spending overall is expected to grow at a slower rate than Medicare and private insurance—growth in spending per enrollee has been lower than or comparable to Medicare and private insurance since the early 1990s. More than two-thirds of expenditure growth since the mid-1970s has been due to enrollment growth, reflecting the program's important role in providing coverage for millions of low-income individuals and families who otherwise would have no source of health insurance.

The chapter also examines recent changes in Medicaid spending, including the impact of the

Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) eligibility expansion to the new adult group and the increase in spending brought on by the introduction of high-cost specialty drugs. It concludes with projections of enrollment and spending growth by eligibility group for future years.

Chapter 2: Addressing Growth in Medicaid Spending: State Options

Chapter 2 focuses on the policy levers that states currently have available to control Medicaid spending. As Medicaid program spending grows in absolute and relative terms and becomes a larger share of state budgets, states have incentives to limit growth in per-person spending and overall Medicaid costs. The federalist structure of Medicaid provides states with many options for the design and administration of their programs.

In this chapter, MACPAC describes the range of policy drivers that affect Medicaid spending at the state level, from federal requirements that create a spending floor in every state to areas where states have flexibility in the design and administration of their programs. The chapter examines options under current authorities, such as managing enrollment, limiting benefits, determining provider payments, changing delivery systems, and strengthening program integrity. The chapter also describes state requests for additional program changes under demonstration authority that currently are not allowed under federal statute.

In designing their programs and responding to changing economic conditions, states make choices among available policy options; different policy approaches have different effects on the magnitude and direction of spending changes, as well as on other aspects of the program. Typically, states seek first to minimize direct effects on beneficiaries. For example, states have kept Medicaid provider payments low compared to other payers rather than rolling back eligibility, and they have increasingly

sought to avoid blunt benefit and payment cuts through the use of value-based purchasing approaches. However, there are limits on the extent to which states can obtain further savings, including the requirement to meet minimum federal standards for coverage and access and the lack of resources needed to implement more sophisticated purchasing methods.

Future analyses will provide a more in-depth examination of state options to manage and design their programs to enhance efficiency, reduce costs, and improve health care quality. We will also examine areas where Congress has already provided states with alternatives and the reasons why states have chosen not to implement certain options. Finally, we will assess the potential outcomes associated with different choices, including the effects on federal and state spending, beneficiaries, and providers, and will explore the trade-offs associated with each to help inform future debate on redesigning Medicaid's financing structure.

Chapter 3: Alternative Approaches to Federal Medicaid Financing

Concerns about the level and rate of growth in federal Medicaid expenditures have prompted some policymakers to consider changes that would alter the trajectory of spending—including alternatives to the current financing structure—that would reduce the rate of growth in Medicaid spending. Chapter 3 presents the Commission's initial analysis of these financing alternatives.

The current financing structure has been criticized for its open-ended match of state expenditures, as well as for its encouragement of financing arrangements that substitute federal funds for state funds without necessarily increasing or improving services for Medicaid enrollees. On the other hand, the existing financing structure helps to ensure that states have the resources to respond to current events such as recessions, natural disasters, and public health emergencies. The

chapter concludes with a side-by-side comparison of major approaches to financing reform—block grants, capped allotments, per capita caps, and shared savings—looking at how each could affect not only state decision making and federal savings, but also beneficiaries and providers.

As proposals to restructuring federal Medicaid financing are further specified, the Commission will continue to explore the implications of any changes.

Chapter 4: Functional Assessments for Long-Term Services and Supports

Chapter 4 takes a focused look at the tools used by state Medicaid programs to assess applicants' health conditions and functional needs when determining functional eligibility for LTSS as well as in creating specific care plans for eligible individuals. The movement to home and community-based services and managed LTSS, as well as interest in better understanding the substantial costs of providing LTSS, highlights the role of functional assessments in determining how to deliver services efficiently.

However, the federal government does not require states to use a particular functional assessment tool; MACPAC's inventory of state practices found that there are at least 124 tools currently in use. States choose assessment tools for a variety of reasons. Some states find independently developed tools easier to implement; some prefer tools customized to their beneficiary population; and some state decisions are driven by the availability of funding.

The chapter discusses the relative merits and drawbacks of moving toward a single national tool to assess functional status. On one hand, a single national tool would facilitate analyses of LTSS use across states that would reflect the variation in beneficiary needs. However, states that have recently invested in new tools might find it burdensome to implement another new tool so soon. Moreover, currently there is no clear empirical

or operational reason to pick one existing tool over another. Given the substantial amount of activity at the Centers for Medicare & Medicaid Services to develop and validate new questions and domains for assessing functional status, the Commission will continue to monitor developments.

Introduction to Medicaid Spending and Financing Analyses

Since its first report in March 2011, the Medicaid and CHIP Payment and Access Commission has been examining trends in program spending in MACStats, featuring analyses of trends by service and eligibility pathway, and has been presenting statistics on Medicaid's share of state and federal budgets and comparisons to spending by other payers. In its reports to Congress and issue briefs, the Commission has also taken a close look at spending patterns and service use for specific populations including dually eligible beneficiaries, people with disabilities, beneficiaries with behavioral health conditions, and others. Our analyses have also focused on state variation and temporal trends in expenditures for supplemental payments to hospitals and nursing facilities, prescription drugs, and other services. This work has helped shed light on the unique role Medicaid plays within the broader health system and has allowed us to offer insights on specific opportunities to improve policy.

Now, for the first time, the Commission presents analyses of Medicaid spending in a broader context in three related chapters. This work responds to a direct request from the chairs of congressional committees with interest in Medicaid that we develop a long-term work plan focused on the program's spending trajectory, state incentives to ensure the program's sustainability, and financing reforms. At the request of the ranking members of these committees, our work also considers the implications of these spending trends and changes to financing under discussion on access to care, provider rates and participation, and enrollment.

Discussion of spending and financing in Medicaid inevitably goes to the tensions inherent in a program designed as a federal-state partnership.

States use many techniques to control spending, including selective use of eligibility pathways, widespread use of managed care, imposition of tight limits over provider payment, and strict management of coverage and utilization. Federal policy sets broad rules for allowable state expenditures and imposes reporting and other requirements to ensure accountability to taxpayers and program beneficiaries. Federal spending, however, is largely a function of state choices, and with limited exceptions (for example, coverage of low-income non-disabled adults and the temporary primary care payment increase), allowable expenditures are matched at the same rate without singling out those that have greatest value to population health and the economy as a whole. It is also worth noting, however, that states may forgo the opportunity to draw down federal funds due to budget constraints and their own policy preferences. On the other hand, the current financing structure has been criticized for encouraging states to substitute federal funds for state funds (by converting formerly state-funded programs or services to Medicaid in order to draw down federal matching funds) without providing any additional services or improving the value of services provided to Medicaid enrollees. But states have protested changes that would limit how they raise the non-federal share of total Medicaid program spending, pointing to the importance of these financing arrangements in providing sufficient resources to meet the program's goals.

Chapter 1 looks at Medicaid spending through a variety of lenses, considering how the program has grown over its history and the drivers of this growth, highlighting in particular recent trends related to expansion to the new adult group under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) and the introduction of new high-cost specialty drugs. Our analyses point to the many different factors that affect Medicaid spending growth, including medical price inflation, the aging of the population, economic shifts affecting the rate of poverty and both job growth and loss, innovations in medical

practice and technology, and changes in the mix and health status of the covered population, as well as changes in Medicaid policy such as required and optional eligibility expansions. In this chapter, the Commission highlights Medicaid's growing share of federal and state budgets, as well as its growth as a share of national health expenditures and gross domestic product. At the same time, Medicaid spending overall is expected to grow at a slower rate than Medicare and private insurance; growth in spending per enrollee has been lower than or comparable to Medicare and private insurance since the early 1990s. In fact, more than two-thirds of expenditure growth since the mid-1970s has been due to enrollment growth, reflecting the program's important role in providing coverage for millions of low-income individuals and families who otherwise would have no source of health insurance.

Our analysis of spending trends also points to Medicaid's important role in financing services provided to people with disabilities and the frail elderly. About one third of historical growth in benefit spending can be attributed to increased enrollment of individuals eligible on the basis of disability. Given the high average spending per person for these individuals (more than three times that of non-disabled adults and more than five times that of non-disabled children), even low rates of enrollment growth for this group can have a large effect on total Medicaid spending. In addition to covering medical care for this population, Medicaid also finances long-term services and supports (LTSS) and accounts for more than 60 percent of the nation's long-term care expenditures, which are covered to a more limited extent by other payers, including Medicare.

Although federal policies, such as expansions of coverage to children, pregnant women, and others, have played an important part in shaping Medicaid's role as a major payer for health services, state decisions also affect the program's spending trajectory. As we discuss in Chapter 2, the federal-state structure of Medicaid provides

states with many options for designing and administering their programs that affect spending, including coverage of optional eligibility groups and services, provider payment methods and rates, and strategies to address the volume and intensity of services, including delivery system reforms. Mindful of the need to balance state budgets, states have strong interests in holding down spending as well as multiple tools to limit growth in per-person spending and the overall rate of cost growth in Medicaid. Typically, states seek first to minimize direct effects on beneficiaries; for example, states have kept Medicaid provider payments low compared to other payers. States have also become more sophisticated purchasers, trying to avoid blunt benefit and payment cuts by contracting with managed care organizations to implement care management programs, developing value-based purchasing to better tie provider payments to measures of quality and other outcomes, and working to minimize fraud, waste, and abuse. These different policy approaches have different effects on the magnitude and direction of spending changes, as well as on other aspects of the program.

Concerns about the level and rate of growth in federal Medicaid expenditures have prompted some policymakers to identify Medicaid's financing structure, under which the federal government matches allowable state expenditures on an open-ended basis, as a root cause of federal spending growth. In Chapter 3, we describe the current financing structure, commenting on its origins as well as features that have been criticized. In particular, we note that this structure allows Medicaid to respond to secular events such as recessions, natural disasters, and public health emergencies. We then outline several major approaches to financing reforms—block grants, capped allotments, per capita caps, and shared savings—and consider how different approaches to the design of these policies might result in federal savings and affect state decision making, as well as how such constraints might affect beneficiaries, providers, and others.

A key part of the Commission’s statutory charge to review and assess Medicaid policy is to bring rigor and evidence to the policy discussion on issues that are core to the Medicaid program’s current roles of providing access to medical care for millions of low-income Americans, covering LTSS, and wrapping around other sources of coverage, including employer-sponsored insurance and Medicare, as well as serving as a critical source of revenue for safety-net providers delivering care to both Medicaid beneficiaries and the uninsured. The chapters that follow provide new information on spending trends, analyze how federal and state policy choices influence that spending, and tease out the critical decision points associated with significant changes in the respective responsibilities of the states and the federal government. While the Commission has not taken a position on the preferred level or rate of growth in Medicaid expenditures, the ability of states to manage spending, or the advisability of changes in financing, we hope that both federal and state policymakers find these analyses useful as they plan for the future. We anticipate continuing our work in these areas to advise Congress and others as more detailed Medicaid reform proposals are discussed.

CHAPTER 1

Trends in Medicaid Spending

Trends in Medicaid Spending

Key Points

- Medicaid is growing as a share of gross domestic product (GDP), national health care spending, and the federal budget, but it accounts for a smaller share of GDP and national health expenditures than Medicare and private insurance, and a smaller share of the federal budget than Medicare.
- Medicaid's share of state budgets depends upon how it is calculated. Medicaid accounted for 25.6 percent of state budgets in state fiscal year 2014 with all state and federal sources of funding included, but 15.3 percent of state budgets when only the state-funded portion was counted.
- Medicaid's rate of growth in spending per enrollee has been comparable to or lower than that of Medicare and private insurance since the early 1990s, and it is projected to be lower than that of Medicare and private insurance in the future.
- The majority (70.7 percent) of Medicaid benefit spending growth from fiscal year (FY) 1975 to FY 2012 (adjusted for health care price inflation) is attributable to growth in enrollment as opposed to growth in spending per enrollee (29.3 percent). When examining spending growth by eligibility group, almost half is attributable to individuals eligible on the basis of disability.
- Because Medicaid spending per enrollee varies substantially across eligibility groups, enrollment mix has a strong effect on average spending per enrollee. In FY 2012, spending per enrollee for individuals eligible on the basis of disability and those age 65 and older was more than three times that of adults eligible on a basis other than disability and more than five times that of children eligible on a basis other than disability.
- In 2014, total Medicaid spending grew 8 percent, largely due to enrollment growth, with most of the increase due to expansion to the new adult group. Because the federal government covered 100 percent of the costs of these new enrollees, federal spending grew 13 percent compared to 1 percent by states.
- In 2014, prescription drug spending increased by more than 20 percent, partly due to the introduction of high-cost treatments for hepatitis C. Even so, spending for prescription drugs accounts for about 6 percent of total Medicaid benefit spending. Growth rates are expected to decrease in the future as states negotiate higher supplemental rebates for hepatitis C treatments and other high-cost drugs.
- Spending is projected to grow about 6 percent annually over the next decade, reflecting diminishing expansion effects, expiration of the primary care payment increase, and negotiation with drug manufacturers.

CHAPTER 1: Trends in Medicaid Spending

Since its inception in 1965, the Medicaid program has grown to become a major payer in the health care system, accounting for almost \$500 billion in combined federal and state spending for fiscal year (FY) 2014. Although Medicaid accounted for about 16 percent of U.S. health care spending in calendar year (CY) 2014, it accounted for a smaller share of national health expenditures than Medicare (20 percent) and private insurance (33 percent) (MACPAC 2016a). For certain types of services, such as long-term services and supports (LTSS), Medicaid accounts for a larger portion of total U.S. spending than any other payer. In CY 2014, Medicaid financed almost one-third of nursing facility services and over half of the category of other health, residential, and personal care, a category that includes a variety of home and community-based services (MACPAC 2016a). Some policymakers have expressed concerns about the growth and sustainability of Medicaid as it becomes a larger share of both federal and state budgets.

Growth in aggregate Medicaid spending has led the program to account for an increasing share of gross domestic product (GDP), national health care spending, and federal and state budgets. Most of the historical growth in Medicaid spending has been due to increases in enrollment. Growth in Medicaid spending per enrollee has generally been moderate compared to other benchmarks. Much of the growth in Medicaid spending in FY 2014 was attributable to the increase in enrollment to adults newly eligible for Medicaid as a result of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) as well as an increase in prescription drug spending due to the introduction of new high-cost drugs.

This chapter examines Medicaid spending through a variety of lenses. It begins by comparing the

growth in Medicaid spending as a share of national health expenditures and federal and state budgets to other programs and benchmarks. The chapter then examines the components of spending growth, which include changes in enrollment and spending per enrollee. The chapter concludes by examining recent changes in Medicaid spending (in particular, the impact of the eligibility expansion to the new adult group) and projections in enrollment and spending growth by eligibility group for future years. This chapter largely focuses on national trends because much of the historical and projected Medicaid spending information is available only at the national level. The factors and components of growth contributing to national spending trends may vary from those in any particular state.¹

Medicaid Share of U.S. Health Care Spending

Health care spending is growing as a share of the nation's economy, and Medicaid spending mirrors that trend. Between 1970 and 2014, U.S. health care spending increased from 7.0 percent of GDP to 17.5 percent; over the same period, Medicaid spending increased from 0.5 percent of GDP to 2.9 percent (OACT 2015a, 2015b). Much of the historical growth in Medicaid spending as a percentage of GDP can be explained by the growth in overall health care spending as a percentage of GDP (Kronick and Rousseau 2007).

Spending for Medicaid, Medicare, and private insurance has increased as a share of U.S. health care spending over time; in contrast, the share attributable to out-of-pocket spending and other third-party payer spending (such as private philanthropy, workers' compensation, state and local subsidies to hospitals and other facilities, and government public health activities) has decreased. From 1975 to 1989, Medicaid's share of national health expenditures remained nearly constant at about 10 percent; it then grew rapidly between 1989 and 1996 to 15 percent (Kronick and Rousseau 2007). In 2014,

the most recent year for which historical data are available, combined federal and state expenditures for Medicaid accounted for about 16 percent of U.S. health care spending. In comparison, Medicare spending accounted for 20 percent of U.S. health care spending and private insurance accounted for 33 percent (MACPAC 2016a).

Although Medicaid enrollment and spending are expected to increase with the expansion to the new adult group, Medicaid is projected to remain a smaller share of U.S. health care spending than Medicare and private insurance: Medicaid's share of national health expenditures is projected to reach 17 percent in 2015 and to decrease slightly through 2024, while Medicare is projected to reach 23 percent through a steady climb over the same period, and private insurance is projected to fall to 32 percent after a brief increase (MACPAC 2015a, OACT 2015c).

For certain types of services, such as LTSS, Medicaid accounts for a larger portion of total U.S. spending than any other payer, reflecting Medicaid's unique role in providing these services. In CY 2014, Medicaid financed 32 percent of nursing facility services and 56 percent of the category of other health, residential, and personal care, which includes a variety of home and community-based services (MACPAC 2016a). An analysis of national health expenditures using slightly different service categories found that Medicaid accounted for 61 percent of all LTSS spending in CY 2012, that is, \$134 billion out of a total of \$220 billion (O'Shaughnessy 2014). Medicaid also pays for more than one-quarter (27 percent) of all spending on mental health services and about one-fifth (21 percent) of all spending on substance abuse treatment (SAMHSA 2013).

Medicaid as Share of Federal Spending

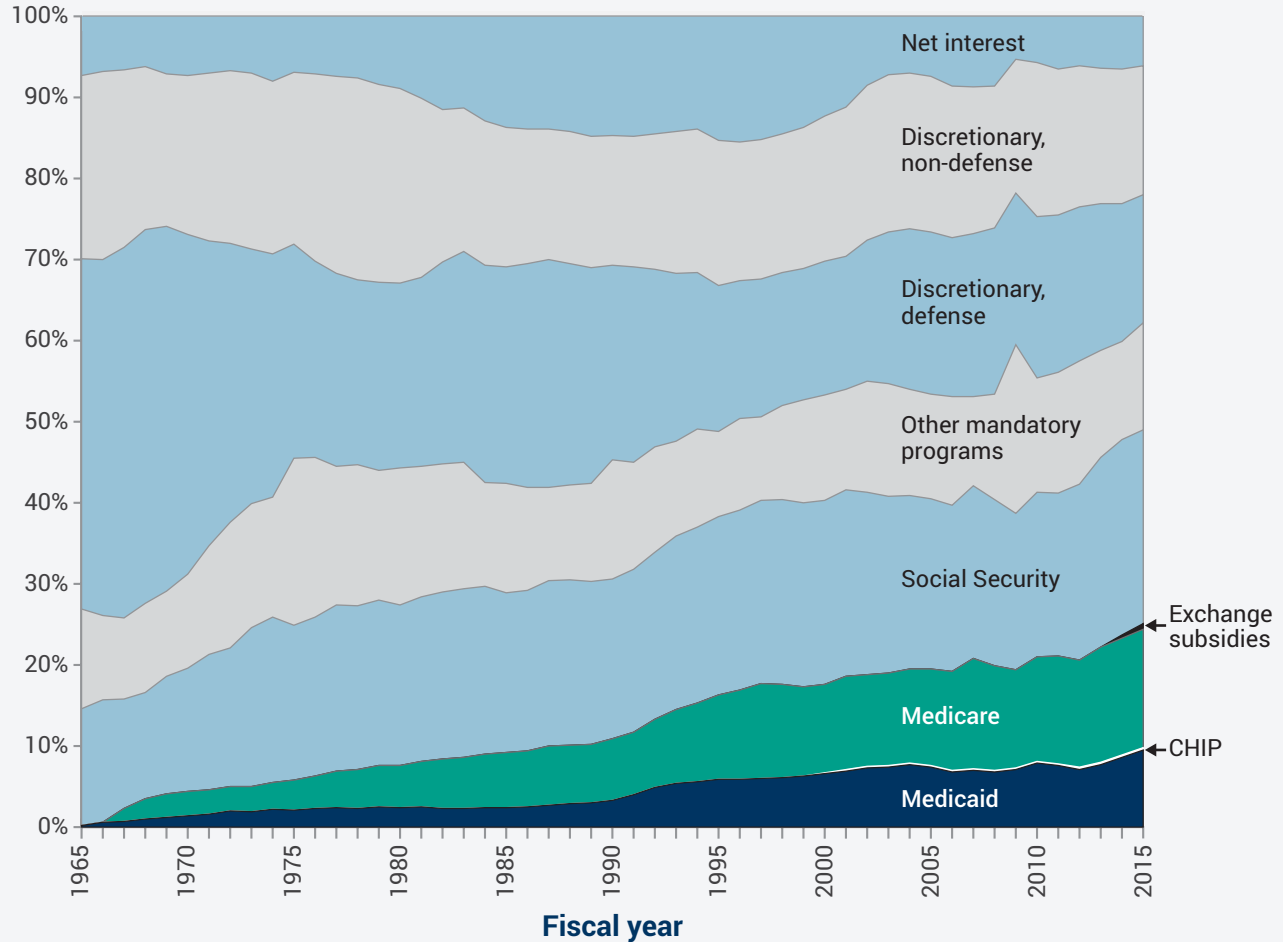
As with Medicare and Social Security, federal outlays for the Medicaid program are mandatory

spending, meaning that the amounts are generally driven by statutory criteria such as eligibility and benefits as opposed to annual appropriations. However, Medicaid is financed entirely by general revenues, while Medicare and Social Security receive substantial financing from dedicated revenue sources such as payroll taxes. Mandatory spending programs comprised less than 30 percent of the federal budget when Medicare and Medicaid were enacted in 1965; today, their share is about 60 percent. During this time period, spending for health care-related programs, including Medicaid, Medicare, the State Children's Health Insurance Program (CHIP), and exchange subsidies, has grown to one-quarter of federal outlays (Figure 1-1).

Medicaid grew from 1.4 percent of federal outlays in FY 1970 to 9.5 percent in FY 2015. Since 2000, Medicaid has grown slightly faster than Medicare, with Medicaid growing at an average rate of 7.5 percent a year compared to Medicare at 7.1 percent (Figure 1-1). Both programs expanded substantially during this period—Medicaid expanded eligibility to the new adult group in 2014 and Medicare added prescription drug coverage under Medicare Part D in 2006. But even with the recent growth in enrollment due to the new adult group, Medicaid's 9.5 percent share of the federal budget was smaller than Medicare's 14.6 percent share in FY 2015 (MACPAC 2016b).

Over the next several years, Medicaid is projected to grow at a rate that is comparable to or slower than Medicare. The Office of Management and Budget projects federal Medicaid spending to grow at an average of 4 percent a year compared to 5 percent for Medicare from FY 2015 to FY 2020 (MACPAC 2016c). The Congressional Budget Office projects both Medicaid and Medicare to grow at an average rate of 5.6 percent annually from FY 2015 to FY 2020 and projects Medicaid to grow at an average rate of 5.3 percent annually—compared to 7.1 percent for Medicare—from FY 2020 to FY 2025 (CBO 2016a, 2016b).

FIGURE 1-1. Major Health Programs and Other Components of the Federal Budget as a Share of Federal Outlays, FYs 1965–2015



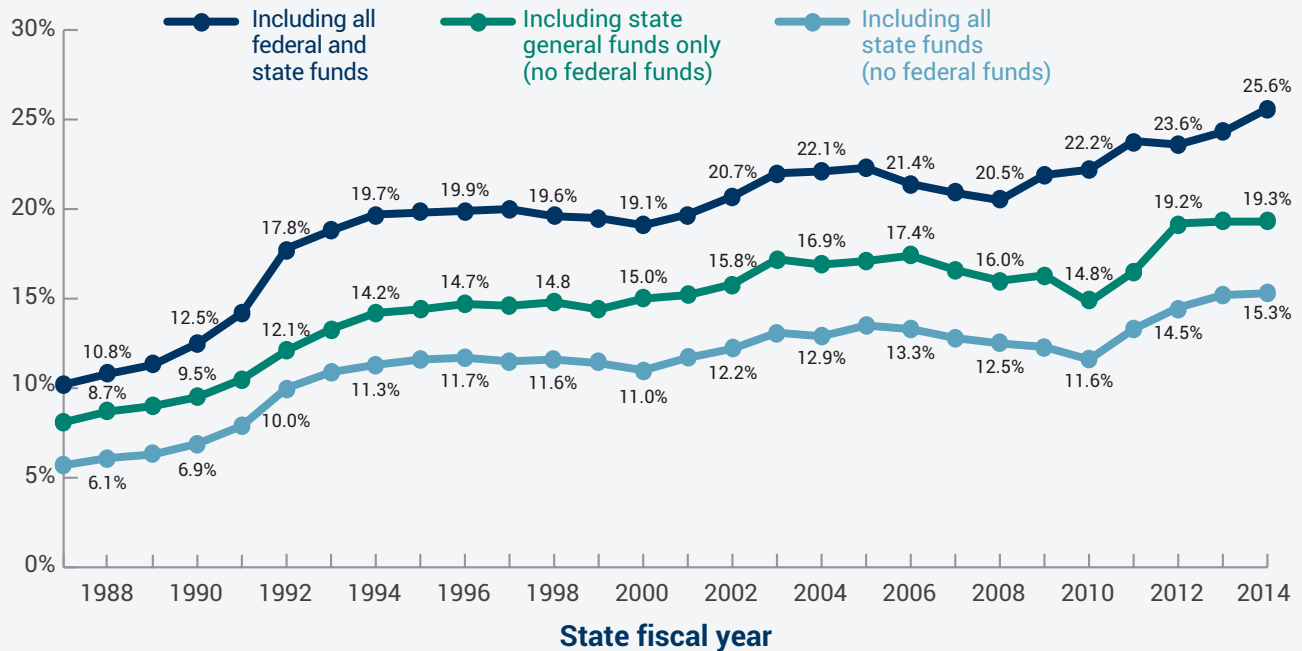
Note: FY is fiscal year.
Source: MACPAC 2016b.

Medicaid’s Share of State Budgets

Medicaid accounts for a large share of state budgets, but that share differs substantially depending on how it is measured.² Medicaid’s share of a state’s budget also varies from state to state (MACPAC 2016d). Looking at spending across all states for state fiscal year (SFY) 2014, Medicaid accounted for over one-quarter (25.6 percent) of state budgets, including funds from all state and federal sources (Figure 1-2).

Another way to look at state spending is to consider the state-funded portion of state budgets (i.e., excluding federal funds), because this is the amount that states must finance on their own through taxes and other means. States must provide the non-federal, or state, share of Medicaid in order to draw down federal matching funds. Excluding federal matching funds, Medicaid accounted for 19.3 percent of spending from state general funds (e.g., raised through income, sales, and other broad-based state taxes) in SFY 2014 (Figure 1-2).

FIGURE 1-2. Medicaid’s Share of State Budgets Including and Excluding Federal Funds, SFYs 1987–2014



Note: SFY is state fiscal year. The all federal and state funds category reflects amounts from any source. The state general funds only category reflects amounts from revenues raised through income, sales, and other broad-based state taxes. The all state funds only category reflects amounts from any non-federal source; these include state general funds, other state funds (amounts from revenue sources that are restricted by law for particular government functions or activities, which for Medicaid includes provider taxes and local funds), and bonds (expenditures from the sale of bonds, generally for capital projects). Amounts shown here reflect the most recent information available in cases where data for a given year were published and then updated in a subsequent report.

Source: MACPAC 2016e.

Funding for the non-federal share of Medicaid can come from a variety of sources. By law, at least 40 percent of the non-federal share of total Medicaid expenditures must be financed by the state and up to 60 percent may come from local governments. States have a significant amount of flexibility in using dedicated sources of revenue including health care-related taxes on providers, intergovernmental transfers (IGTs), and certified public expenditures (CPEs), and have increasingly relied on these additional sources of revenue to finance the program. In SFY 2012, 69 percent of funds came from state general revenues, 16 percent came from local governments (including IGTs and CPEs), 10 percent came from health care-related taxes, and 5 percent came from other

sources (GAO 2014). When all available sources of non-federal funding are considered—including state general funds, bonds, and other sources such as health care-related taxes and local funds—Medicaid spending accounted for 15.3 percent of the state budget derived from these funds (Figure 1-2).

Regardless of how Medicaid’s share of state budgets is measured, a similar growth trajectory is observed over the SFY 1987 to 2008 period (Figure 1-2). In SFYs 2009 and 2010, however, the program’s share of state-funded budgets (excluding federal funds) remained stable or dropped, while its share of total state budgets (including federal funds) continued to increase. This divergence was largely due to a temporary increase in the Medicaid

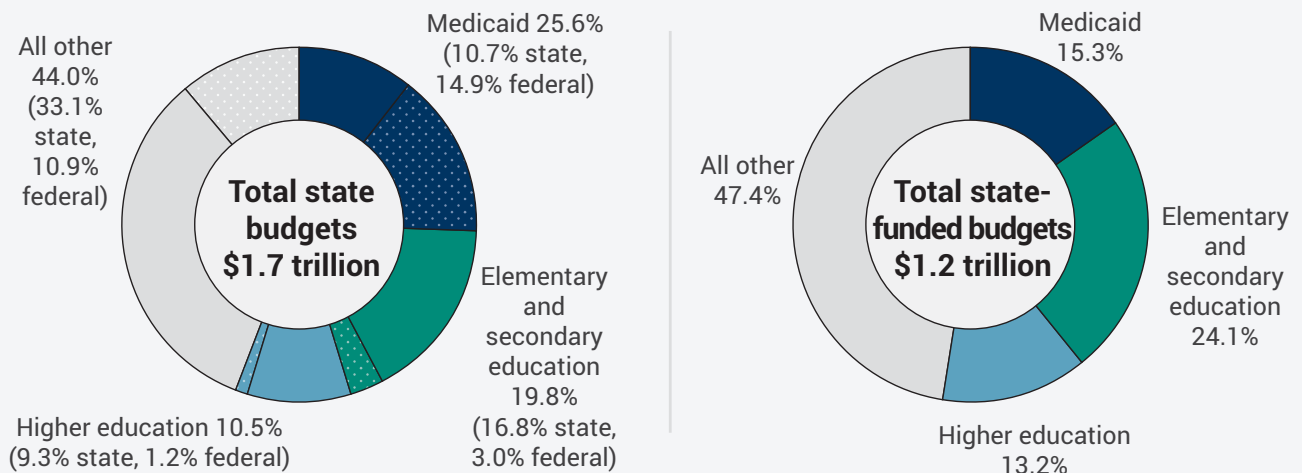
federal medical assistance percentages (FMAPs) under the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5), which was intended to provide states with fiscal relief during an economic downturn. The temporary increase ran from the first quarter of FY 2009 through the third quarter of FY 2011. By SFY 2011, Medicaid’s share of state-funded budgets had returned to previous levels. In SFY 2014, Medicaid’s share of total state budgets increased, but its share of state-funded budgets remained unchanged due to 100 percent federal funding available for the new adult group.

Many governors and state legislators have raised concerns that growth in Medicaid spending is squeezing out spending for other priorities. Although Medicaid is one of the largest budget items for states, it is important to note that Medicaid receives a greater percentage of its funding from federal sources than other programs do. When all state and federal funds are counted,

Medicaid is the largest portion of state budgets (25.6 percent), followed by elementary and secondary education (19.8 percent) and higher education (10.5 percent) (Figure 1-3). Excluding federal funds, elementary and secondary education (24.1 percent) is the largest portion of state-funded budgets, followed by Medicaid (15.3 percent) and higher education (13.2 percent) (Figure 1-3).

Relative to education, Medicaid’s share of spending is even smaller when all spending by both state and local governments is considered. This is due to variation in the level of government at which spending for various functions occurs. For example, the majority of Medicaid spending occurs at the state level: the state Medicaid agency is generally the entity that pays health care providers or managed care organizations for services rendered to Medicaid beneficiaries. By contrast, both state and local governments may make payments for elementary and secondary education. Higher education spending

FIGURE 1-3. Distribution of Medicaid, Education, and All Other Spending from Total State Budgets versus State-Funded State Budgets, SFY 2014



Note: SFY is state fiscal year. Total state budgets include all state funds (solid segments) and federal funds (dotted segments). State-funded state budgets include all non-federal funds, and consist of state general funds (expenditures from revenues raised through income, sales, and other broad-based state taxes), other state funds (expenditures from revenue sources that are restricted by law for particular government functions or activities, which for Medicaid includes provider taxes and local funds), and bonds (expenditures from the sale of bonds, generally for capital projects).

Source: MACPAC 2016 analysis of NASBO 2015.

generally occurs at the state level.³ As a result, although Medicaid’s share of spending by state governments (from all revenue sources, including federal dollars) was nearly 26 percent and education’s share was about 30 percent in SFY 2014, when amounts that include spending by both state and local governments are examined, Medicaid’s share is smaller—an estimated 17 percent or less in SFY 2012—and education’s share is about the same at 28 percent (Figure 1-3) (MACPAC 2015b).⁴

Growth in Spending per Enrollee

The annual growth rate in spending per enrollee in Medicaid has been comparable to or lower than the annual growth rate in spending per enrollee in Medicare and private insurance since the early 1990s (Table 1-1). For the past 15 years (1999 to 2014),

not only has the annual growth rate in spending per enrollee in Medicaid been lower than the annual growth rate in spending per enrollee in Medicare and private insurance, but it has also been lower than the average rate of price inflation for medical services as measured by the medical care component of the Consumer Price Index (CPI) (Table 1-1).

Changes in spending per enrollee are influenced by a number of factors, including changes in prices and payment rates, the breadth of covered benefits, the amount of beneficiary cost sharing, and the mix and composition of the beneficiary population. For example, the decrease in Medicaid spending per enrollee and the large increase in Medicare spending per enrollee between 2005 and 2006 reflects the introduction of Medicare Part D and the accompanying shift in drug spending for dually eligible beneficiaries from Medicaid to Medicare.⁵

TABLE 1-1. Average Annual Growth in Medicaid Spending per Enrollee Compared to Various Benchmarks, 1987–2023

	1987–1991	1991–1999	1999–2005	2005–2006 ¹	2006–2013	2013–2014	2014–2023 ²
Average annual growth in spending per enrollee by coverage type							
Medicaid	9.2%	5.9%	2.8%	-0.3%	1.9%	-2.0%	3.6% ³
Medicare	7.8	5.9	6.6	16.5	2.6	2.4	4.2
Private	14.2	5.3	8.8	4.8	4.4	3.2	4.0–6.0 ^{3,4}
Average annual growth in prices and economic output							
CPI-U	4.6	2.6	2.7	3.2	2.1	1.6	2.0
CPI-U medical care	8.0	4.4	4.3	4.0	3.4	2.4	4.0
GDP	6.1	5.8	5.2	5.8	2.7	4.1	4.0

Notes: CPI-U is Consumer Price Index for All Urban Consumers. GDP is gross domestic product. Growth rates reflect calendar years except in the case of Medicaid and private insurance for 2014–2023, which reflect fiscal years. Time periods displayed through 2014 were selected by grouping years with roughly similar Medicaid growth rates. Growth rates are not controlled for changes in enrollee mix or benefit design.

¹ Reflects implementation of Medicare Part D, which created a new drug benefit for Medicare enrollees and shifted drug costs for dually eligible beneficiaries from Medicaid to Medicare.

² Data are projected.

³ Projected growth is for fiscal years 2014–2023.

⁴ Private health insurance spending per enrollee is projected to grow by an average of 4.3 percent per year over the FY 2014–2018 period (CBO 2015). Private health insurance spending per enrollee is projected to increase by an average of 5.3 percent per year over the FY 2016–2025 period (CBO 2016c). CBO projects premiums for private plans will increase by an average of about 4 percent per year from FY 2014 through FY 2018 and by 5 percent to 6 percent per year from FY 2019 to FY 2025 (CBO 2016d).

Source: MACPAC 2016 analysis of BLS 2016; CBO 2016c, 2016d, 2016e, 2015; OACT 2015a, 2015b, 2015c; and Trustees 2015.

Between 2013 and 2014, the decrease in Medicaid spending per enrollee reflects a shift in the mix of enrollees—the addition of relatively lower-cost adults who enrolled through the Medicaid expansion shifted the enrollment mix to include a higher proportion of lower-cost individuals.

Between FY 2014 and FY 2023, Medicaid spending per enrollee is projected to grow at an average of about 3.6 percent annually, which is higher than the growth rate over the previous decade, but lower than the projected growth rate for Medicare and private insurance over the same time period. This higher growth rate relative to recent years reflects a number of assumptions by the Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS), including assumptions that states would institute fewer provider payment rate freezes and reductions and would allow more rate increases in the future, that home and community-based services for enrollees with disabilities would continue to expand, and that there would be a modest increase in medical inflation (OACT 2015d, 2014a).⁶

Components of Spending Growth

Changes in Medicaid spending can be driven by changes in the number of people enrolled in the program, changes in average spending per enrollee, or both. Factors driving growth in Medicaid spending per person include the mix of people enrolled in the program, the volume and intensity of the services enrollees use, and the prices paid for those items and services.

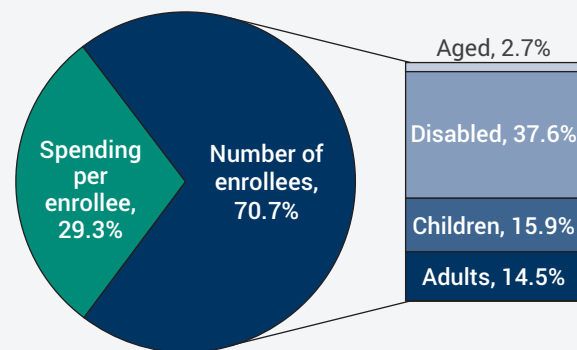
Enrollment

The majority of historical growth in real Medicaid spending (adjusted for health care price inflation) can be attributed to enrollment. From FY 1975 to FY 2012, more than two-thirds (70.7 percent) of growth in real Medicaid benefit spending was due to increases in the number of enrollees (Figure 1-4).

Enrollment growth among individuals eligible on the basis of disability accounted for over one-third of the historical growth (Figure 1-4). Given the high average spending per person for individuals who are eligible on the basis of disability, even low rates of enrollment growth for this population can have a large effect on total Medicaid spending.

Not all enrollment growth is driven by eligibility expansions. For example, population aging alone can increase Medicaid enrollment because low-income individuals can become eligible for Medicaid when they turn 65 if they qualify for Supplemental Security Income or need LTSS. Decreases in income during economic recessions also increase enrollment under existing eligibility rules, particularly among children and adults eligible on a basis other than disability. In addition, efforts to expand outreach and simplify the

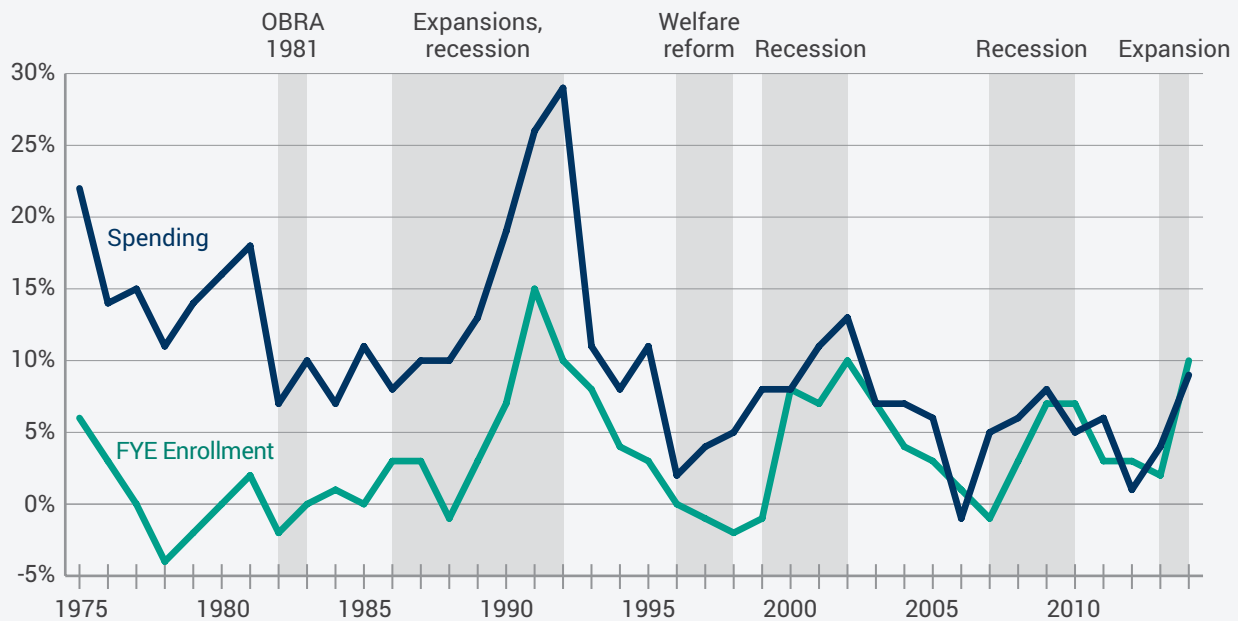
FIGURE 1-4. Growth in Real Medicaid Benefit Spending Due to Enrollment by Eligibility Group, FYs 1975–2012



Notes: FY is fiscal year. Dollar amounts were adjusted for inflation using the gross domestic product (GDP) price deflator for health care.

Source: MACPAC 2016 analysis of Centers for Medicare & Medicaid Services (CMS) 2012 Medicare & Medicaid Statistical Supplement data from Tables 13.4 and 13.10 (for FY 1975), and Medicaid Statistical Information System (MSIS) data as of December 2014 and CMS-64 Financial Management Report (FMR) net expenditure data as of June 2015 (for FY 2012).

FIGURE 1-5. Annual Growth Rates in Medicaid Enrollment and Spending, FYs 1975–2014



Note: FY is fiscal year. FYE is full-year equivalent, which also may be referred to as average monthly enrollment. OBRA is Omnibus Budget Reconciliation Act. All numbers exclude CHIP-financed coverage. Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Enrollment counts are full-year equivalents and for FYs 2012–2014 are projected; FYs 1999–2014 include estimates for Puerto Rico and the Virgin Islands.

Source: Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, 2015, data compilation provided to MACPAC staff, April 17, 2015. (Figure adapted from Exhibit 9 in MACStats: Medicaid and CHIP data book, December 2015, Washington, DC: MACPAC.)

enrollment process can increase take-up rates among the eligible population and increase enrollment.

Policy changes and economic conditions play an important role in Medicaid enrollment and spending and can result in sizeable changes from year to year (Figure 1-5). For example, in the late 1970s and early 1980s, high economy-wide inflation led to high Medicaid spending growth even during times of low enrollment growth. From the mid-1980s to the mid-1990s, many Medicaid-specific changes occurred, including eligibility expansions that increased both enrollment and spending as well as states’ use of disproportionate share hospital (DSH) payments and alternative financing mechanisms that increased spending. As spending growth rates spiked at over 25 percent between 1990 and 1992, Congress passed

legislation to place aggregate caps on DSH spending and restrict the use of health care-related taxes, which led to a slowdown in spending growth in the following years (Klemm 2000). In the mid-to-late 1990s, growth was affected by changes in federal Medicaid policy, including 1996 welfare reform legislation that severed the link between Medicaid eligibility and receipt of cash welfare assistance for low-income families, which had the effect of decreasing Medicaid enrollment (Klemm 2000). Growth rates accelerated in years around the recessions of 2001 and 2007 to 2009, then slowed as economic conditions improved (Young et al. 2013, Holahan et al. 2007). Medicaid spending actually decreased from FYs 2005 to 2006, primarily due to the implementation of Medicare Part D, which shifted the coverage of outpatient prescription drugs for dually eligible beneficiaries from Medicaid to Medicare (Holahan et al. 2007).⁷

In FY 2014, growth rates were primarily driven by an adult eligibility expansion; as of January 2016, 31 states and the District of Columbia had chosen to adopt the adult expansion (MACPAC 2015c).⁸

Spending per enrollee

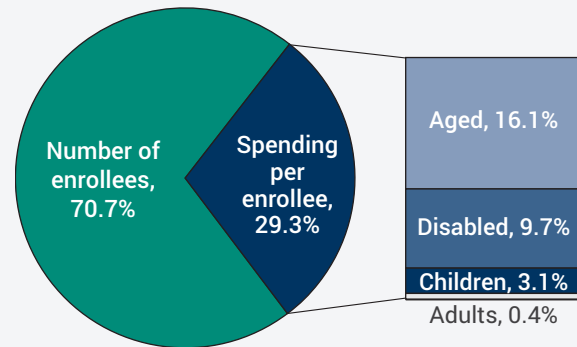
Less than one-third (29.3 percent) of growth in real Medicaid benefit spending between FY 1975 and FY 2012 was due to increases in spending per enrollee (Figure 1-6). The growth due to increases in spending per enrollee shown here reflects an increase in the volume and intensity of Medicaid services because spending has been adjusted for health care price inflation and changing enrollment mix. The majority of the increase in spending per enrollee was attributable to individuals eligible on the basis of disability and those age 65 and over (Figure 1-6).

Medicaid benefit spending per enrollee varies substantially across states. In FY 2012, the average spending per enrollee across states ranged from 70 percent to 190 percent of the national average (MACPAC 2015d). This variation reflects several factors, including the breadth of benefits that states choose to cover, the proportion of enrollees receiving the full benefit package or a more limited version, the health status and other characteristics of enrollees, the underlying costs of delivering health care services in specific geographic areas, and state policies regarding benefit limits, provider payments, care management, and other program features. Other factors affecting spending per enrollee may include efforts to re-engineer delivery systems, changes to beneficiary incentives through cost sharing or other means, and program integrity initiatives to reduce improper spending.

Enrollee mix

Per enrollee spending varies substantially across the different Medicaid eligibility groups. In FY 2012, children eligible on a basis other than disability averaged the least amount of benefit spending

FIGURE 1-6. Growth in Real Medicaid Benefit Spending Due to Spending per Enrollee by Eligibility Group, FYs 1975–2012



Notes: FY is fiscal year. Dollar amounts were adjusted for inflation using the gross domestic product (GDP) price deflator for health care.

Source: MACPAC 2016 analysis of Centers for Medicare & Medicaid Services (CMS) 2012 Medicare & Medicaid Statistical Supplement data from Tables 13.4 and 13.10 (for FY 1975), and Medicaid Statistical Information System (MSIS) data as of December 2014 and CMS-64 Financial Management Report (FMR) net expenditure data as of June 2015 (for FY 2012).

at \$2,679 per enrollee, and individuals eligible on the basis of disability had the highest average benefit spending at \$17,848 per enrollee (Figure 1-7). Individuals eligible on the basis of disability and those age 65 and older accounted for about one-quarter of Medicaid enrollees, but about two-thirds of program spending (MACPAC 2015e, 2015f). When the components of historical growth in real Medicaid benefit spending are examined by eligibility group, almost half of the growth is attributable to individuals who are eligible on the basis of disability (Figures 1-4 and 1-6).

As a result of these spending differences across enrollees, the overall average Medicaid spending per enrollee is heavily influenced by enrollment mix across the different eligibility groups. For example, the increase in relatively low-cost adults through Medicaid expansions beginning in 2014 shifted the

enrollment mix to include a higher portion of lower-cost individuals. Overall Medicaid benefit spending per enrollee is estimated to have increased by 0.3 percent in FY 2014, but when changes in enrollment mix that reflected the influx of the newly eligible adults are excluded, the estimated increase is 3.1 percent (OACT 2015d). Over the next 10 years, Medicaid benefit spending per enrollee is projected to grow at an average annual rate of 3.5 percent; when the effects of changes in the enrollment mix are excluded, benefit spending per enrollee is projected to grow at an average annual rate of 4.1 percent (OACT 2015d).

Volume, mix, and intensity of services

The differences in per enrollee spending across eligibility groups reflect the differences in health status of the enrollees, thus also reflecting the volume, mix, and intensity of services used by those enrollees. Much of the spending for individuals who qualify on the basis of disability and those age 65 and older reflects the use of LTSS. LTSS accounted for over one-third (37 percent) of spending for individuals eligible on the basis of disability and over half (64 percent) of spending for those age 65 and older (MACPAC 2015g). In fact, the average per enrollee spending for LTSS alone for individuals eligible on the basis of disability and individuals age 65 and older was greater than the total per enrollee spending for either children or adults eligible on a basis other than disability (Figure 1-7). LTSS users made up only 6 percent of enrollees but accounted for over 40 percent of spending in FY 2012 (MACPAC 2015h).

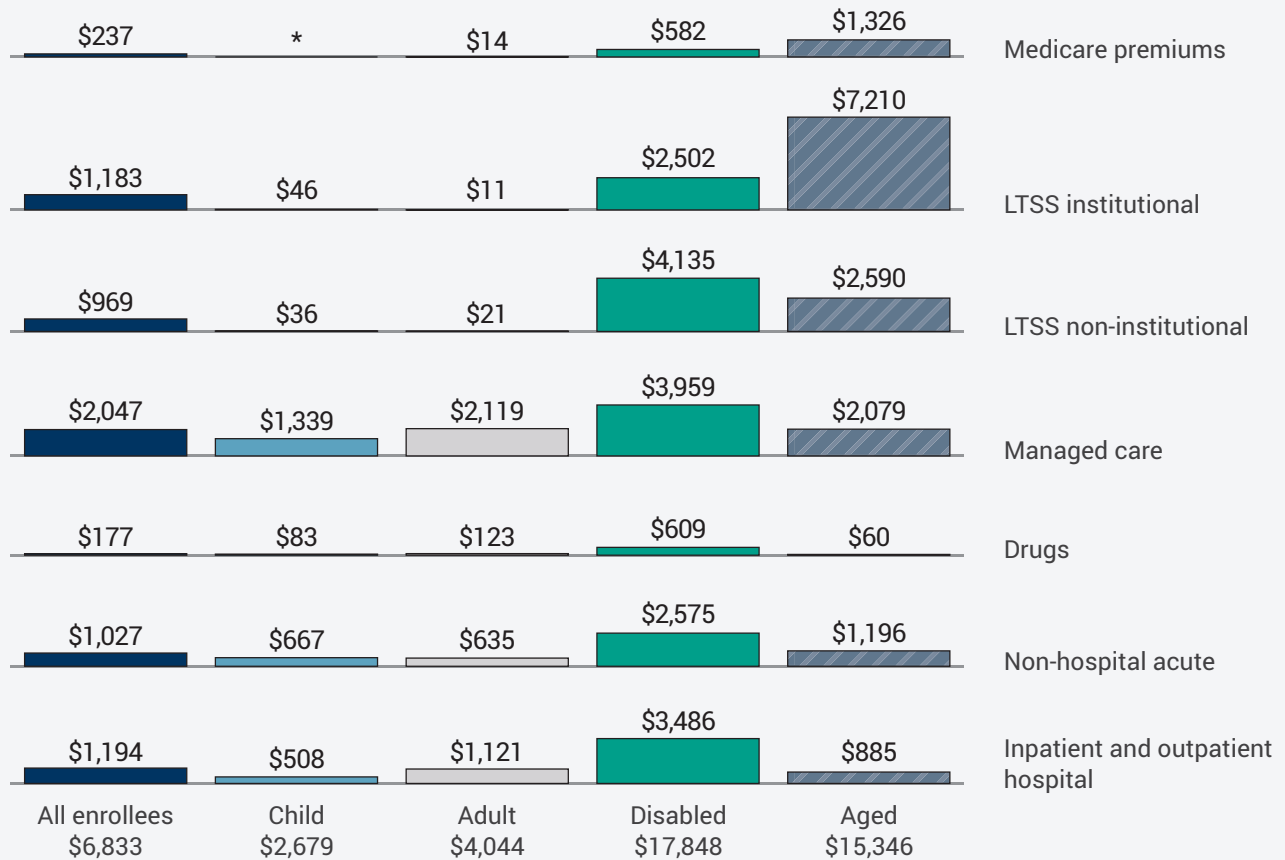
Among enrollees with similar health status, differences in the volume, mix, and intensity of services across states may reflect the flexibility states have in designing their own Medicaid programs, including the breadth of benefits a state covers, limits or restrictions on those benefits, the level and setting of care (e.g., nursing facility versus home and community-based LTSS), and the delivery systems and level of care management

provided (e.g., primary care case management, managed care). Because of the amount of spending associated with LTSS, many states have sought to reduce institutionalization and provide more services in the community. This shift can provide long-term cost savings (Kaye et al. 2009). Over the next 10 years, the growth in average benefit cost for individuals eligible on the basis of disability and those age 65 and older is expected to be slower than other eligibility groups due in large part to the relatively slower growth in the cost of LTSS as states continue using more home and community-based services to postpone enrollee need for long-term care facilities (OACT 2015d). Even disregarding LTSS, individuals eligible on the basis of disability use a considerable amount of services, with their fee-for-service spending for hospital and other acute care services being higher than total spending per enrollee for either children or adults. For children and adults, just over half of benefit spending is for capitation payments made to managed care plans because states have put more than half of these beneficiaries into comprehensive managed care (Figure 1-7). The data do not allow us to estimate what proportion of the capitation payments went toward individual services provided by the managed care plans.

Prices

The amounts that states pay for any particular service (i.e., unit prices) are developed by each state and must be approved by CMS to ensure that they are consistent with the principles set forth in statute that payments be consistent with efficiency, economy, quality, and access, and safeguard against unnecessary utilization (§ 1902(a)(30)(A) of the Social Security Act). Medicaid payments for a particular service may vary substantially across states due to the use of different payment methods. For example, states may use different payment methods to pay for inpatient hospital services, including cost reimbursement, per diem, per stay, and prospective payment based on diagnosis-related groups (MACPAC 2014a). But even when states

FIGURE 1-7. Medicaid Benefit Spending per Full-Year Equivalent Enrollee by Eligibility Group and Service Category, FY 2012



Notes: FY is fiscal year. LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. About 737,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged. Amounts are fee for service unless otherwise noted, and they reflect all enrollees, including those with limited benefits. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under Section 1115 waiver expenditure authority, which were previously included. See <https://www.macpac.gov/macstats/data-sources-and-methods/> for additional information.

* Values less than \$1 are not shown.

Sources: MACPAC 2015 analysis of MSIS data as of December 2014 and analysis of CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of June 2015. (Figure reprinted from Exhibit 19 in *MACStats: Medicaid and CHIP data book*, December 2015, Washington, DC: MACPAC.)

use similar payment methods, payment rates can still vary substantially due to differences in state policy goals, local market conditions, and the underlying costs of delivering health care services in a specific geographic area. For example, states generally pay physicians based on a fee schedule,

but a 2012 survey of Medicaid physician fees for a selection of commonly used services found that Medicaid fees paid by different states ranged from 58 percent of the national average in Rhode Island to 242 percent of the national average in Alaska (Zuckerman and Goin 2012).

Year-to-year changes in unit price may or may not track with underlying growth in overall health care prices. The 2012 physician fee survey found that Medicaid fee-for-service payment rates for the selected services increased 4.9 percent between 2008 and 2012; over this same time period, the CPI increased 4.4 percent and the medical care component of the CPI increased 14.9 percent (Zuckerman and Goin 2012). States are not required to make inflationary adjustments; instead, they may change payment rates to support particular policy goals (e.g., to increase provider participation and access), to tie payment rates to the attainment of certain benchmarks related to quality, or to accommodate state budget constraints.

Additionally, state payments for a particular service may be influenced by mechanisms for financing the non-federal share, such as health care-related provider taxes and contributions from local governments. These non-general fund sources of financing are often used in conjunction with supplemental payments, which are typically lump-sum payments made to a provider in addition to the standard payment rate for services. These

supplemental payments play an important role in Medicaid payment to certain providers such as hospitals and nursing facilities (MACPAC 2014b, 2012). For example, supplemental payments comprised over 40 percent of total Medicaid payments to hospitals in FY 2014 (MACPAC 2015i).

Medicaid Spending in 2014 and Beyond

Total Medicaid spending increased by about 8 percent in FY 2014, rising from \$460 billion in FY 2013 to \$498 billion (MACPAC 2015j). The spending growth was much higher for some services than for others in 2014, reflecting a variety of factors, including increases in enrollment and changes in enrollment mix, payment policy, and the mix of services within a service category (Table 1-2). Because much of the spending growth was attributable to the new adult group, growth was higher in services that the new adult group was most likely to use. LTSS, including nursing and retirement facilities and other health, residential,

TABLE 1-2. Distribution and Annual Growth of Medicaid Benefit Spending by Type of Service, FYs 2006–2016

Type of service	Share of benefit spending 2014 ¹	Average annual growth 2006–2013	Annual growth 2013–2014	Projected growth	
				2015	2016
Hospital	38%	5%	8%	9%	6%
Other health, residential, and personal care	19	6	3	4	5
Physician and clinical	14	7	23	6	0
Nursing and retirement facilities	11	2	3	3	4
Home health	7	8	4	7	6
Prescription drugs	6	2	24	13	3
Dental	2	9	14	13	6
Other professional	1	7	17	15	6
Durable medical equipment	1	6	12	9	7

Note:

¹ Components may not sum to 100 percent due to rounding.

Source: MACPAC 2016 analysis of OACT 2015a, 2015c.

and personal care services, were less likely to be used by the new adult group, and spending for these services increased the least in 2014. Spending for physician and clinical, dental, and other professional services was partly driven by policy changes that included expanded coverage for adults and a mandated primary care payment increase under the ACA, which required states to pay primary care providers fees that were at least equal to Medicare fees. The availability of new high-cost drugs, particularly for the treatment of hepatitis C, also contributed to much higher than average growth for the prescription drug category in 2014 (Box 1-1). The managed care share of total Medicaid benefit spending increased by almost 6

percentage points, from 31.6 percent in FY 2013 to 37.5 percent in FY 2014; nearly all individuals gaining eligibility through the new adult group were enrolled in managed care plans, and many states, including non-expansion states, increased their use of managed care (MACPAC 2015k). The CMS Office of the Actuary projects that spending growth rates for 2015 and beyond will be lower going forward, at about 6 percent annually over the next decade. These projections reflect factors that include the moderation of expansion effects, expiration of the primary care payment increase, and negotiation with drug manufacturers (Keehan et al. 2015).

BOX 1-1. Prescription Drug Spending

Prescription drug spending was a key driver of the increase in national health spending from 2013 to 2014 for all payers. After many years of low to moderate growth, overall prescription drug spending for all payers increased 12 percent in 2014, and the increase for Medicaid was even higher at 24 percent (Martin et al. 2016). The increase in prescription drug spending was largely the result of increased enrollment under the expansion to the new adult group and the introduction of new, high-cost drugs to treat conditions such as hepatitis C.

In CYs 2013 to 2014, gross Medicaid drug spending (i.e., spending before rebates) increased more in states that expanded Medicaid eligibility to the new adult group than in states that did not expand Medicaid. Gross drug spending increased 24.6 percent in expansion states compared to 14.1 percent in non-expansion states. This 10 percentage point difference provides a sense of the impact of expansion in eligibility; however, the data do not tell us exactly how much of the annual increase in gross spending is due solely to the Medicaid expansion (MACPAC 2016f).

Additionally, there has been an increase in the use and price of high-cost specialty drugs. In CY 2014, drugs costing over \$1,000 per claim accounted for less than 1 percent (0.9 percent) of claims but almost one-third (32 percent) of total gross drug spending. A substantial amount of the increase in high-cost drugs in 2014 was attributable to the introduction of new treatments for hepatitis C in late 2013 (Sovaldi) and 2014 (e.g., Harvoni, Viekira Pak). The introduction of these new hepatitis C treatments led to an increase in Medicaid spending for hepatitis C treatment from \$0.4–\$0.6 billion in CYs 2011 to 2013 to \$1.8 billion in CY 2014, which was more than the prior three years combined. The \$1.4 billion spent on new hepatitis C drugs accounted for about 20 percent of the \$7.3 billion increase in gross drug spending between CY 2013 and CY 2014 (MACPAC 2016f). Prescription drug spending in 2015 and beyond is expected to increase less because states have been able to negotiate higher supplemental rebates as different manufacturers bring new hepatitis C drugs to the market (Loftus 2015).

Impact of Medicaid expansion

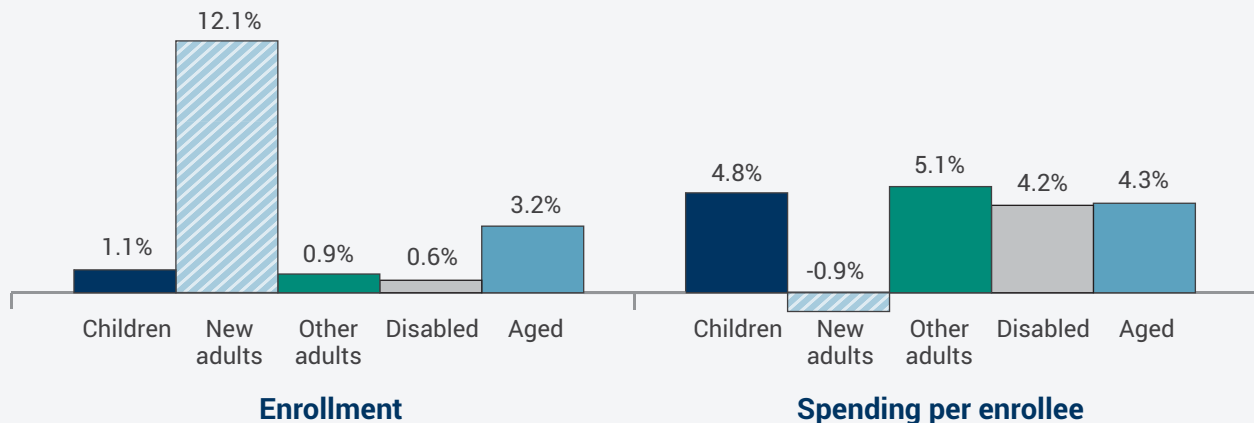
The growth in Medicaid spending in 2014 is largely attributable to enrollment growth related to the expansion of Medicaid to the newly eligible adult group. Enrollment in Medicaid is estimated to have increased by almost 10 percent, with most of the increase associated with the new adult group. Excluding the newly eligible adults, enrollment increased by about 2.3 percent (OACT 2015d). Growth in the newly eligible adult group is expected to drive overall enrollment growth over the next decade. From FY 2014 to FY 2023, the newly eligible adult group is projected to grow 12 percent on an annual basis compared to growth rates of 3 percent or less for the other eligibility groups (Figure 1-8). Most of the growth in the newly eligible adult group is front-loaded in FYs 2014–2016, with most of the enrollment assumed to occur in FY 2014. Enrollment growth in FY 2015 and FY 2016 is projected to be about 6 percent, reflecting increased enrollee take-up and increases in the number of states expanding Medicaid eligibility after 2014 (OACT 2015d).

As mentioned previously, the expansion to the new adult group has affected overall Medicaid spending

per enrollee by changing the enrollee mix to include a greater proportion of lower-cost individuals. From FYs 2014 to 2023, changes in the enrollment mix are project to decrease Medicaid benefit spending per enrollee by an average of 0.5 percentage points per year (OACT 2015d). With the exception of the new adult group, growth in Medicaid spending per enrollee for FYs 2014 to 2023 is projected to be somewhat higher than price inflation as measured by the medical care component of the CPI (4.0 percent) over the same period (Figure 1-8). The projected decrease in Medicaid spending per enrollee for new adults reflects moderation in the use of services as pent-up demand for medical care decreases and a healthier mix of individuals enroll over time; it also assumes certain changes in managed care capitation rates as states collect more data and experience to use in setting rates (OACT 2015d).

Impact of expansion on federal spending. Most of the growth in Medicaid spending in FY 2014 consisted of an increase in federal spending, which rose by about 13 percent, from \$267 billion in FY 2013 to \$303 billion in FY 2014. In comparison, overall state spending on Medicaid increased by only about 1 percent, from \$193 billion in FY 2013 to \$195 billion in FY 2014. This difference in the increase in

FIGURE 1-8. Average Annual Growth in Projected Enrollment and Spending per Enrollee, FYs 2014–2023



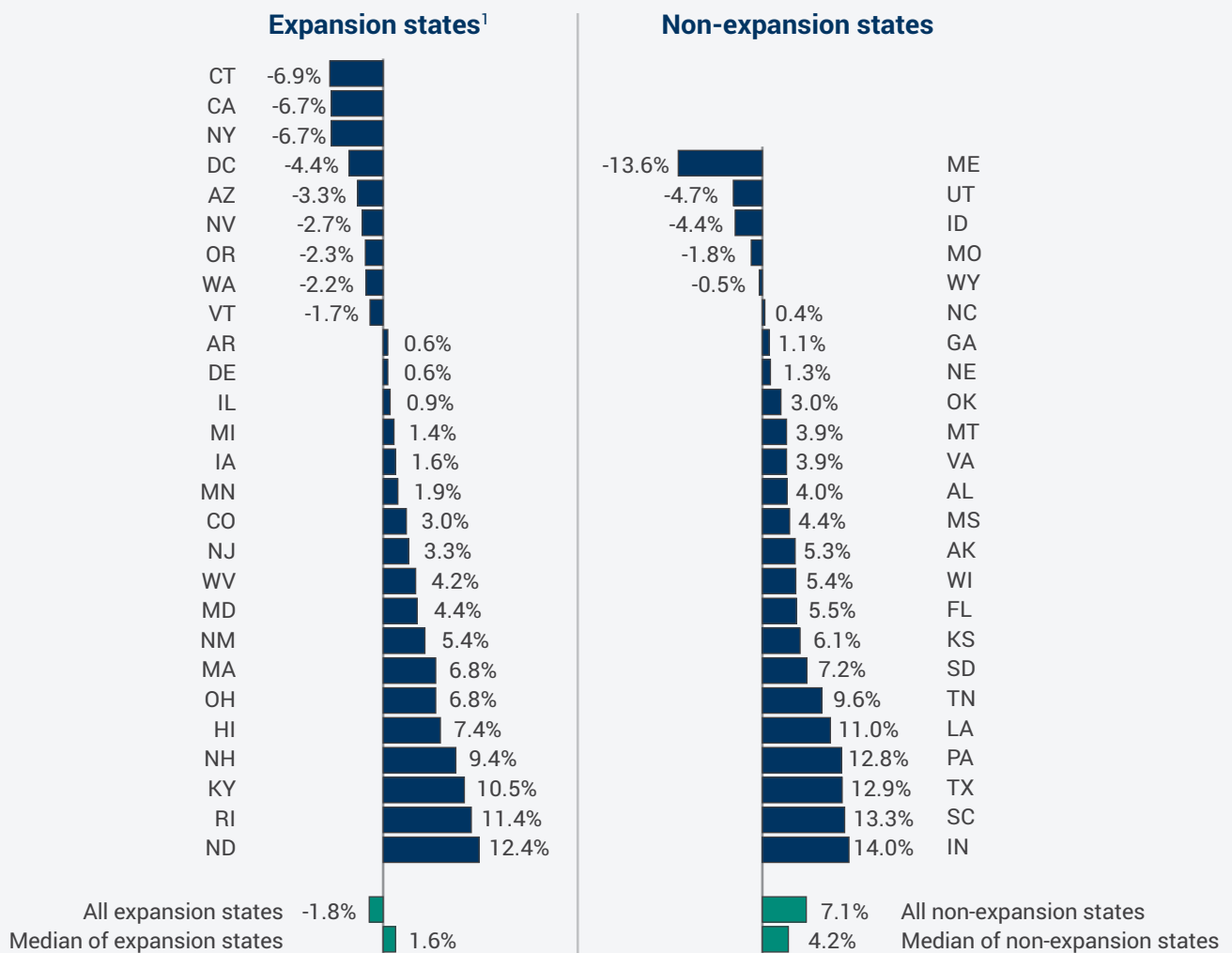
Note: FY is fiscal year.

Source: MACPAC 2015 analysis of OACT 2015d (Tables 13, 15, and 16).

federal and state spending is the result of the 100 percent federal funding available for newly eligible adult enrollees. As a result of the increased federal match for the new adult group, the federal share of Medicaid spending on benefits at the national level increased from its historical average of 57 percent to 60 percent (MACPAC 2015j).

Impact of expansion on state spending. Overall state spending on Medicaid increased by only about 1 percent in FY 2014, and expansion states had a median growth rate that was almost one-third that of non-expansion states (Figure 1-9). Among expansion states, aggregate state spending decreased by 1.8 percent, and the median change

FIGURE 1-9. Growth in State Medicaid Spending (Excluding Federal Funds) in Expansion and Non-Expansion States, FY 2014



Notes: FY is fiscal year. California had not certified its third and fourth quarter CMS-64 Financial Management Report (FMR) submissions as of April 5, 2016. Figures presented may change if states revise their expenditure data after April 5, 2016.

¹ Expansion states include only those that expanded before the end of FY 2014; coverage became effective January 1, 2014, in these states except for Michigan (effective April 1, 2014) and New Hampshire (effective August 15, 2014). Pennsylvania and Indiana expanded in FY 2015 and are shown in the non-expansion category.

Source: MACPAC 2016 analysis of CMS-64 FMR net expenditure data as of April 5, 2016.

in state spending was an increase of 1.6 percent. Among non-expansion states, aggregate state spending increased by 7.1 percent, and the median change in state spending was an increase of 4.2 percent. The differences in the change in state spending between expansion and non-expansion states may reflect a variety of factors. Expansion states that had previously expanded to cover adults up to at least 100 percent of the federal poverty level before the enactment of the ACA can receive a phased-in increase in their federal matching rate for childless adults under age 65 beginning on January 1, 2014 (Rudowitz 2014). This increase in federal match would reduce state spending for this group of beneficiaries. Additionally, many non-expansion states saw a decrease in their FMAP rate that resulted in a shift in spending from federal to state dollars. Particularly among expansion states with the largest increases in state spending, it is possible that some have not yet claimed the full amount of enhanced FMAP to which they may be entitled for new adult group enrollees; revisions to prior period reporting are common and may be reported in future data submissions, and this could result in a decrease in the change in state spending for these states. The state Medicaid spending growth in some expansion states may also reflect a shift of state dollars to Medicaid because activities and populations previously supported with state general funds alone are now eligible for federal match (Bachrach et al. 2016).

Endnotes

- ¹ Additional state-level spending information may be found in MACStats, our annual publication of Medicaid data and information. The most recent MACstats and prior publications can be found at <https://www.macpac.gov/macstats/>.
- ² The composition of health spending at the federal, state, and local levels is beyond the scope of this chapter. However, Medicaid is the largest component of state and local government spending on health care; its share was 39 percent in 2013, followed by health insurance contributions for state and local employees at 33 percent, and spending for other health programs (including maternal and child health, vocational rehabilitation, general assistance, school health, CHIP, public health activities, other state and local programs, Part D state phased-down payments, and investment in research, structures and equipment) at 29 percent (OACT 2014b).
- ³ State funding systems for education vary greatly, and some have moved toward increasing their share of funding for elementary and secondary education by substituting state funds for local funds, often to reduce local government reliance on property taxes (NASBO 2015). Nearly half of all public elementary and secondary education revenue was from state sources in SFY 2012 (Dixon 2014).
- ⁴ Medicaid's share is estimated because spending for the program cannot be precisely isolated in the data on combined state and local spending from the U.S. Census Bureau's Survey of Government Finances (SGF), for which SFY 2012 information is the most recent. The 17 percent share is a high estimate obtained by summing two SGF categories that are not limited to amounts paid by Medicaid: public welfare vendor payments (12 percent) and hospitals (5 percent). The public welfare vendor payments category reflects payments made directly to private purveyors for medical care, burials, and other commodities and services provided under welfare programs. Among other items, the hospitals category includes services provided directly by the government through its own hospitals and health agencies, which may be paid in part through disproportionate share hospital (DSH) and other Medicaid amounts.

⁵ Although Medicaid is no longer directly responsible for paying for most prescription drugs used by dually eligible beneficiaries, states still pay for part of the cost of their Part D coverage through monthly phased-down state contributions—commonly referred to as clawback payments—that offset some of Medicare’s spending for these individuals. These clawback payments are included in the data on Medicaid’s share of state budgets but are typically not included in other estimates of Medicaid spending.

⁶ Specific examples are not given, but the Office of the Actuary (OACT) noted that during and immediately after the 2007 to 2009 recession, states took stronger actions to limit expenditure growth, including freezing or reducing provider rates. In more recent years, states have made fewer provider reimbursement rate reductions and have instituted rate increases. OACT also notes that the use of home and community-based services can substantially reduce expenditures for enrollees who would otherwise have to enter a nursing home or who transition from institutional to community settings, but that the expanding use of these services by those who do not otherwise need nursing home care can add to overall program costs. When averaging over the period 2014 to 2023, growth in spending per enrollee resulting from these factors is moderated by low growth in spending per enrollee through 2016 resulting from the influx of new adults whose costs are lower than the cost of an average beneficiary.

⁷ This change in Medicaid spending does not include the clawback payments states must make to Medicare Part D.

⁸ This count includes Louisiana. The governor of Louisiana has issued an executive order to implement a Medicaid expansion effective July 1, 2016.

References

Bachrach, D., P. Boozang, A. Herring, and D.G. Reyneri. 2016. *States expanding Medicaid see significant budget savings and revenue gains*. Princeton, NJ: State Health Reform Assistance Network, Robert Wood Johnson Foundation. <http://statenetwork.org/wp-content/uploads/2016/03/State-Network-Manatt-States-Expanding-Medicaid-See-Significant-Budget-Savings-and-Revenue-Gains-March-2016.pdf>.

Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (Trustees). 2015. Table V.D1.: HI and SMI Average per Beneficiary Costs. In *2015 Annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Washington, DC: Trustees. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf>.

Bureau of Labor Statistics (BLS), U.S. Department of Labor. 2016. Data from Consumer Price Index—All Urban Consumers (U.S. All items, 1982-84=100 - CUUR0000SA0) and U.S. Medical care (1982-84=100 - CUUR0000SAM). <http://data.bls.gov/cgi-bin/surveymost?cu>.

Congressional Budget Office (CBO). 2016a. *Detail of spending and enrollment for Medicaid for CBO’s March 2016 baseline*. Washington, DC: CBO. <https://www.cbo.gov/sites/default/files/51301-2016-03-Medicaid.pdf>.

Congressional Budget Office (CBO). 2016b. *Congressional Budget Office’s March 2016 Medicare baseline*. Washington, DC: CBO. <https://www.cbo.gov/sites/default/files/51302-2016-03-Medicare.pdf>.

Congressional Budget Office (CBO). 2016c. *Federal subsidies for health insurance coverage for people under 65: 2016 to 2026*. Washington, DC: CBO. <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline.pdf>.

Congressional Budget Office (CBO). 2016d. *Private health insurance premiums and federal policy*. Washington, DC: CBO. https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf.

Congressional Budget Office (CBO). 2016e. *January 2016 Baseline Forecast—Data Release (Quarterly)*. Washington, DC: CBO. <https://www.cbo.gov/sites/default/files/51135-2016-01-Economic%20Projections.xlsx>.

Congressional Budget Office (CBO). 2015. *Updated budget projections: 2015 to 2025*. Washington, DC: CBO. https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/49973-UpdatedBudgetProjections_0.pdf.

- Dixon, M. 2014. *Public education finances: 2012*. 2012 Census of governments, report no. G12-CG-ASPEF. Washington, DC: U.S. Census Bureau. <http://www2.census.gov/govs/school/12f33pub.pdf>.
- Holahan, J., M. Cohen, and D. Rousseau. 2007. *Why did Medicaid spending decline in 2006? A detailed look at program spending and enrollment, 2000–2006*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7697.pdf>.
- Kaye, H.S., M. LaPlante, and C. Harrington. 2009. Do noninstitutional long-term care services reduce Medicaid spending? *Health Affairs* 28, no. 1: 262–272. <http://content.healthaffairs.org/content/28/1/262.abstract>.
- Keehan, S.P., G.A. Cuckler, A.M. Sisko, et al. 2015. National health expenditure projections, 2014–24: Spending growth faster than recent trends. *Health Affairs* 34, no. 8: 1407–1417. <http://content.healthaffairs.org/content/early/2015/07/15/hlthaff.2015.0600.abstract>.
- Klemm, J.D. 2000. Medicaid spending: A brief history. *Health Care Financing Review* 22, no. 1: 105–112. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/00fallpg105.pdf>.
- Kronick, R., and D. Rousseau. 2007. Is Medicaid sustainable? Spending projections for the program's second forty years. *Health Affairs* 26, no. 2: w271-w287. <http://content.healthaffairs.org/content/26/2/w271.abstract>.
- Loftus, P. 2015. States work to strike deals for Hep C drug discounts. *The Wall Street Journal*, January 29.
- Martin, A., M. Hartman, J. Benson, et al. 2016. National health spending in 2014: Faster growth driven by coverage expansion and prescription drug spending. *Health Affairs* 35, no. 1: 150–160. <http://content.healthaffairs.org/content/early/2015/11/25/hlthaff.2015.1194>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2016a. Exhibit 3: National health expenditures by type and payer, 2014. <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-3.-National-Health-Expenditures-by-Type-and-Payer-2014-1.pdf>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2016b. Exhibit 4: Major health programs and other components of federal budget as a share of federal outlays, FYs 1965–2015. <https://www.macpac.gov/wp-content/uploads/2015/11/EXHIBIT-4.-Major-Health-Programs-and-Other-Components-of-Federal-Budget-as-a-Share-of-Federal-Outlays-FYs-1965-2015-1.pdf>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2016c. *Analysis of Fiscal year 2017 historical tables: Budget of the U.S. Government, Tables 6.1, 8.5, and 8.7*. Washington, DC: Office of Management and Budget, <http://www.gpo.gov/fdsys/search/pagedetails.action?granuleId=&packageId=BUDGET-2017-TAB>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2016d. Exhibit 5: Medicaid as a share of states' total budgets and state-funded budgets, SFY 2014. <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-5.-Medicaid-as-a-Share-of-States%E2%80%99-Total-Budgets-and-State-Funded-Budgets-SFY-2014-1.pdf>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2016e. Exhibit 13: Medicaid as a share of state budgets including and excluding federal funds, SFYs 1987–2014. <https://www.macpac.gov/wp-content/uploads/2015/11/EXHIBIT-13.-Medicaid-as-a-Share-of-State-Budgets-Including-and-Excluding-Federal-Funds-SFYs-1987-2014.pdf>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2016f. *Medicaid spending for prescription drugs*. January 2016 issue brief. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2016/01/Medicaid-Spending-for-Prescription-Drugs.pdf>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2015a. Exhibit 12: Historical and projected national health expenditures by payer for selected years, 1970–2024. In *MACStats: Medicaid and CHIP data book*. December 2015. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-12.-Historical-and-Projected-National-Health-Expenditures-by-Payer-for-Selected-Years-1970%E2%80%932024-1.pdf>.
- Medicaid and CHIP Payment and Access Commission (MACPAC). 2015b. Analysis of data in Barnett, J.L., C.L. Sheckells, S. Peterson, and E.M. Tydings. *2012 Census of Governments: Finance—State and local government summary report*. Economy-wide statistics briefs: Public sector, no.

G12-CG-ALFIN. Washington, DC: U.S. Census Bureau. <https://www.census.gov/content/dam/Census/library/publications/2014/econ/g12-cg-alfin.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015c. Figure: State Medicaid expansion decisions, January 2016. https://www.macpac.gov/wp-content/uploads/2015/01/ExpansionMap_Jan2016-01.png.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015d. Exhibit 22: Medicaid benefit spending per full-year equivalent (FYE) enrollee by state and eligibility group, FY 2012. In *MACStats: Medicaid and CHIP data book*. December 2015. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-22.-Medicaid-Benefit-Spending-Per-Full-Year-Equivalent-FYE-Enrollee-by-State-and-Eligibility-Group-FY-2012.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015e. Exhibit 14: Medicaid enrollment by state, eligibility group, and dually eligible status, FY 2012 (thousands). In *MACStats: Medicaid and CHIP data book*. December 2015. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-14.-Medicaid-Enrollment-by-State-Eligibility-Group-and-Dually-Eligible-Status-FY-2012-thousands.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015f. Exhibit 21: Medicaid spending by state, eligibility group, and dually eligible status, FY 2012 (millions). In *MACStats: Medicaid and CHIP data book*. December 2015. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-21.-Medicaid-Spending-by-State-Eligibility-Group-and-Dually-Eligible-Status-FY-2012-millions.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015g. Exhibit 18: Distribution of Medicaid benefit spending by eligibility group and service category, FY 2012. In *MACStats: Medicaid and CHIP data book*. December 2015. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-18.-Distribution-of-Medicaid-Benefit-Spending-by-Eligibility-Group-and-Service-Category-FY-2012.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015h. Exhibit 20: Distribution of Medicaid enrollment and benefit spending by users and non-users

of long-term services and supports, FY 2012. In *MACStats: Medicaid and CHIP data book*. December 2015. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-20.-Distribution-of-Medicaid-Enrollment-and-Benefit-Spending-by-Users-and-Non-Users-of-Long-Term-Services-and-Supports-FY-2012.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015i. Exhibit 23: Medicaid supplemental payments to hospital providers by state, FY 2014 (millions). In *MACStats: Medicaid and CHIP data book*. December 2015. <https://www.macpac.gov/wp-content/uploads/2015/11/EXHIBIT-23.-Medicaid-Supplemental-Payments-to-Hospital-Providers-by-State-FY-2014-millions.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015j. Exhibit 16: Medicaid spending by state, category, and source of funds, FY 2014 (millions). In *MACStats: Medicaid and CHIP data book*. December 2015. <https://www.macpac.gov/wp-content/uploads/2015/01/Medicaid-Spending-by-State-Category-and-Source-of-Funds-FY-20141.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015k. Exhibit 17: Total Medicaid benefit spending by state and category, FY 2014 (millions). In *MACStats: Medicaid and CHIP data book*. December 2015. <https://www.macpac.gov/wp-content/uploads/2015/01/Total-Medicaid-Benefit-Spending-by-State-and-Category-FY-20141.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2014a. Table: State Medicaid payment policies for inpatient hospital services. <https://www.macpac.gov/publication/macpac-inpatient-hospital-payment-landscapes/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2014b. *Report to the Congress on Medicaid and CHIP*. March 2014. Washington, DC: MACPAC. <https://www.macpac.gov/publication/report-to-the-congress-on-medicare-and-chip-314/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2012. *Report to the Congress on Medicaid and CHIP*. March 2012. Washington, DC: MACPAC. <https://www.macpac.gov/publication/report-to-the-congress-on-medicare-and-chip-312/>.

National Association of State Budget Officers (NASBO). 2015. *State expenditure report: Examining fiscal 2013–2015 state spending*. Washington, DC: NASBO. <https://www.nasbo.org/sites/default/files/State%20Expenditure%20Report%20%28Fiscal%202013-2015%29S.pdf>.

Office of the Actuary (OACT), Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015a. National health expenditures by type of service and source of funds: Calendar years 1960 to 2014. Baltimore, MD: OACT. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE2014.zip>.

Office of the Actuary (OACT), Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015b. Historical national health expenditures. Tables 1, 3, and 21. Baltimore, MD: OACT. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip>.

Office of the Actuary (OACT), Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015c. National health expenditure (NHE) amounts by type of expenditure and source of funds: Calendar years 1960–2024 in PROJECTIONS format. Baltimore, MD: OACT. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/nhe60-24.zip>.

Office of the Actuary (OACT), Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015d. *2014 Actuarial report on the financial outlook for Medicaid*. Baltimore, MD: OACT. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2014.pdf>.

Office of the Actuary (OACT), Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014a. *2013 Actuarial report on the financial outlook for Medicaid*. Baltimore, MD: OACT. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/medicaidReport2013.pdf>.

Office of the Actuary (OACT), Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014b. Table 1: National Health Expenditures by Type of Sponsor, Aggregate Amounts, Calendar Years 1987–2013 (\$ billions). Baltimore, MD: OACT. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/sponsors.zip>.

O'Shaughnessy, C. 2014. *National spending for long-term services and supports (LTSS), 2012*. Washington, DC: National Health Policy Forum. http://www.nhpf.org/library/the-basics/Basics_LTSS_03-27-14.pdf.

Rudowitz, R. 2014. *Understanding how states access the ACA enhanced Medicaid match rates*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/>.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2013. *National expenditures for mental health services and substance abuse treatment 1986–2009*. HHS Publication no. SMA-13-4740. Rockville, MD: SAMHSA. <http://store.samhsa.gov/shin/content//SMA13-4740/SMA13-4740.pdf>.

U.S. Government Accountability Office (GAO). 2014. *Medicaid financing: States' increased reliance on funds from health care providers and local governments warrants improved CMS data collection*. Report no. GAO-14-627 [Reissued on March 13, 2015]. Washington, DC: GAO. <http://www.gao.gov/products/GAO-14-627>.

Young, K., R. Garfield, L. Clemans-Cope, et al. 2013. *Enrollment-driven expenditure growth: Medicaid spending during the economic downturn, FY 2007–2011*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8309-02.pdf>.

Zuckerman, S., and D. Goin. 2012. *How much will Medicaid physician fees for primary care rise in 2013? Evidence from a 2012 survey of Medicaid physician fees*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8398.pdf>.

CHAPTER 2

Addressing Growth in Medicaid Spending: State Options

Addressing Growth in Medicaid Spending: State Options

Key Points

- The rate of growth in Medicaid spending reflects not only decisions made by federal and state policymakers, but also factors beyond the control of government officials, including changes in the economy and the health system. Although the availability of federal Medicaid funding may give states an incentive to increase program spending, states also have incentives to limit growth in per-person spending and overall Medicaid costs.
- The federal government sets minimum requirements that states must comply with to receive federal Medicaid funds, reflecting statutory and regulatory decisions about how federal dollars can be used and how states can be held accountable. However, the federalist structure of the program also provides states with many options for the design and administration of their programs.
- Current authorities allow states to use many different policy levers to reduce spending and achieve other program efficiencies. In designing their programs and responding to changing economic conditions, states take advantage of this flexibility to decide whether to cover optional eligibility groups and services, determine provider payment methods and rates, define coverage parameters for covered services, and adopt strategies to address the volume and intensity of services.
- Different policy approaches have different effects on the magnitude and direction of spending changes, as well as on other aspects of the program. Typically states seek first to minimize direct effects on beneficiaries. For example, states have kept Medicaid provider payments low compared to other payers rather than rolling back eligibility.
- States increasingly seek to avoid blunt benefit and payment cuts by contracting with managed care organizations and developing other value-based purchasing approaches to better tie payments to measures of quality and outcomes.
- There are practical and policy limits on a state's ability to obtain further savings, including minimum federal standards for coverage and access and the technical and administrative resources needed to implement more sophisticated payment models.

CHAPTER 2: Addressing Growth in Medicaid Spending: State Options

As described in Chapter 1, Medicaid program spending has grown in absolute and relative terms and become a larger share of both federal and state budgets, leading policymakers to express concerns about the sustainability of the program. There are differences of opinion, however, as to what is driving growth, and these differences in the diagnosis of the problem lead to different solutions being offered for the future. Some, including the chairs of committees with interest in Medicaid, have pointed to Medicaid's financing structure, under which the federal government will match allowable state expenditures, as a root cause of expenditure growth. Alternatives to this approach are discussed in detail in Chapter 3, with the Commission noting that the extent to which these approaches would incentivize states towards greater efficiency and value, and how such constraints will affect beneficiaries, providers, health plans, and others, depends upon how federal dollars would flow to states and the tools that states use to hold down expenditure growth.

The analysis in Chapter 1 shows that about 70 percent of growth in real Medicaid spending (adjusted for health care price inflation) can be attributed to enrollment, which has increased as a result of both policy decisions and economic and demographic changes. Current public discussion of Medicaid enrollment has focused on changes brought about by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), which include expansion to the new adult group in more than half of the states, as well as increased enrollment among individuals previously eligible for Medicaid but not enrolled (sometimes referred to as the woodwork or

welcome mat effect). Historically, however, from 1975 to 2012, the major source of growth has been from enrollment of people with disabilities.

Slightly less than one-third of growth in real Medicaid benefit spending has been due to increases in spending per enrollee, reflecting policy decisions as well as broader changes in the health system, including medical price inflation and changes in disease patterns and treatment modalities. The average cost per enrollee is determined by the benefits covered, the prices paid for those benefits, and how efficiently those benefits are delivered. Within the Medicaid program, the federal government sets minimum requirements in each of these areas, which states must comply with to receive federal funds. These requirements reflect statutory and regulatory decisions about how federal dollars can be used and how states can be held accountable.

Although the availability of federal Medicaid funding may give states an incentive to increase program spending, states also have incentives to limit growth in per-person spending and overall Medicaid costs. The federalist structure of the program provides states with many options for the design and administration of their programs. Options include covering non-mandatory eligibility groups and services, determining provider payment methods and rates, and adopting strategies to address the volume and intensity of services. Many cost containment strategies are intended to minimize direct effects on beneficiaries; for example, states have kept Medicaid provider payments low compared to other payers. States have also become more sophisticated purchasers, trying to avoid blunt benefit and payment cuts by contracting with managed care organizations to implement care management programs and by developing value-based purchasing approaches to better tie provider payments to measures of quality and outcomes. These different policy approaches have different effects on the magnitude and direction of spending changes, as well as on other aspects of the program.

In this chapter, we describe the range of policy drivers that affect Medicaid spending at the state level, from the federal requirements that create a spending floor in every state, to areas where states have flexibility in the design and administration of their programs. The sections are organized according to the choices available under current authorities (e.g., managing enrollment, limiting benefits, determining provider payments, changing delivery systems, and strengthening program integrity). Given the limits on state flexibility, even under demonstration authority afforded the Secretary of the U.S. Department of Health and Human Services (the Secretary), the chapter also describes requests by states for additional program changes not currently allowed under federal statute.

Clearly, there are also many federal policies that affect Medicaid spending. For example, federal categorical eligibility policies that drive overall program enrollment are the single largest contributor to Medicaid spending, as described in Chapter 1 of this report. Benefit rules, such as the requirements for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and the entitlement to nursing facility services (but not home and community-based services), limit delivery options, and federal payment rules, including upper payment limits and actuarial soundness rules, constrain state autonomy in setting provider payments. Changes to these policies, or the introduction of new policies established under new authorities, could change the trajectory of program spending as much or more than the state policy levers discussed in this chapter. Investigation of these options could be an area for future Commission work.

Eligibility

As noted above, program enrollment is the largest factor contributing to increases in Medicaid expenditures, accounting for over two-thirds of spending growth over the last 35 years. Enrollment has increased as a result of new federal

requirements, state options, and changes in the economy, as well as a result of overall population growth. Reductions in eligibility can result in immediate cost savings for states but also in loss of coverage for those eliminated from the rolls, because most Medicaid enrollees cannot afford alternative sources of health insurance. For this reason, Congress has imposed maintenance-of-effort (MOE) requirements on states that prevent them from closing budget gaps during recessions by reducing Medicaid eligibility.

Reflecting Medicaid's historical links to cash assistance programs, state Medicaid programs must cover certain mandatory eligibility groups, including low-income children and pregnant women, individuals receiving Supplemental Security Income (SSI), and low-income Medicare enrollees (Box 2-1). The explicit link between Medicaid coverage and cash assistance was eliminated in 1996 with passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA, P.L. 104-193). Congress added many eligibility groups over time, including additional groups of low-income children in 1984 and 1987, qualified Medicare beneficiaries in 1988, higher-income working disabled individuals in 1999, and uninsured women needing treatment for breast or cervical cancer in 2000 (MACPAC 2011a).

Most recently, the ACA extended Medicaid eligibility to all adults under age 65 (including parents and adults without dependent children) with incomes below 138 percent of the federal poverty level (FPL), although a subsequent Supreme Court ruling in June 2012 effectively made the expansion a state option.^{1,2} As of January 2016, 31 states and the District of Columbia have chosen to adopt the adult expansion, some through alternative approaches using Section 1115 waivers. States that have chosen not to implement the expansion have raised concerns about the state share of costs for the expansion group, among others (Scott 2012).

States also have the option to cover many other eligibility categories, including adults with

BOX 2-1. Mandatory Medicaid Eligibility Groups, 2016

- Low-income families
- Families receiving transitional medical assistance
- Children with Title IV-E adoption assistance, foster care, or guardianship care
- Extended Medicaid due to child or spousal support collections
- Mandatory poverty level-related pregnant women
- Qualified pregnant women and children
- Mandatory poverty level-related infants
- Deemed newborns
- Mandatory poverty level-related children age 1–5
- Working disabled under 1619(b)
- Mandatory poverty level-related children age 6–18
- Qualified disabled and working individuals
- Individuals receiving SSI
- Qualified Medicare beneficiaries
- Blind or disabled individuals eligible in 1973
- Qualifying individuals (Medicare-related)
- Institutionalized individuals continuously eligible since 1973
- Specified low-income Medicare beneficiaries
- Disabled adult children
- Individuals who are essential spouses
- Aged, blind, and disabled individuals in 209(b) states
- Individuals receiving mandatory state supplements
- Individuals who lost eligibility for SSI or SSP due to an increase in OASDI benefits in 1972
- Individuals who would be eligible for SSI or SSP but for OASDI COLA increases since April 1977
- Disabled widows and widowers ineligible for SSI due to increase in OASDI
- Disabled widows and widowers ineligible for SSI due to early receipt of Social Security

Notes: SSI is Supplemental Security Income. SSP is state supplemental payment. OASDI is old age, survivor, and disability insurance. COLA is cost-of-living adjustment.

Sources: Centers for Medicare & Medicaid Services (CMS) and the Social Security Act.

disabilities with employment income greater than permitted under SSI limits, children and pregnant women with income above 138 percent FPL, and individuals eligible for long-term services and supports with incomes up to 300 percent of the SSI benefit rate.³ States also have the option to cover the medically needy, that is, individuals with incomes too high for Medicaid who must spend down to a medically needy income level by deducting incurred medical expenses from the amount of income that is counted for Medicaid eligibility purposes (MACPAC 2016a).

State decisions about covering optional eligibility groups directly affect Medicaid spending, and states vary according to which optional groups they cover. For example, almost every state covers the optional group of women needing treatment for breast or cervical cancer, but only 13 states extend Medicaid coverage to youth who age out of foster care in other states (CDC 2016, Brooks et al. 2016).⁴ Although states can drop optional eligibility groups when budgets are tight, most states that restrict eligibility do so only when other opportunities for cost containment, such as

cutting provider rates or reducing benefits, have been exhausted. For example, in 2003, in response to state budget pressure resulting from the economic recession, 18 states restricted benefits, but only 2 eliminated their medically needy programs completely (Smith et al. 2003).

Federal requirements also affect a state's ability to cut optional groups. As noted above, at various times, Congress has imposed MOE provisions that prevent states from reducing eligibility below a certain historical threshold for both mandatory and optional groups. For example, the ACA includes an MOE provision effective through fiscal year (FY) 2019 that prevents states from reducing children's eligibility below levels in place on the date of its enactment on March 23, 2010.

States have more frequently used changes to eligibility standards and processes to reduce eligibility without dropping entire groups (Smith et al. 2003). For example, during the recession of 2008 and prior to the imposition of MOE requirements under the 2009 stimulus bill (American Recovery and Reinvestment Act of 2009, P.L. 111-5), states implemented measures intended to reduce Medicaid enrollment including adding asset tests, changing the effective date of retroactive eligibility, increasing documentation requirements, and requiring face-to-face interviews for enrollment (Smith et al. 2007). The ACA removed much state flexibility in this area by introducing the uniform modified adjusted gross income (MAGI) eligibility standard for low-income families, effective in 2014, and by eliminating states' ability to use income disregards, asset tests, certain application procedures (e.g., face-to-face interviews) as tools to manage enrollment.

Recently, a few states have used Section 1115 waiver demonstration authority to test alternative eligibility requirements in conjunction with the optional expansion of Medicaid to cover previously ineligible adults (MACPAC 2016b). Five states (Iowa, Michigan, Arkansas, Indiana, and Montana) require new adult enrollees to pay premiums or

make monthly contributions toward payment for services. Three states (Iowa, Indiana, and Montana) have been granted waiver authority to disenroll enrollees with incomes above 100 percent FPL for non-payment of premiums. In Iowa, individuals may re-enroll at any time; in Indiana, disenrolled individuals can be denied re-enrollment for six months; and in Montana enrollees are able to re-enroll once they pay overdue premiums or after three months (MACPAC 2016b). However, the Centers for Medicare & Medicaid Services (CMS) have not approved state requests to waive Medicaid rules limiting aggregate out-of-pocket spending to 5 percent of income, or to make a work requirement or referral a condition of Medicaid eligibility (Rudowitz and Musumeci 2015).

Benefits

Increases in the cost of providing Medicaid benefits also contribute to the overall growth in Medicaid spending. States exercise considerable control over spending by choosing whether or not to cover optional services, defining coverage parameters for covered services, implementing utilization management tools, and imposing nominal cost sharing. However, federal waiver authority is needed for states to implement certain types of benefit changes, such as enhanced cost sharing or selective provider contracting.

States must cover certain mandatory services, such as inpatient hospital and physician services (Box 2-2), but have discretion in coverage decisions about a wide range of optional services, such as physical therapy, personal care services, and adult dental services. States vary widely in the degree to which they cover services classified as optional: 42 states covered hospice in 2012, but only 15 states offered the health home benefit in 2014 (KFF 2012, Moses 2014).⁵ In addition, although coverage for some services is considered optional in the statute, in practice, coverage is needed to provide access to appropriate care. For

BOX 2-2. Mandatory Medicaid Benefits, 2016

- Inpatient hospital services
- Laboratory and X-ray services
- Outpatient hospital services
- Nursing facility services (for persons age 21 and over)
- Physician services
- Federally qualified health centers
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals under age 21
- Certified pediatric or family nurse practitioner services (to the extent authorized to practice under state law or regulation)
- Family planning services and supplies
- Rural health clinic services
- Tobacco cessation counseling and pharmacotherapy for pregnant women
- Nurse-midwife services (to the extent authorized to practice under state law or regulation)
- Freestanding birth centers (when licensed or otherwise recognized by the state)
- Non-emergency transportation to medical care
- Home health services (for those who qualify for an institutional level of care)

Notes: Federal regulations at 42 CFR 431.53 require states to provide non-emergency transportation services; they may do so as an administrative function or as part of the Medicaid benefit package. EPSDT services include screening, vision, dental, and hearing services and any medically necessary service listed in the Medicaid statute, including optional services that are not otherwise covered by a state if needed to treat an illness or condition detected during screening.

Sources: Centers for Medicare & Medicaid Services (CMS) and the Social Security Act.

example, prescription drugs are considered an optional covered item in Medicaid but are covered by every state because they are integral to the practice of medical care and are needed to avoid other costs associated with conditions that can be treated pharmaceutically. Although most home and community-based services (e.g., private duty nursing, personal care services) are optional, states must cover many of these services to meet their legal and strategic goals as they rebalance the delivery of long-term services and supports (LTSS) between institutions and the community.

Although benefits generally must be equivalent in amount, duration, and scope for enrollees within a state (known as the comparability requirement) and offered throughout the state (the statewideness requirement), the breadth of coverage for individual benefits—including mandatory benefits—can

vary significantly across states.⁶ For example, as documented in MACPAC's June 2015 report to Congress, the 26 states that provide optional restorative dental benefits to adults impose a variety of coverage limits, including annual limits on the number of fillings and crowns an enrollee can get, the types of crowns that can be used on certain teeth, and how often root canals can be performed (MACPAC 2015a). States also place limits on annual dollar amounts or the number of adult dental services they will cover within a certain time frame. Finally, states can limit services based on medical necessity criteria or implement prospective, concurrent, and retrospective utilization control procedures. For example, many states require prior authorization for services such as medical equipment, certain prescription drugs, certain physician procedures, and non-emergency hospital admissions.

States can make incremental changes to benefit coverage to contain costs, or they can add or drop entire categories of optional benefits from Medicaid in response to changing economic conditions; however, such changes on their own typically do not lead to meaningful budget savings. Here, state policies on adult dental benefits are illustrative. Between 2003 and 2012, 20 states made at least one large-scale change in dental benefits for adult Medicaid enrollees, including three states (California, Idaho, and Illinois) that eliminated coverage of non-emergency dental services for adults and then later reinstated that coverage as state revenues improved (MACPAC 2015a). While as noted above, every state covers prescription drugs, which are optional by statute, nearly all states have developed sophisticated programs to manage drug utilization within the parameters allowed by federal rules (NCSL 2016).

The Deficit Reduction Act of 2005 (P.L. 109-171) created a new way for states to manage benefits by enrolling certain groups, primarily non-disabled adults and children, in alternative benchmark or benchmark-equivalent benefits, also known as alternative benefit plans (ABPs). ABPs are permitted to cover different benefits than traditional Medicaid and may therefore be less costly to the state.⁷ States can provide coverage equivalent to specified benchmark plans, such as those offered to state or federal employees, or define a benchmark benefit appropriate for the targeted population, subject to approval by the Secretary. Although benchmark coverage for Medicaid enrollees must meet certain federal requirements, including coverage of essential health benefits (EHBs), states can establish ABPs that do not include all mandatory Medicaid benefits (e.g., they can omit coverage of nursing facility services) if those benefits are not included in the coverage against which the alternative benefit plan is benchmarked.⁸ Still, even though the ABP option has been available for over 10 years, few states have chosen to implement it.

A few states have sought waivers of coverage requirements for certain required benefits, particularly in conjunction with the optional expansion of Medicaid to cover previously ineligible adults. Two states, Iowa and Indiana, have received time-limited waivers of the requirement to provide access to non-emergency medical transportation (NEMT) as part of a demonstration to evaluate the effect of not covering NEMT on access to other services (MACPAC 2016b). These waivers were allowed because while states are required by federal rules to provide necessary transportation, NEMT is not defined in statute as a benefit. CMS did not approve a request by Iowa to waive the requirement to provide EPSDT services to newly eligible 19- and 20-year olds (Rudowitz and Musumeci 2015). CMS's decision on the Iowa request reflects the agency's position that it does not have the authority to waive benefit requirements, including EPSDT rules.

States, like private insurers, can also use cost sharing to discourage use of certain services. For example, to encourage the use of lower cost generic drugs, many states require copayments for branded drugs but not for the generic equivalent. States can also impose higher copayments when beneficiaries visit a hospital emergency department for non-emergency services. There are federal limits regarding who may be charged these fees, the services for which they may be charged, and the amount allowed. Certain vulnerable groups, such as children and pregnant women, are exempt from most out-of-pocket costs (CMS 2016).

In some cases, states have been granted authority under 1115 demonstration waivers to test different approaches to the use of cost sharing for Medicaid beneficiaries. As part of their waivers to expand Medicaid to cover previously ineligible adults, Arkansas, Indiana, and Michigan use an approach similar to a health savings account, in which enrollees make monthly or quarterly contributions toward payment for services (MACPAC 2016b).

However, CMS did not approve a request by Michigan to waive the Medicaid rule limiting aggregate out-of-pocket spending to 5 percent of income by raising cost-sharing obligations for persons with incomes above 100 percent FPL to 7 percent of their income (Dickson 2015).

Provider Payments

States have considerable flexibility in determining fee-for-service provider payment methods and amounts (MACPAC 2015b). Although states are required to demonstrate that payment changes do not jeopardize access to care, for the most part federal rules do not specifically direct payment amounts or limits.⁹ Medicaid programs typically pay less than other insurers for most services; a recent comparison of rates paid for physician services by Medicaid and Medicare found that state Medicaid programs paid 66 percent of Medicare rates, on average, although the differential varied across states (KFF 2014).

Within current federal rules, states can develop provider rate-setting processes and fee schedules for different services and programs and can establish supplemental payments to providers, subject to the upper payment limit (which prohibits Medicaid from paying more than Medicare would pay for the same service, in the aggregate). As a result, states vary widely in how they pay providers, a situation that reflects individual state policy decisions, practice patterns, and geographic differences in markets and costs. For example, a MACPAC review of inpatient payment policies for all state Medicaid programs found that states use a wide range of payment methods, including cost-based reimbursement, payment based on diagnosis-related groups (DRGs), and per diem payments (MACPAC 2014). States can also manage prices through pay-for-performance programs, state-negotiated supplemental pharmacy rebates, competitive bidding, and other practices.

When facing fiscal pressures, states often prefer to reduce or freeze provider rates before making other program cuts—like benefit or eligibility changes—that affect beneficiaries more directly (Smith et al. 2015). During the economic downturn from 2001 to 2004, every state froze or cut provider payment rates to control costs (Smith et al. 2010). During the next recession, from FY 2008 to FY 2010, despite the availability of stimulus funds, states again cut or froze provider rates, particularly for hospitals and nursing facilities (Smith et al. 2010). As economic conditions have improved, states have been less willing to implement provider rate cuts, and many have begun restoring rates to previous levels and increasing rates. A 2015 survey of recent legislative actions found that—in contrast to the majority of states in prior years—only three states in FY 2015 and five states in FY 2016 had implemented or planned inpatient hospital rate reductions, while a similar number of states planned or implemented reductions in nursing home, outpatient, physician, and dental rates (Smith et al. 2015).

There are limits to how much states can constrain provider payments. As noted above, the federal equal access provision requires Medicaid programs to ensure that payments are sufficient to ensure access comparable to that available to the general population in that geographic area.¹⁰ Other federal rules affect payments to federally qualified health centers and hospitals serving a disproportionate share of low-income patients (MACPAC 2011a). In addition, market dynamics and the payment policies of other payers (particularly Medicare) can affect providers' willingness to participate in Medicaid. Moreover, to improve quality and outcomes, some states are implementing more sophisticated payment mechanisms, such as bundled payments for certain surgical procedures or pay-for-performance arrangements based on achievement of specific quality metrics. These mechanisms can require investments in additional administrative or technical capacity, not only by the state Medicaid agency, but also by providers.

Payment rates for Medicaid managed care plans are evaluated by CMS using different criteria than those used to evaluate fee-for-service payment methodologies. For example, capitation rates must be developed in accordance with generally accepted actuarial principles and practices, they must be appropriate for the population and services included in the managed care program, and they must be certified by qualified actuaries. In certifying rates, actuaries consider whether the rates are expected to cover all reasonable, appropriate, and attainable costs that plans are anticipated to incur under the managed care contract, a standard that is unique to managed care programs. In addition to incorporating the anticipated costs under the managed care contract, capitation rates can also incorporate the anticipated savings that managed care plans can reasonably be expected to achieve through the implementation of cost containment strategies that are not available under fee-for-service arrangements (discussed below).

Delivery Systems

State Medicaid programs—like many other payers—have responded to cost growth by implementing policies intended to counteract the inherent inflationary incentives of an unmanaged fee-for-service payment system. Chief among these is managed care, in which states contract with private health plans on a fixed (capitated) payment basis to provide Medicaid benefits to defined groups of enrollees. This approach can moderate cost growth through two mechanisms. First, federal rules allow managed care plans to use certain tools to limit the growth of per-person spending, including selective provider contracting, the use of drug formularies, and the option to offer alternative services in lieu of covered Medicaid services if the alternative services are more cost-effective. Second, by transferring insurance risk to private plans, states can gain greater predictability in their costs, limiting the state's own risk to costs associated with increases in enrollment (within

the limits of the actuarial soundness rules). In these ways, state Medicaid programs can not only achieve greater cost predictability, but can also require and enforce full adherence to standards for access and improvements in the quality of care, goals that are difficult to achieve under fee for service.¹¹

While enrollment in comprehensive managed care was low compared to fee-for-service Medicaid for many years, by 2011 the share of Medicaid beneficiaries enrolled in managed care exceeded 50 percent and has continued to grow, particularly because most states that expanded coverage to previously ineligible adults have chosen to enroll the majority of these new beneficiaries in managed care (Avalere Health 2014). States are also increasingly turning to managed care to help contain costs among populations with above-average needs, including people with disabilities and those in need of LTSS. From 2005 to 2013, the number of states offering managed long-term services and supports (MLTSS) more than doubled, from 6 to 14 states, and additional states plan to implement new MLTSS arrangements in future years (Mathematica 2016, Smith et al. 2015).

States can implement managed care in their Medicaid programs under multiple federal authorities. In the program's early years, mandated enrollment in managed care was possible only under Section 1115 demonstration or Section 1915(b) freedom-of-choice waivers, but the enactment of the 1997 Balanced Budget Act (BBA, P.L. 105-33) gave states a state plan option allowing mandated managed care enrollment (except for certain children with special needs, Medicare beneficiaries, and American Indians). Many states continue to seek waivers to implement managed care because these waivers allow states to mandatorily enroll a more comprehensive group of enrollees and can be coupled with other program reforms, such as alternate financing approaches (CMS 2015a). However, in exchange for the flexibility offered by waivers, states must meet budgetary criteria and provide regular reports and

evaluations to CMS to show that the requirements of the waiver are being met. Evidence of the effectiveness of state initiatives in this area is mixed (AcademyHealth 2015).

More recently, many states have complemented these efforts with other initiatives that aim to strengthen incentives for value-based delivery of health care. Many states have implemented delivery system reforms that offer financial incentives to providers to affect the volume and intensity of services delivered and shift the focus of the payment system from volume to value (Smith et al. 2015). Value-based purchasing approaches in Medicaid include accountable care organizations, bundled payments, and patient-centered medical homes, which can be implemented under existing state plan authority. Some states have pursued broader reforms using demonstration waiver authority to address the total cost of care. A number of states have also engaged in multipayer efforts to design new payment- and service-delivery models to improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid, and all residents of participating states (Takach et al 2015).

States have found that, regardless of the type of value-based model pursued, substantial resources are needed to implement new payment models (NAM 2016). CMS has provided start-up funding to some states through State Innovation Model grants, and states are increasingly using Delivery System Reform Incentive Payment (DSRIP) demonstration waivers to support hospitals and other providers as they try to transform their delivery systems (MACPAC 2015b). Although some of these models have already generated positive results, most of them are still in their infancy and have not yet led to measurable savings. Early results from several demonstrations have yielded only inconclusive or mixed results on quality and utilization (Wholey et al. 2016, RTI 2014).

Program Integrity

The U.S. Government Accountability Office (GAO) designated Medicaid as a high-risk program in 2003 due to its size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight (GAO 2015). In 2014, CMS estimated that the Medicaid program had an overall improper payment rate of 6.7 percent, lower than the Medicare improper payment rate for that year (CMS 2015b, 2015c). This includes improper payments made for all reasons, including claims processing errors, eligibility determination errors, and lack of medical record documentation to substantiate claims. Because fraud is particularly difficult to detect, its precise magnitude is unknown, though analysis has shown that the great majority of Medicaid providers do not engage in such actions (Rosenbaum et al. 2009).

States and the federal government conduct a variety of program integrity activities meant to ensure that federal and state taxpayer dollars are spent appropriately on delivering high quality, necessary care, and on preventing fraud, waste, and abuse. States must ensure that eligibility decisions are made correctly, that prospective and participating providers meet federal and state participation requirements, that services provided to enrollees are medically necessary and appropriate, and that provider payments are made in the correct amount and for the appropriate services. When an improper payment is identified, the state must return the federal share to CMS, but may use the retained state share for any approved purpose (42 CFR 433.300).

MACPAC has previously noted challenges in implementing effective and efficient Medicaid program integrity practices—these challenges include insufficient collaboration and information sharing among federal agencies and states; lack of information on the effectiveness of program integrity initiatives and appropriate performance measures; incomplete and outdated data; and insufficient program integrity resources

for delivery system models other than fee for service (MACPAC 2011b). Additional ongoing investments at the state and federal level are needed to enhance and improve both front-end program integrity controls to prevent fraud and postpayment reviews to identify waste, fraud, and abuse. These investments can reduce the amount of program dollars wasted on improper payments, but states cannot eliminate waste, fraud, and abuse entirely because the costs of identifying every potential improper payment would eventually outweigh the potential losses and unduly burden legitimate providers.

Conclusion

This chapter provides an overview of the policy levers available to states and the federal government under current program authorities to reduce spending and achieve other program efficiencies. We will conduct more in-depth analyses of options intended to provide states with flexibility to manage and design their programs to enhance efficiency, reduce costs, and improve health care quality. We will also examine areas where Congress has already provided states with alternatives and the reasons, such as the ability to achieve similar goals through alternate authority, why states have chosen not to implement certain options. Finally, we will assess the potential outcomes associated with different choices, including the effects on federal and state spending, beneficiaries, and providers, and we will explore the trade-offs associated with each. These additional analyses will help inform future debate on redesigning Medicaid's financing structure.

Endnotes

- ¹ The ACA also set a single income eligibility disregard equal to 5 percentage points of the FPL. For this reason, eligibility is often referred to at its effective level of 138 percent FPL, even though the federal statute specifies 133 percent FPL.
- ² Prior to the enactment of the ACA, adults not eligible on the basis of disability without dependent children were generally excluded from Medicaid unless the state covered them under a Section 1115 waiver.
- ³ At times, Congress has imposed limits on states' ability to terminate coverage of optional eligibility groups by enacting MOE provisions. The ACA included provisions requiring states to maintain the eligibility levels in place at the time the ACA was enacted—for adults in Medicaid until 2014 and for children in Medicaid and the State Children's Health Insurance Program (CHIP) until 2019.
- ⁴ Although low-income adults without dependent children is a mandatory group under the statute, the Supreme Court ruling in 2012 effectively made the ACA expansion of coverage to this group optional by removing the Secretary's enforcement mechanism.
- ⁵ States receive an enhanced 90 percent federal match for the first eight fiscal quarters of the health home benefit. Other optional services are matched at the state's regular federal medical assistance percentage (FMAP).
- ⁶ States have discretion to vary the amount, duration, or scope of the services that they cover as long as each service is "sufficient in amount, duration, and scope to reasonably achieve its purpose" and is not arbitrarily denied or reduced due to an individual beneficiary's diagnosis, type of illness, or condition (42 CFR 440.230). States are generally required to make Medicaid benefits available to all eligible individuals, regardless of their geographic location within the state.
- ⁷ Groups excluded from mandatory enrollment in benchmark coverage are individuals who are medically frail or have special medical needs, pregnant women, persons dually enrolled in Medicaid and Medicare, certain parents, and individuals who qualify for Medicaid on the basis of blindness or disability.

⁸ States must assure access to federally qualified health center (FQHC) services, rural health clinic (RHC) services, non-emergency medical transportation, family planning services and supplies, and EPSDT services for children under age 21 either through the alternative benefit packages or as additional benefits provided by the state. States must also meet the mental health parity requirements. The ACA added a requirement that benchmark coverage must include the 10 EHBs offered in the individual and small group insurance markets. The EHBs include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

⁹ The foundational statutory provision for Medicaid provider payment requires that states provide payment for all Medicaid-covered services to “safeguard against unnecessary utilization,” be “consistent with efficiency, economy, and quality of care,” and be “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area” (§ 1902(a)(30)(A) of the Social Security Act).

¹⁰ Medicaid providers have used this provision to sue state Medicaid agencies for inadequate Medicaid payment rates, but on March 31, 2015, the U.S. Supreme Court precluded future lawsuits when it decided in *Armstrong v. Exceptional Child Center, Inc.*, that Medicaid providers do not have the right to sue Medicaid agencies regarding payment rates under the Supremacy Clause of the Constitution or under Section 1902(a)(30)(A) of the Social Security Act.

¹¹ Cost containment is not the only reason states implement Medicaid managed care: this model also allows states to make improvements in the delivery of health services and obtain better value (even if spending is not reduced) through provider contracting and quality oversight.

References

AcademyHealth. 2015. *Evidence roadmap: Medicaid managed care*. Washington, DC: AcademyHealth. https://www.academyhealth.org/files/FileDownloads/AH_Evidence%20Roadmap11%20v3.pdf.

Avalere Health. 2014. Medicaid managed care enrollment set to grow by 13.5 million. October 23, 2014, press release. Washington, DC: Avalere Health. http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1414069964_20141023_Medicaid_Managed_Care_Press_Release_FINAL.pdf.

Brooks, T., S. Miskell, S. Artiga, et al. 2016. *Medicaid and CHIP eligibility, enrollment, renewal, and cost-sharing policies as of January 2016: Findings from a 50-state survey*. Washington, DC: Kaiser Family Foundation. <http://kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey>.

Centers for Disease Control (CDC), U.S. Department of Health and Human Services. 2016. National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Atlanta, GA: CDC. <http://www.cdc.gov/cancer/nbccedp/about.htm>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. Cost sharing. Baltimore, MD: CMS. <https://www.medicare.gov/medicaid-chip-program-information/by-topics/cost-sharing/cost-sharing.html>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015a. *Medicaid managed care enrollment and program characteristics, 2013*. Baltimore, MD: CMS. <https://www.medicare.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2013-managed-care-enrollment-report.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015b. *Medicaid and CHIP 2014 improper payments report*. Baltimore, MD: CMS. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP->

[Compliance/PERM/Downloads/2014MedicaidandCHIPAnnualErrorRateReport1.pdf](#).

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015c. *Medicare fee-for-service 2014 improper payments report*. Baltimore, MD: CMS. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/MedicareFeeforService2014ImproperPaymentsReport.pdf>.

Dickson, V. 2015. Michigan Medicaid waiver appears to save eligibility for 600,000 residents. *Modern Healthcare*, December 17. <http://www.modernhealthcare.com/article/20151217/NEWS/151219876>.

Kaiser Family Foundation (KFF). 2014. Medicaid-to-Medicare fee index. Washington, DC: Kaiser Family Foundation. <http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index>.

Kaiser Family Foundation (KFF). 2012. Medicaid benefits data collection. Washington, DC: Kaiser Family Foundation. <http://kff.org/data-collection/medicaid-benefits>.

Mathematica Policy Research (Mathematica). 2016. *Medicaid managed care trends and snapshots 2000–2013*. Baltimore, MD: Centers for Medicare & Medicaid Services. <https://www.medicare.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2013-medicare-managed-care-trends-and-snapshots-2000-2013.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016a. Exhibit 36: Medically needy program thresholds as percent of FPL, 2014. In *MACStats: Medicaid and CHIP data book*. December 2015. Washington, DC: MACPAC. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-36.-Medicaid-Income-Eligibility-Levels-as-a-Percentage-of-the-FPL-for-Individuals-Age-65-and-Older-and-Persons-with-Disabilities-by-State-2015.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016b. *Expanding Medicaid to the new adult group through Section 1115 waivers*. February 2016. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2016/02/Waiver-Summaries-Overview.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015a. *Report to Congress on Medicaid and CHIP*. June 2015. Washington, DC: MACPAC. <https://www.macpac.gov/publication/june-2015-report-to-congress-on-medicare-and-chip>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015b. *Report to Congress on Medicaid and CHIP*. March 2015. Washington, DC: MACPAC. <https://www.macpac.gov/publication/march-2015-report-to-congress-on-medicare-and-chip>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2014. Table: State Medicaid payment policies for inpatient hospital services. Washington, DC: MACPAC. <https://www.macpac.gov/publication/macpac-inpatient-hospital-payment-landscapes>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2011a. *Report to the Congress on Medicaid and CHIP*. March 2011. Washington, DC: MACPAC. <https://www.macpac.gov/publication/report-to-the-congress-on-medicare-and-chip-311/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2011b. *Report to the Congress on Medicaid and CHIP*. June 2011. Washington, DC: MACPAC. <https://www.macpac.gov/publication/report-to-congress-the-evolution-of-managed-care-in-medicare/>.

Moses, K. 2014. Presentation before the Medicaid and CHIP Payment and Access Commission, April 10, 2014, Washington, DC. <https://www.macpac.gov/wp-content/uploads/2015/01/2014AprilSession1a.pdf>.

National Association of Medicaid Directors (NAMD) and Bailit Health. 2016. *The role of state Medicaid programs in improving the value of the health care system*. Washington, DC: NAMD. http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicare.pdf.

National Conference of State Legislatures (NCSL). 2016. Recent Medicaid prescription drug laws and strategies. Washington, DC: NCSL. <http://www.ncsl.org/research/health/medicaid-pharmaceutical-laws-and-policies.aspx>.

Rosenbaum, S., N. Lopez, and S. Stifler. 2009. *Health insurance fraud: An overview*. Washington, DC: Department of

Health Policy, School of Public Health and Health Services, The George Washington University. http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1227&context=sphhs_policy_facpubs.

RTI International (RTI). 2014. *State Innovation Models (SIM) initiative evaluation model test base year annual report*. Baltimore, MD: Centers for Medicare & Medicaid Services. http://downloads.cms.gov/files/cmmti/SIM-Round1-ModelTest-FirstAnnualRpt_5_6_15.pdf.

Rudowitz, R., and M. Musumeci. 2015. *The ACA and Medicaid expansion waivers*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers>.

Scott, D. 2012. Medicaid Expansion & States: Will They or Won't They? *Governing*, December 2012. <http://www.governing.com/topics/health-human-services/gov-medicaid-expansion-and-states.html>.

Smith, V., K. Gifford, E. Ellis, et al. 2015. *Medicaid reforms to expand coverage, control costs and improve care: Results from a 50-state Medicaid budget survey for state fiscal years 2015 and 2016*. Washington, DC: Kaiser Family Foundation and National Association of Medicaid Directors. <http://kff.org/medicaid/report/medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2015-and-2016/>.

Smith, V., K. Gifford, E. Ellis, et al. 2010. *Hoping for economic recovery, preparing for health reform: A look at Medicaid spending, coverage and policy trends—results from a 50-state Medicaid budget survey for state fiscal years 2010 and 2011*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8105.pdf>.

Smith, V., K. Gifford, E. Ellis, et al. 2007. *As tough times wane, states act to improve Medicaid coverage and quality: Results from a 50-state Medicaid budget survey for state fiscal years 2007 and 2008*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7699.pdf>.

Smith, V., R. Ramesh, K. Gifford, et al. 2003. *States respond to fiscal pressure: State Medicaid spending growth and cost containment in fiscal years 2003 and 2004*

results from a 50-state survey. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/states-respond-to-fiscal-pressure-state-medicaid-spending-growth-and-cost-containment.pdf>.

Takach, M., C. Townley, R. Yalowich et al. 2015. Making multipayer reform work: What can be learned from medical home initiatives. *Health Affairs* 34, no. 4: 662.72. <http://www.commonwealthfund.org/publications/in-brief/2015/apr/making-multipayer-reform-work>.

U.S. Government Accountability Office (GAO). 2015. *High risk series: An update*. Report no. GAO-15-290. Washington, DC: GAO. <http://www.gao.gov/assets/670/668415.pdf>.

U.S. Government Accountability Office (GAO). 2012. *Opportunities for financial savings and program improvements in Medicare and Medicaid remain*. Report no. GAO-12-719T. Washington, DC: GAO. <http://www.gao.gov/assets/600/590722.pdf>.

Wholey, D., M. Finch, N. Shippee, et al. 2016. *Evaluation of the State of Minnesota's Health Care Homes Initiative evaluation report for years 2010–2014*. Minneapolis, MN: Division of Health Policy and Management, School of Public Health, University of Minnesota. z.umn.edu/hch2016report.

CHAPTER 3

Alternative Approaches to Federal Medicaid Financing

Alternative Approaches to Federal Medicaid Financing

Key Points

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

CHAPTER 3: Alternative Approaches to Federal Medicaid Financing

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

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

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

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

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

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

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

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

Medicaid's Current Financing Structure

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

Formula for federal financing

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

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

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

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

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

Non-federal share of Medicaid financing

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

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

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

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

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

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

Allowable state expenses

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

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

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

Responsiveness of the current financing structure

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

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

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

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

State incentives and spending decisions

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

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

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

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

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

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

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

Alternative Financing Proposals

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

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

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

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

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

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

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

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

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

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

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

Block grants

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

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

BOX 3-1. Aggregate Limits under Section 1115 Demonstrations

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

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

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

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

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

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

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

Capped allotments

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

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

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

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

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

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

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

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

Per capita caps

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

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

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

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

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

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

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

Medicaid shared savings

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

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

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

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

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

Design Considerations

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

Establishing spending limits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Defining the level of state contribution

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

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

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

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

Deciding which programmatic pieces to include

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

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

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

Determining the level of state flexibility and accountability

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

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

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

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

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

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

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

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

Potential Effect on States and Enrollees

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

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

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

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

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

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

Conclusion

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

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

Endnotes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

References

- Antos, J., J. Capretta, L. Chen, et al. 2015. *Improving health and health care: An agenda for reform*. Washington, DC: American Enterprise Institute. <https://www.aei.org/wp-content/uploads/2015/12/Improving-Health-and-Health-Care-online.pdf>.
- Cassidy, A. 2013. Health policy brief: *Per capita caps in Medicaid*. Washington, DC: Health Affairs. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=90.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016a. Section 1115 of the Social Security Act Medicaid demonstration: Flint, Michigan Section 1115 demonstration. March 3, 2016. Baltimore, MD: CMS. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-health-impacts-potential-lead-exposure-ca.pdf>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016b. Telephone conversation with MACPAC Staff, January 13.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2005. CMS takes emergency steps to ease health care access to Katrina evacuees. September 9, 2005, press release. Baltimore, MD: CMS. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2005-Fact-sheets-items/2005-09-09.html>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2003. *Medicaid school-based administrative claiming guide*. Baltimore, MD: CMS. <https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/medicaidbudgetexpendsystem/downloads/schoolhealthsvcs.pdf>.
- Committee on the Budget, U.S. House of Representatives. 2015. Concurrent Resolution on the Budget—Fiscal Year 2016. House Report no. 114-47, 103-108. <http://www.gpo.gov/fdsys/pkg/CRPT-114hrpt47/pdf/CRPT-114hrpt47.pdf>.
- Committee on the Budget, U.S. House of Representatives. 2014. Concurrent Resolution on the Budget—Fiscal Year 2015. House Report no. 113-403, 74-77. <http://www.gpo.gov/fdsys/pkg/CRPT-113hrpt403/pdf/CRPT-113hrpt403.pdf>.
- Congressional Budget Office (CBO). 2013. Chapter 5: Options related to health, health option 1: Impose caps on federal spending for Medicaid. In *Options for reducing the deficit: 2014–2023*. Washington, DC: CBO. <https://www.cbo.gov/sites/default/files/cbofiles/attachments/44715-OptionsForReducingDeficit-3.pdf>.
- Congressional Budget Office (CBO). 2012. *The long-term budgetary impact of paths for federal revenues and spending specified by Chairman Ryan*. Washington, DC: CBO. http://cbo.gov/sites/default/files/cbofiles/attachments/03-20-Ryan_Specified_Paths_2.pdf.
- Congressional Budget Office (CBO). 2011. Chapter 2: Mandatory spending options. In *Reducing the deficit: Spending and revenue options*. Washington, DC: CBO. <http://www.cbo.gov/sites/default/files/03-10-reducingthedeficit.pdf>.
- Congressional Budget Office (CBO). 2008. Chapter 8: Financing and paying for services in Medicaid and the State Children's Health Insurance Program. In *Budget options volume 1: Health care*. Washington, DC: CBO. <https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/12-18-healthoptions.pdf>.
- Coughlin, T.A., B.K. Bruen, J. King. 2004. States' use of Medicaid UPL and DSH financing mechanisms. *Health Affairs* 23, no. 2: 245–257. <http://content.healthaffairs.org/content/23/2/245.full>.
- Dilger, R.J., and E. Boyd. 2014. *Block grants: Perspectives and controversies*. July 15. Report no. R40486. Washington, DC: Congressional Research Service. <https://fas.org/sgp/crs/misc/R40486.pdf>.
- Falk, G. 2016. *The Temporary Assistance for Needy Families (TANF) block grant: Responses to frequently asked questions*. February 3. Report no. RL32760. Washington, DC: Congressional Research Service. <https://www.fas.org/sgp/crs/misc/RL32760.pdf>.
- Finegold, K., L. Wherry, and S. Schardin. 2004. *Block grants: Historical overview and lessons learned*. Washington, DC: Urban Institute. <http://www.urban.org/research/publication/block-grants-0>.

Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services. 2000. Section 1: Medicaid program overview. In *A profile of Medicaid*. Baltimore, MD: HCFA. <https://www.cms.gov/TheChartSeries/downloads/2Tchartbk.pdf>.

Hill, I. 1990. Improving state Medicaid programs for pregnant women and children. *Health Care Financing Review* 1990, Supplement: 75–87. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4195155/>.

Holahan, J., M. Buettgens, C. Carroll, and V. Chen. 2012. *National and state-by-state impact of the 2012 House Republican budget plan for Medicaid*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8185-02.pdf>.

Houston, R., and T. McGinnis. 2013. *Adapting the Medicare Shared Savings Program to Medicaid accountable care organizations*. Hamilton, NJ: Center for Healthcare Strategies, Inc. <http://www.chcs.org/resource/adapting-the-medicare-shared-savings-program-to-medicare-accountable-care-organizations/>.

Kaiser Family Foundation (KFF). 2012. *Health care costs: A primer*. Washington, DC: KFF. <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7670-03.pdf>.

Kates, J. 2011. *Medicaid and HIV: A national analysis*. Washington, DC: Kaiser Family Foundation. <http://kff.org/hiv/aids/report/medicaid-and-hiv-a-national-analysis/>.

Mach, A.L. 2016. *Puerto Rico and health care finance: Frequently asked questions*. February 3. Report no. R44275. Washington, DC: Congressional Research Service. <https://www.fas.org/sgp/crs/row/R44275.pdf>.

Manley, E., State of New Jersey, Department of Children and Families. 2016. E-mail to MACPAC staff, April 28.

McClellan, M. 2013. Moving forward on Medicaid reform: Shared savings in Medicaid, and how to do it. *Health Affairs Blog*, September 5. <http://healthaffairs.org/blog/2013/09/05/moving-forward-on-medicare-reform-shared-savings-in-medicare-and-how-to-do-it>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016a. Federal Medical Assistance Percentages

(FMAPs) and Enhanced FMAPs (E-FMAPs) by State. Washington, DC: MACPAC. <https://www.macpac.gov/publication/federal-medical-assistance-percentages-fmaps-and-enhanced-fmaps-e-fmaps-by-state-selected-periods/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016b. Federal match rate exceptions. Washington, DC: MACPAC. <https://www.macpac.gov/federal-match-rate-exceptions/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016c. Federal match rates for Medicaid administrative activities. Washington, DC: MACPAC. <https://www.macpac.gov/federal-match-rates-for-medicare-administrative-activities/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015a. Chapter 3: The intersection of Medicaid and child welfare. In *Report to Congress on Medicaid and CHIP*. June 2015. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2015/06/Intersection-of-Medicaid-and-Child-Welfare.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015b. Exhibit 19: Medicaid benefit spending per full-year equivalent (FYE) enrollee by eligibility group and service category, FY 2012. In *MACStats: Medicaid and CHIP Data Book*. December 2015. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-19.-Medicaid-Benefit-Spending-Per-Full-Year-Equivalent-FYE-Enrollee-by-Eligibility-Group-and-Service-Category-FY-2012.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015c. Exhibit 15: Medicaid full-year equivalent enrollment by state and eligibility group. In *MACStats: Medicaid and CHIP Data Book*. December 2015. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2015/11/EXHIBIT-15.-Medicaid-Full-Year-Equivalent-Enrollment-by-State-and-Eligibility-Group-FY-2012-thousands.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013. Chapter 2: Medicaid primary care physician payment increase. In *Report to the Congress on Medicaid and CHIP*. June 2013. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/01/Medicaid_Primary_Care_Physician_Payment_Increase.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2012. Chapter 3: State approaches for financing Medicaid and update on federal financing of CHIP. In *Report to the Congress on Medicaid and CHIP*. March 2012. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/01/State_Approaches_for_Financing_Medicaid_and_Update_on_Federal_Financing_of_CHIP.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2011. Chapter 6: Improving Medicaid and CHIP data for policy analysis. In *Report to the Congress on Medicaid and CHIP*. March 2011. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/01/Improving_Medicaid_and_CHIP_Data_for_Policy_Analysis_and_Program_Accountability.pdf.

National Association of State Budget Officers (NASBO). 2015. *State expenditure report: Examining fiscal 2013–2015 state spending*. Washington, DC: NASBO. <http://www.nasbo.org/sites/default/files/State%20Expenditure%20Report%20%28Fiscal%202013-2015%29S.pdf>.

Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. 2015. National health expenditure (NHE) amounts by type of expenditure and source of funds: Calendar years 1960–2024 in projections format, as of July 2015. Washington, DC: OACT. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/nhe60-24.zip>.

Office of Management and Budget (OMB). 2004. Letter to the heads of executive departments and establishments regarding “Cost principles for state, local, and Indian tribal governments.” May 10, 2004. https://www.whitehouse.gov/omb/circulars_a087_2004/.

Oregon Health Policy Board (OHPB), State of Oregon (OHA). 2016. *Background: Oregon’s Medicaid demonstration*. Salem, OR: OHPB. <https://www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx>.

Smith, V.K., K. Gifford, E. Ellis, et al. 2015. *Medicaid reforms to expand coverage, control costs and improve care: Results from a 50-state Medicaid budget survey for state fiscal years 2015 and 2016*. Washington, DC: Kaiser Family Foundation and National Association of Medicaid Directors. <http://files.kff.org/attachment/report-medicare-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicare-budget-survey-for-state-fiscal-years-2015-and-2016>.

[kff.org/attachment/report-medicare-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicare-budget-survey-for-state-fiscal-years-2015-and-2016](http://files.kff.org/attachment/report-medicare-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicare-budget-survey-for-state-fiscal-years-2015-and-2016).

Smith, V.K., K. Gifford, E. Ellis, et al. 2011. *Moving ahead amid fiscal challenges: A look at Medicaid spending, coverage, and policy trends: Results from a 50-state Medicaid budget survey for state fiscal years 2011 and 2012*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8248.pdf>.

Tatum, A. 2015. *Medicaid misallocation: How the federal government miscalculates state funding needs*. Mountain View, CA: California Common Sense. <http://uscommonsense.org/pdf/55.pdf>.

United Hospital Fund (UHF). 2002. Disaster relief Medicaid fact sheet, March 4, 2002. New York, NY: UHF. <http://www.uhfnyc.org/publications/103951>.

U.S. Department of Health and Human Services (HHS). 2016a. *2015 Annual report on the quality of care for adults enrolled in Medicaid*. Washington, DC: HHS. <https://www.medicare.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-adult-sec-rept.pdf>.

U.S. Department of Health and Human Services (HHS). 2016b. New hospitals and health care providers join successful, cutting-edge federal initiative that cuts costs and puts patients at the center of their care. January 11, 2016, press release. Washington, DC: HHS. <http://www.hhs.gov/about/news/2016/01/11/new-hospitals-and-health-care-providers-join-successful-cutting-edge-federal-initiative.html>.

U.S. Department of Health and Human Services (HHS). 2012. *Fiscal year 2013: Budget in brief – strengthening health and opportunity for all Americans*. Washington, DC: HHS. <https://wayback.archive-it.org/3920/20140403203230/http://www.hhs.gov/budget/fy2013/budget-brief-fy2013.pdf>.

U.S. Government Accountability Office (GAO). 2016. *Medicaid: Changes to funding formula could improve allocation of funds to states*. Report no. GAO-16-377T. Washington, DC: GAO. <http://www.gao.gov/assets/680/675072.pdf>.

U.S. Government Accountability Office (GAO). 2014. *Medicaid financing: States’ increased reliance on funds from*

- health care providers and local governments warrants improved CMS data collection.* Report no. GAO-14-627 [Reissued on March 13, 2015]. Washington, DC: GAO. <http://www.gao.gov/products/GAO-14-627>.
- U.S. Government Accountability Office (GAO). 2013a. *Medicaid: Alternative measures could be used to allocate funding more equitably.* Report no. GAO-13-434. Washington, DC: GAO. <http://www.gao.gov/assets/660/654477.pdf>.
- U.S. Government Accountability Office (GAO). 2013b. *Medicaid demonstration waivers: Approval process raises cost concerns and lacks transparency.* Report no. GAO-13-384. Washington, DC: GAO. <http://www.gao.gov/assets/660/655483.pdf>.
- U.S. Government Accountability Office (GAO). 2012. *Department of Health and Human Services: Opportunities for financial savings and program improvements in Medicare and Medicaid remain.* Report no. GAO-12-719T. Washington, DC: GAO. <http://www.gao.gov/assets/600/590722.pdf>.
- U.S. Government Accountability Office (GAO). 2011. *Medicaid: Prototype formula would provide automatic, targeted assistance to states during economic downturns.* Report no. GAO-12-38. Washington, DC: GAO. <http://www.gao.gov/assets/590/586185.pdf>.
- U.S. Government Accountability Office (GAO). 2008. *Medicaid demonstration waivers: Recent HHS approvals continue to raise cost and oversight concerns.* Report no. GAO-08-87. Washington, DC: GAO. <http://www.gao.gov/assets/280/271789.pdf>.
- U.S. Government Accountability Office (GAO). 2007. *Children's health insurance: States' SCHIP enrollment and spending experiences and considerations for reauthorization.* Report no. GAO-07-558T. Washington, DC: GAO. <http://www.gao.gov/assets/120/115622.pdf>.
- U.S. Government Accountability Office (GAO). 2004. *Medicaid: Intergovernmental transfers have facilitated state financing schemes.* Report no. GAO-04-574T. Washington, DC: GAO. <http://www.gao.gov/assets/120/110702.pdf>.
- U.S. Government Accountability Office (GAO). 1995. *Block grants: Characteristics, experience, and lessons learned.* Report no. GAO/HEHS-95-74. Washington, DC: GAO. <http://www.gao.gov/assets/230/220911.pdf>.
- U.S. Government Accountability Office (GAO). 1994. *Medicaid: States use illusory approaches to shift program costs to Federal Government.* Report no. GAO/HEHS-94-133. Washington, DC: GAO. <http://www.gao.gov/assets/230/220257.pdf>.
- Waller, M. 2005. *Block grants: Flexibility vs. stability in social services.* Washington, DC: The Brookings Institution. <http://www.brookings.edu/research/papers/2005/12/welfare-waller>.
- Weil, A. 2013. Promoting cooperative federalism through state shared savings. *Health Affairs* 32, no. 8: 1493–1500. <http://content.healthaffairs.org/content/32/8/1493.full.html>.

APPENDIX 3A: Medicaid Financing Alternatives

TABLE 3A-1. Comparison of Medicaid Financing Approaches

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

TABLE 3A-1. (continued)

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

TABLE 3A-1. (continued)

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

Notes: FMAP is federal medical assistance percentage.

Source: MACPAC analysis.

CHAPTER 4

Functional Assessments for Long-Term Services and Supports

Functional Assessments for Long-Term Services and Supports

Key Points

- Functional assessment tools are sets of questions about an applicant's health conditions and functional needs that state Medicaid programs use to determine functional eligibility for long-term services and supports (LTSS) and to create specific care plans for eligible individuals.
- The federal government does not require states to use a particular assessment tool to determine eligibility or to develop a care plan.
- MACPAC's analysis of states' functional assessment tools shows that there are at least 124 tools currently in use. On average, states are using three different tools each, as they generally use separate tools for different populations.
- States that use managed care plans to deliver LTSS either require plans to use a certain tool or allow them to use a tool of their choosing. There is limited information about the tools used by plans, in part because some of these tools are proprietary.
- Almost all states use at least one tool that they developed themselves, which we refer to as homegrown tools. States report that the use of homegrown tools is driven largely by their need for customized tools for their populations and their desire to incorporate stakeholder input. Staff in states that use independently developed tools said those tools were easier to implement than homegrown tools.
- Use of a single national tool or set of core questions about functional status would facilitate analyses of LTSS use across states that would reflect the variation in beneficiary needs. Such information could be used for multiple purposes, including development of benchmarks for appropriate care, setting payment rates, and identifying strategies that promote better use of state and federal resources.
- Moving to a national tool, however, would be burdensome for those states that have recently invested in new tools, and there is currently no clear empirical or operational reason to pick one existing tool over another.
- Given the rapid change in LTSS programs and work that the Centers for Medicare & Medicaid Services is doing to test new approaches to functional assessment and electronic exchange of care plans, the Commission does not advocate moving to a national tool at this time, but we will continue to monitor developments in this area.

CHAPTER 4: Functional Assessments for Long-Term Services and Supports

Medicaid is the nation's primary payer for long-term services and supports (LTSS) for individuals with physical and cognitive disabilities. These services generally focus on helping people maintain (and sometimes improve) their ability to perform basic tasks of everyday life, such as bathing and dressing, and skills needed for independent living, such as preparing meals and managing money. In order for individuals to receive Medicaid-covered LTSS, they must be determined eligible based on two types of criteria. First, they must meet financial eligibility criteria, with income and assets consistent with state-defined thresholds.¹ Second, they must meet state-defined functional eligibility criteria, which are based on physical and cognitive abilities. To determine whether an individual meets a state's functional eligibility criteria, also referred to as their level of care criteria, states use functional assessment tools—sets of questions that collect information on an applicant's health conditions and functional needs. Such tools may also be used to develop a care plan of specific services that an individual will receive upon being determined eligible for coverage.

The federal government does not require state Medicaid programs to use any particular assessment tool to determine eligibility for Medicaid-covered LTSS or to develop a care plan. In states with managed long-term services and supports (MLTSS) programs, care plans are developed using either a state-selected tool or—depending on state requirements—a tool chosen by the managed care plan into which a beneficiary is enrolled.² MACPAC's inventory of assessment tools shows that there are, at a minimum, 124 tools currently in use for eligibility determination and care planning. MACPAC also found that only a few states use the same tool across all their LTSS programs.

Methods for assessing functional status are of interest to the Commission for three reasons. First, a disproportionate share of Medicaid expenditures are for LTSS users. In fiscal year (FY) 2012, 43.4 percent of Medicaid expenditures (\$169.2 billion) were spent on LTSS users, even though LTSS users comprised only 6.2 percent (4.3 million) of Medicaid beneficiaries (MACPAC 2015). Assessment of functional status has a direct effect on eligibility determination and the services that beneficiaries use.

Second, changes in the delivery system for LTSS are highlighting the role of functional assessments. Increasingly, LTSS are being provided in homes and community-based settings rather than in institutions. In FY 2013, for the first time in the history of the Medicaid program, the proportion of LTSS expenditures for home and community-based services (HCBS) was greater than the proportion of expenditures for institutional services (Eiken et al. 2015). The movement to HCBS has expanded the breadth of services used to address individuals' LTSS needs and keep them integrated in the community. In addition, more states are establishing MLTSS programs, and these call for decisions about how managed care plans are to conduct care planning and which assessment tools they use.

Third, the substantial costs associated with providing LTSS raise concerns about whether services are delivered in the most efficient manner. This question, however, requires information about costs relative to need. But because states use such varied approaches to functional assessment, it is not currently possible to compare LTSS needs across populations in different states or compare beneficiary access to services across states. Comparable data on the needs of LTSS users would also be useful in evaluating different LTSS program designs and the relationship of payment to services provided. Such information could shed light on the quality of care provided to individuals with LTSS needs, allow for inclusion of the severity of LTSS needs in the development of payment rates, highlight state innovations that are effective and worthy of replication, and suggest potential

changes in federal policy to incentivize adoption of effective approaches.

In this chapter, we describe how functional assessment tools are currently being used across states at the state and federal level. We begin by describing how functional assessments are used in eligibility determination and in care planning. The chapter then focuses on federal guidance affecting assessments and various federal initiatives to support states in improving tools and standardizing data elements.

Next, we present the results of new research conducted for MACPAC that documents the wide variation in functional assessment tools across all 50 states and the District of Columbia. We have documented the dozens of disparate tools currently in use by state Medicaid programs as well as the many ways states are measuring needs for specific activities, such as bathing and dressing. Our interviews with Medicaid program staff in different states found that their decisions about creating a new tool or using one that already exists are influenced in part by their perceptions of the level of customization needed and the ease of implementation. Finally, we look at the advantages and disadvantages of developing a national functional assessment tool or using other means for making it possible to collect more comparable assessment data across states.

Functional Eligibility Criteria: Variation by Eligibility Pathway

Individuals must meet functional eligibility criteria to receive Medicaid coverage for LTSS, whether in an institution or the community. These functional criteria vary by eligibility pathway and by state, and the type of pathways that are available to an individual depends on the state in which they reside (Table 4-1). About two in five Medicaid beneficiaries who received LTSS in FY 2010 enrolled through the Supplemental Security Income (SSI) eligibility pathway (MACPAC 2014).³

In most states, individuals eligible for SSI are automatically eligible for Medicaid, including—if they meet functional eligibility criteria—LTSS offered under the state plan. States also have an option to provide Medicaid coverage to individuals who have LTSS needs but whose incomes are too high for them to be eligible through the SSI-related pathway. States cover these individuals through other eligibility pathways; some of these other eligibility pathways use the SSI-related functional eligibility criteria, and others use state-established level of care criteria.

States have flexibility in determining the level of functional impairment that will be used for each of their eligibility pathways. A high threshold for the level of care criteria might be requiring an individual to be dependent in four or more activities of daily living (ADLs), while a lower threshold might require dependency in only two ADLs.⁴ Access to most HCBS are based on having needs severe enough for institutional care, but some states use Section 1915(i) authority, which allows states to offer services to individuals meeting less stringent criteria.

Functional Assessment Process: Eligibility Determination and Care Planning

Functional eligibility for Medicaid-covered LTSS is determined using functional assessment tools. Depending on the state, the entity responsible for conducting the Medicaid eligibility functional assessment may be the state or local health department, an area agency on aging, an aging and disability resource center, or a contracted vendor (Tucker and Kelley 2011, Shirk 2009). The functional assessment is typically conducted in a face-to-face interview in the individual's home, which helps ensure that environmental issues, such as need for home modifications, are addressed (Shirk 2009).

TABLE 4-1. Medicaid Eligibility Pathways for Long-Term Services and Supports

Eligibility pathway		Age group served			Functional assessment criteria	Receives full state plan benefits	Benefits conditional upon LOC criteria	
		≥ 65	19–64	<19			Institutional LTSS	HCBS waiver
SSI-related		Yes	Yes	Yes	Adults ≥ 65: None; Adults 18–64: Blindness or permanent, medically determinable impairment that results in the inability to do any substantial gainful activity	Yes	NF: Yes; All other institutions at state option	At state option
					Children < 18: Permanent, medically determinable impairment that results in marked and severe functional limitations		Children < 18: Yes, if determined medically necessary under EPSDT.	
Poverty-related		Yes	Yes	Yes	Same as SSI	Yes	NF: Yes; All other institutions at state option	At state option
Medicaid buy-in	BBA 97 eligibility	No	Yes	16–18 only	Same as SSI	Yes	At state option	At state option
	Basic eligibility group	No	Yes	16–18 only	Same as SSI	Yes	At state option	At state option
	Medical improvement group	No	Yes	16–18 only	Must have a medically improved disability (based on SSI disability determination)	Yes	At state option	At state option
	Family Opportunity Act	No	No	Yes	Same as SSI	Yes	At state option	At state option
Medically needy		Yes	Yes	Yes	Same as SSI	At state option	At state option	At state option
Special income rule		Yes	Yes	Yes	State-established LOC for NF, ICF, or hospital	Yes	At state option	At state option
TEFRA/Katie Beckett		No	No	Yes	State-established LOC for NF, ICF, or hospital	Yes	No	At state option
Section 1915(i) state plan HCBS		Yes	Yes	Yes	State-established LOC less than for NF, ICF, or hospital	At state option	No	At state option

Notes: LOC is level of care. LTSS is long-term services and supports. HCBS is home and community-based services. SSI is Supplemental Security Income. NF is nursing facility. EPSDT is Early and Periodic Screening, Diagnostic, and Treatment. BBA 97 is the Balanced Budget Act of 1997 (P.L. 105-33); this and other buy-in eligible pathways allow states to cover individuals with disabilities who work and have incomes too high to qualify for Medicaid. ICF is intermediate care facility. TEFRA is the Tax Equity and Fiscal Responsibility Act (P.L. 97-248), the TEFRA/Katie Beckett pathway provides Medicaid eligibility to children with severe disabilities whose family income would ordinarily be too high to qualify for Medicaid. For beneficiaries receiving institutional or HCBS waiver LTSS under any eligibility pathway, states have an option to disregard parent or spousal income and to allow beneficiaries to retain income under personal needs allowances or monthly maintenance needs allowances.

Sources: HRTW National Resource Center 2013, SSA 2013, Stone 2011.

If an individual is eligible for more than one LTSS program, the state may require assessment with multiple tools, which can be a time-consuming process for the individual and assessors.

Once determined eligible for Medicaid, a care plan is developed using either the eligibility determination tool or a separate tool. For individuals whose LTSS benefits are covered under fee for service, care plan development and ongoing case management is often assigned to care coordinators from the same entities that conducted the eligibility determination. Care coordinators are then responsible not only for determining which services a Medicaid beneficiary should receive and the frequency and duration of those services, but also for connecting the beneficiary to service providers. In states with MLTSS, care plans

are developed by care coordinators employed by the managed care plan in which the beneficiary is enrolled or by a third party contracted by the plans to provide these services (Box 4-1).

Federal Role in Functional Assessment

Federal requirements for functional assessment tools

Federal laws and regulations do not require the use of specific tools for either eligibility determination or care planning, and they do not require the collection

BOX 4-1. Functional Assessments and Managed Long-Term Services and Supports

The number of states with managed long-term services and supports (MLTSS) programs has risen rapidly in recent years, growing from just 8 in 2004 to 22 in 2014 (Terzaghi 2015, Saucier et al. 2012). Another 11 states are in the process of implementing or considering such programs (Terzaghi 2015). In MLTSS, states contract with managed care plans to provide long-term services and supports (LTSS) to beneficiaries in exchange for a capitated payment. These plans are responsible for providing the broad range of LTSS benefits within the capitated rate. In order to coordinate the services beneficiaries receive, managed care plans may employ case managers directly or delegate coordination to a third-party case management service. In either circumstance, case managers are responsible for developing beneficiary care plans (with input from the beneficiaries, their family members, other persons providing support, and providers), and also serve as the beneficiaries' main point of contact for dealing with issues such as scheduling transportation to and from medical appointments and connecting to community resources and activities.

States that adopt MLTSS must make certain decisions about the use of assessment tools. Some states (e.g., Minnesota and Texas) require all plans to use a certain tool, while others (e.g., Tennessee and Wisconsin) allow each plan to use the tool of its choosing, albeit with certain requirements or restrictions (Ingram et al. 2013). Some plans develop proprietary tools, while others may use tools available on the market. States may also require plans to collect specific data elements and report those results to the state for purposes such as quality monitoring and the setting of capitation rates (Atkins and Gage 2014). States also set other requirements for plans, including specific timeframes for completion of assessments for new enrollees and reassessments of existing beneficiaries, as well as qualifications and training requirements for the case managers conducting assessments (Ingram et al. 2013).

of specific data elements. Federal laws and regulations do have the following requirements:

- The assessment to determine eligibility for nursing facilities must be ordered and provided under the direction of a physician (42 CFR 440.40(a)).
- Nursing facilities must conduct comprehensive assessments to determine each resident's functional capacity soon after admission and no less than once every 12 months (more often if there is a change in condition that requires a new assessment in the interim), and the assessment should be conducted or coordinated by a registered professional nurse (§ 1919(b)(3) of the Social Security Act).
- A physician must certify that an individual with intellectual disabilities needs intermediate care facility services (42 CFR 456.360).
- States that use the Community First Choice Section 1915(k) state plan option must use a person-centered care plan based on an assessment of functional need (42 CFR 441.535).⁵ These states must also restrict eligibility to cover only individuals who require a level of care equivalent to that provided in an institution (42 CFR 441.510(c)).
- HCBS waiver eligibility must be limited to those who require a level of care equivalent to that provided in an institution (§ 1902(a)(10)(A)(ii)(VI) of the Social Security Act).
- In states with MLTSS, managed care plans are required to comprehensively assess beneficiaries' LTSS needs and use person-centered care planning processes (42 CFR 438.208(c)). Sub-regulatory guidance further specifies that states approve the tools a managed care plan uses and that such tools assess physical, psychosocial, and functional needs (CMCS 2013).

By contrast, care planning assessments for nursing facility residents are strictly prescribed: all nursing

facilities must use the same assessment tool, the Minimum Data Set (MDS), for all residents.⁶ Similarly, home health agencies delivering Medicare-covered home health services are required to use a common care planning assessment tool, the Outcome and Assessment Information Set (OASIS)—this requirement has been in place since 1999.

CMS functional assessment initiatives

Although requirements for functional assessment tools are limited, the Centers for Medicare & Medicaid Services (CMS) recently implemented two initiatives to provide resources to states to make changes to their existing tools.

The Balancing Incentive Program. The Balancing Incentive Program, for which program funding ended in 2015, was one of several recent initiatives to expand Medicaid beneficiaries' access to HCBS and reduce state reliance on institutional care.⁷ Participating states earned an enhanced federal match for the HCBS provided to beneficiaries during the demonstration, and in turn were required to implement certain structural changes in their LTSS delivery systems. One of these structural changes was the adoption of a standardized functional assessment process and an instrument or instruments to determine eligibility for Medicaid-funded LTSS if such tools were not already in use (CMS 2016a). Further, these assessments had to include a core set of domains related to medical needs, ADLs, instrumental activities of daily living (IADLs), and mental and behavioral health needs (MAG and NEC 2015). However, CMS did not require states to use any particular questions or a specific tool if a state's existing tools covered the specified domains. Seven of the 18 participating states needed only to add questions to their existing tools to meet these requirements, and 4 of the states met all of CMS's requirements without making any changes. In addition, seven states implemented an entirely new tool during the program, although that may have been for reasons other than ensuring that the core domains were included (MAG and NEC 2015).

States that implemented a new tool during the program reported that the resources provided by the Balancing Incentive Program eased the implementation process. Some of these states had planned to overhaul their existing tools prior to their participation in the Balancing Incentive Program and found that the additional resources helped make that possible. For example, New York noted that the resources provided by the Balancing Incentive Program helped facilitate the implementation of a tool that was already in development (MAG and NEC 2016).

Testing Experience and Functional Tools

demonstration. CMS is currently developing a set of assessment questions through the Testing Experience and Functional Tools demonstration. In March 2014, CMS awarded planning grants to Medicaid programs in nine states as part of the demonstration to test several tools related to LTSS quality and assessments. Six of the participating states (Arizona, Colorado, Connecticut, Georgia, Kentucky, and Minnesota) will be testing the Functional Assessment Standardized Items (FASI) tool with a sample of their Medicaid beneficiaries at the time of reassessment, sometimes alongside their existing functional assessment tools. Field testing is expected to begin in the second half of 2016, with refinements and additional testing planned through 2017 (CMS 2016b).

The FASI tool includes domains covering identifying information, functional abilities and goals, assistive devices, support needs, and caregiver assistance. The tool is based on the Continuity Assessment Record and Evaluation tool used in Medicare post-acute care settings (e.g., long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health agencies) and is being pilot tested as part of a broad CMS effort to standardize assessment data resulting from the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act, P.L. 113–185). The IMPACT Act requires CMS to implement standardized assessment measures for Medicare post-acute care settings to replace

certain setting-specific questions currently in use, and eventually to develop a unified post-acute care payment system. This effort arose in part due to concerns raised by the Medicare Payment Advisory Commission (MedPAC) and others that Medicare patients with similar characteristics are often served in different settings with different payment rates (MedPAC 2015). Gathering similar assessment information from all such providers will increase understanding of the cost of care across settings and the extent to which variation in costs reflects local practice patterns, provider availability, and other factors as opposed to measurable differences in patients' needs.

Once the FASI testing is completed, CMS plans to make it available for use by state Medicaid programs, providing access to a set of pretested and validated data elements for use in functional assessment. CMS may also consider additional uses (Smith 2016). For example, it could potentially be used to collect assessment information across all states, an idea discussed later in this chapter.

The demonstration also includes the electronic Long-Term Services and Supports (eLTSS) Initiative, which is a joint effort between CMS and the Office of the National Coordinator (ONC). CMS and ONC are working to develop standards for interoperable LTSS service plans, which would include information from functional assessments that could be shared among LTSS providers, payers, and individuals receiving the services (ONC and CMS 2016). Six states will be piloting this component of the demonstration, which according to CMS, could improve coordination of health and social services (CMCS 2016).

State Variation in Functional Assessment Tools

Because we could find no published source that examined functional assessment tools in use across all states in a consistent manner, in

2015, MACPAC commissioned a comprehensive inventory of assessment tools used in 50 states and the District of Columbia.⁸ NORC at the University of Chicago, our contractor, reviewed state websites, training materials, and other documentation, and contacted Medicaid officials in states that had not posted information online. This review identified 124 distinct functional assessment tools in use across 50 states and the District of Columbia. Information received directly from states indicated that some are in the process of implementing new tools, which may push that number upward. In addition, in states with MLTSS that permit plans to use a tool of their choosing rather than mandating a tool, those plan-selected tools were not captured by this inventory. Given the proprietary nature of some plan-selected tools, little information is available on them.

On average, states used three functional assessment tools. Moreover, functional assessment tools in use by state Medicaid programs vary widely on virtually every dimension examined, a finding consistent with prior research (MAG et al. 2013, Shirk 2009). Key themes are described below.

States use tools specialized to subpopulations of LTSS users

States often used more than one tool because they used separate tools for different LTSS subpopulations—that is, a state might use one tool for individuals with physical disabilities and another for individuals with intellectual or developmental disabilities. Use of different tools can identify concerns specific to different populations because individuals in each population have different characteristics that are relevant to determining their LTSS needs. For example, a tool for individuals with intellectual or developmental disabilities may ask questions about clarity of the individual's speech, which may not need to be assessed for individuals with physical disabilities. In addition, some states use multiple assessment tools among their waiver

programs if those programs provided different types of services. Some states have separate waivers for administering in-home personal care services and adult day care services.

Almost all states used homegrown tools

Almost all states used homegrown tools rather than those developed independently. Nearly every state (49 of 51) used at least one tool for either eligibility determination or care planning that was state-specific. Only two states used independently developed tools exclusively. However, 28 states used one or more tools developed independently, such as the Supports Intensity Scale (American Association on Intellectual and Developmental Disabilities) and the interRAI Home Care Assessment System (interRAI), alongside the state-specific tools. Another five states used a combination of nationally used tools and tools adapted by the state from existing tools.

Most states use the same tools for care planning

In most states, information from functional assessment tools used to establish eligibility is also used to develop care plans. Forty-one states (using 73 different tools) report using assessment tools to inform plans of care. In some cases, state documents reference the assessment as a source of information to support an independent care planning process. In others, information from the assessment directly enters care management software to populate the plan of care. This may reduce duplication in the collection of information from beneficiaries by case managers.

All states assess health needs

Virtually all states assess functional limitations, clinical needs or health status, and behavior and cognitive status. Assessment of functional support needs, included in tools in 49 states (114

tools), is the most commonly included domain, although how states ask these questions can vary (Box 4-2). Nearly all states use tools that also assess clinical care needs or health and medical concerns (50 states, 108 tools) or cognitive and behavioral support needs (49 states, 108 tools). Clinical and health questions frequently solicit information on an individual's health history, active diagnoses, medications, and clinical services (e.g., wound care or dialysis). Cognitive and behavioral questions used among individuals with intellectual or developmental disabilities are often focused on adaptive and maladaptive behaviors, while tools assessing other populations cover more general ground, such as memory and behaviors that put the individual or others at risk.

Most states seek information on other factors

Most tools also ask about a person's physical environment, psychosocial needs, or other issues. Thirty-nine states use tools that include questions that go beyond identifying needs related to physical, intellectual, or cognitive functioning by gathering information about the individual's physical environment, such as accessibility, functioning appliances, or pests (50 tools). In addition, 43 states use tools that assess psychosocial needs, such as community or social engagement and leisure activities (55 tools).

Most states use paper to record assessments

For data from functional assessments to be reported at the national level, they need to be available electronically; however, many states appear to record results of assessments only on paper. Although some tools are completed electronically and data are stored electronically, it appears that tools used in 42 states (74 tools) are still being recorded on paper. In seven states (10 tools), assessments are recorded on paper but are

eventually stored electronically or linked to another data source.

Some states link assessment results to payments

Functional assessment tools collect a great deal of information that could be used to determine payment rates based on the intensity of services an individual needs. Evidence in this area was limited because the documentation for most tools did not address payment specifically, but in 21 states (27 tools), state documents noted some link between assessment results and payment for LTSS.

Factors Influencing States' Choice of Tools

Given the wide variation among states in tools used for functional assessment, MACPAC sought to understand what influences state choices when it comes to such tools. To gain perspective on states' choices, MACPAC analysts interviewed individuals responsible for administering LTSS programs in eight states: Kansas, Maryland, Massachusetts, Minnesota, Mississippi, Nebraska, Ohio, and Wyoming. Interviewees were typically employees of state Medicaid agencies. States were selected to represent a mix of those using homegrown and independently developed tools, and several states were in the process of selecting a new assessment tool. These interviews helped to illustrate a variety of factors affecting states' choice of tools.

Why states develop homegrown tools

States develop homegrown tools when they feel existing tools do not offer any clear advantages. Staff in one state noted that none of the existing tools had been demonstrated to be better than another. In the absence of a strong case for using

BOX 4-2. Details Matter: Examples of Variation in Specific Assessment Questions

MACPAC’s study found that most states included similar domains (e.g., clinical care needs, functional needs, and cognitive or behavioral needs) in the functional assessment tools used for either eligibility determination or care planning. However, tools differ in how they assess similar characteristics, such as an individual’s need for assistance with activities of daily living (ADLs), assistance with instrumental activities of daily living (IADLs), or cognitive deficits. As illustrated below, the level of detail can vary significantly; the assessment of bathing used in the District of Columbia requests the frequency and duration required, while the assessment in Kentucky does not. The level of detail states collect may be due to differences in their functional eligibility criteria. In addition, greater detail may be useful where states are using a tool to develop a care plan.

TABLE 4-2a. Information on Bathing Needs Collected by the District of Columbia Long-Term Care Assessment Tool

1) Bathing					
7aa–7ad. How frequently is this activity required and for what duration?	___ Minutes per occurrence		= ___ minutes per week		
	___ Times per day				
	___ Days per week				
7ba. Type of assistance required	Required Frequency of Assistance				Bathing Score (7bb):
	Never	Sometimes	Usually	Always	
Cueing or supervision	(0)	(0)	(1)	(2)	
Mechanical assistance only	(0)	(0)	(1)	(1)	
One-to-one 1:1 person physical assist	(0)	(1)	(2)	(3)	
Totally dependent on another person	(0)	(2)	(3)	(4)	
7c. Observations:					

Source: MACPAC reproduction of DC Department of Health Care Finance, 2013, LTCSS Assessment Tool V 1.1, <http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Long%20Term%20Care%20Assessment%20Tool.pdf>.

TABLE 4-2b. Information on Bathing Needs Collected by the Kentucky Medicaid Waiver Assessment Tool

4) Is member independent with bathing	Comments:
<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)	
<input type="checkbox"/> Requires supervision or verbal cues	
<input type="checkbox"/> Requires hands-on assistance with upper body	
<input type="checkbox"/> Requires hands-on assistance with lower body	
<input type="checkbox"/> Requires peri-care	
<input type="checkbox"/> Requires total assistance	
<input type="checkbox"/> Assistance with the use of equipment or assistive devices	

Source: MACPAC reproduction of Commonwealth of Kentucky, 2008, Medicaid Waiver Assessment, <http://chfs.ky.gov/nr/ronlyres/dbec3c06-f397-45ad-8cbb-91f339533fae/0/351revised814web.pdf>.

a particular tool, and without a great deal of federal guidance, the state decided to develop its own tool.

Availability of funding affected tool decisions

States' decisions to implement a new assessment tool, and their choice of tool, were often driven by the availability of resources. Of the state officials we interviewed, two said that funding from the Balancing Incentive Program assisted them in implementing a new tool. Another state that did not participate in the Balancing Incentive Program used administrative funds that were freed up during a transition to MLTSS to implement a new tool. Officials in another state that did not participate in the Balancing Incentive Program noted that they were using several tools and wanted to streamline them but could not do so until they obtained funding for this purpose.

Some states found independently developed tools easier to implement

States were generally motivated to select an independently developed tool rather than develop homegrown tools because they were perceived as easier to implement. States that were using or planning to implement an independently developed tool such as the interRAI noted that adopting independently developed tools had the advantage of requiring fewer resources than developing a homegrown tool. Independent tools are validated and have training materials available.

Some states want customized tools

States that developed their own tools were often motivated by a desire for customization. Several state officials we interviewed told us that state leadership and stakeholders preferred homegrown tools, and emphasized that obtaining buy-in from these groups was important to them. In their judgment, independently developed tools were not sufficiently flexible to meet the state's assessment

needs or to satisfy stakeholders. For example, stakeholders might wish to edit the terminology used in particular questions. However, the three states we interviewed that used the interRAI noted that they had been able to customize it enough to meet their needs.

LTSS delivery models drive use of multiple tools

The way a state organizes delivery of LTSS can lead to the use of multiple tools. In some cases the use of different assessment tools is the result of how different waivers are administered; for instance, when the state Medicaid agency administers the LTSS waivers for individuals age 65 and older and individuals with physical disabilities, and a different agency administers waivers for individuals with intellectual or developmental disabilities. Even when multiple LTSS waivers are run within one agency, different staff members may be responsible for managing different waivers, leading to the use of multiple assessment tools.

Issues in Moving Toward a National Functional Assessment Tool

As noted earlier, the needs of individuals using Medicaid LTSS cannot be easily compared among states. More comparable and reliable data from functional assessments combined with claims data could help federal and state policymakers better understand how different state approaches to eligibility and LTSS delivery affect use of services and expenditures. Combined with information on outcomes, such analyses would allow policymakers and program administrators to judge the effectiveness and efficiency of different approaches and identify practices that should be replicated. This would require either the use of a standardized tool for functional assessment across all states or at least a limited set of comparable

measures such as those currently being tested in the Testing Experience and Functional Tools demonstration. A fully standardized national tool would need to capture the varied needs of different LTSS subpopulations (e.g., by using modules with customized questions for particular groups). Such a tool could be used for eligibility determination, care planning, or both. A national tool for eligibility determination alone might be more feasible to develop than a tool for care planning, which would likely have to capture a broader range of measures.

In 2013, the federal Commission on Long-Term Care recommended the development of a single national assessment tool for care planning that could be used for individuals with cognitive or functional limitations. That commission pointed to two potential benefits of a national tool: helping to ensure that individuals' needs were assessed in a consistent manner, and providing information to be used in program performance and quality of care evaluations (CLTC 2013).

Given the limitations of currently available information, studies of the use of LTSS cannot highlight instances in which individuals with similar LTSS needs are not eligible for the same services because they reside in different states with different eligibility thresholds. A national tool for either eligibility determination or care planning would permit analyses across states that compare beneficiaries' level of assessed need to LTSS use. Data from a national assessment tool, or a set of comparable measures, would make studies of LTSS use more informative by allowing federal and state policymakers to understand how variation along a standard measure of beneficiary need affects use of services. For example, linking standardized data on assessed needs with actual claims data would allow policymakers to see whether individuals with similar ADL limitations were receiving similar (or different) amounts of personal care services, and to compare these levels based on the state of residence. These data could also help policymakers set benchmarks for appropriate levels of service based on need and set payments accordingly.

A national tool would also improve understanding of the cost of LTSS provided. Given the great differences in LTSS programs among states, additional information on LTSS users' needs could provide insight into the cost of services that are being provided in different states. Analyses might demonstrate that certain states are able to provide a higher value of services than others for beneficiaries of similar risk or need, which may in turn help states identify strategies to promote better use of state and federal resources.

A third benefit of a national tool is that it could save states time and money that would otherwise be used to develop new assessment tools. In our research and in the literature, states have noted that federal resources have been vital to their efforts to improve their assessment processes, including reducing duplication (MAG and NEC 2016).⁹ As described earlier, staff in one state we interviewed expressed interest in streamlining the multiple tools they were using but lacked the necessary resources to do so. A national assessment tool would assist states in that situation by providing validated tools, as well as any future updates to the tools.

There are, however, disadvantages to use of a national assessment tool. First, implementation would be burdensome for states that have recently invested in establishing new assessment tools. Implementing a new assessment tool requires substantial resources including purchasing tools from vendors, consulting stakeholders, upgrading information technology, and training of assessors. States that have made recent investments in implementing new tools would likely resist moving to a national tool, especially if such a tool required additional infrastructure upgrades. On the other hand, those states' investments in new tools and infrastructure could be added to the knowledge base informing a national assessment approach.

Another barrier to a national tool is that there is currently no clear favorite. The relative strengths and limitations of existing tools are not well

understood, so there is little basis for making recommendations to states of one tool over another. Instead, states we spoke with said they typically consult peers in other states to better understand their experience with existing tools. Without evidence of a clear advantage of a particular existing tool, states have often developed their own customized tools.

In addition, the rapidly changing landscape of LTSS programs presents a challenge to selecting one tool for all states at this time. States are continuing to change how they organize their LTSS programs, including increasing the use of HCBS, changing or consolidating HCBS waivers, and implementing MLTSS programs. Thus, it might be difficult to develop a tool that meets the needs of all programs and pathways in such a period of experimentation and innovation.

Next Steps

Functional assessment tools play a key role in the provision of Medicaid LTSS by determining which individuals are eligible and which services they should receive. MACPAC's inquiry found that most states are using homegrown assessment tools for both eligibility determination and care planning, and that these tools collect details about beneficiaries' ability to conduct daily tasks in quite different ways. States make choices about assessment tools based on a desire for customization and the availability of funding. Even so, there are potential benefits of moving toward a national assessment tool or at least the standardization of some elements, which would allow comparisons of LTSS program costs and outcomes across states.

The delivery of LTSS is in a period of rapid change. States are expanding the use of managed care, and plans, providers, and beneficiaries are adapting to these developments. In addition, CMS is testing new approaches to functional assessment and the electronic exchange of care plans. Given

these activities, it seems prudent not to move to a national assessment tool until we can learn more from existing tools and approaches. For now, the Commission plans to monitor the continuing evolution of these tools, and looks forward to CMS's findings from the Testing Experience and Functional Tools demonstration, which could inform future efforts for a national assessment approach.

Endnotes

¹ The focus of this chapter is on functional eligibility; more information on financial eligibility can be found in Chapter 2 of the Commission's June 2014 report to Congress on Medicaid's role in providing assistance with long-term services and supports (MACPAC 2014).

² As of 2014, 22 states had established MLTSS programs, in which a managed care plan contracts with the state to provide LTSS (Terzaghi 2015).

³ In order for individuals to qualify under this pathway, they must generally meet the SSI program functional eligibility standards, which include being age 65 or older, or for adults age 18–64, having an impairment that impedes their ability to do any gainful work, or for children age 0–17, having an impairment that results in marked or severe functional limitations (SSA 2013).

⁴ Level of care criteria may be based on specific diagnoses or conditions, on functional status as measured by ADLs, on functional performance measured by instrumental activities of daily living (IADLs), on other functional skills such as adaptive behaviors, or on other criteria. States may also examine an individual's cognitive status, behavioral or other impairments, medical or nursing needs, presence of informal supports, and functional limitations related to ability to perform ADLs and IADLs or other major life activities.

⁵ In 2014, CMS finalized regulations requiring a person-centered care planning process for HCBS provided through state plans and waivers. The regulations require that a person-centered care planning process be driven by the beneficiary to the greatest extent possible. For example, the regulations specify that beneficiaries should be able to choose the individuals who are involved in the planning process on their behalf, that they have choices about the services they receive and the providers they receive services from, and that they contribute to the process by identifying their own goals and preferences (CMS 2014).

⁶ The MDS grew out of the Federal Nursing Home Reform Act in the Omnibus Budget Reconciliation Act of 1987 (OBRA, P.L. 100-203), which required nursing facilities to use a resident assessment process to create a plan of care. At the time, there was no common assessment procedure

in use and each facility had its own process to develop a care plan, which did not provide data that would allow comparisons of resident acuity or care across facilities (Black and Leitch 2012). The MDS has subsequently been used to develop quality indicators for nursing facility care and to develop nursing facility payments for Medicare and, in some states, for Medicaid programs as well (Black and Leitch 2012, Zimmerman et al. 1995).

⁷ The Balancing Incentive Program targeted states that spent less than 50 percent of total LTSS expenditures on HCBS in 2009, and it provided participating states with an enhanced federal match for HCBS that had to be used to expand access to HCBS and implement structural changes to states' LTSS delivery systems (CMS 2016a). One of these structural changes was the adoption of a standardized functional assessment process and instruments to determine eligibility for Medicaid-funded LTSS, if states were not already using such tools (MAG et al. 2013).

⁸ In exploring prior research on functional assessment tools, MACPAC found that most published studies in this area have focused on a sample of states. For example, the Balancing Incentive Program implementation manual contained a comparison of 23 assessment tools, 5 of which were used in more than one state. An in-depth study of nine of the tools used in Balancing Incentive Program states noted that each of them covered ADLs and IADLs as well as cognitive, social, emotional, and behavioral indicators (MAG et al. 2013). Another study of functional assessment tools examined 15 tools used in 13 states, finding similarities in the domains examined (Shirk 2009).

⁹ In states where different assessment tools are used to determine eligibility for different LTSS programs, duplication occurs from maintaining multiple tools because beneficiaries may need to be separately assessed on similar functions to move from one program to another. This can be a substantial burden, not only for staff that conduct the assessments but also for the individuals being assessed.

References

Atkins, G.L., and B. Gage. 2014. *The need to standardize assessment items for persons in need of LTSS*. Washington, DC: Long Term Quality Alliance. <http://www.ltqa.org/wp->

[content/themes/ltqaMain/custom/images/LTQA-The-Need-to-Standardize-Assessment-Items-4-14-1.pdf](#).

Black, P., and K. Leitch. 2012. *Analysis of state approaches to implementing standardized assessments*. Long Beach, CA: Scan Foundation. <http://www.thescanfoundation.org/analysis-state-approaches-implementing-standardized-assessments>.

Center for Medicaid and CHIP Services (CMCS), Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. Email to MACPAC staff, April 19.

Center for Medicaid and CHIP Services (CMCS), Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013. *Guidance to states using 1115 demonstrations or 1915(b) waivers for managed long term services and supports programs*. Baltimore, MD: CMS. <https://www.medicare.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016a. *Balancing Incentive Program*. Baltimore, MD: CMS. <https://www.medicare.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/balancing/balancing-incentive-program.html>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016b. *Testing Experience and Functional Tools (TEFT)*. <https://www.medicare.gov/medicaid-chip-program-information/by-topics/delivery-systems/grant-programs/teft-program.html>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. *Medicaid program: State plan home and community-based services, 5-year period for waivers, provider payment reassignment, and home and community-based setting requirements for Community First Choice and Home and Community-Based Services (HCBS) waivers. Final Rule. Federal Register 79, no. 11 (January 16): 2948–3039*. <http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf>.

Commonwealth of Kentucky, Cabinet for Health and Family Services, Department for Medicaid Services. 2008. *Medicaid Waiver Assessment*. Lexington, KY: Commonwealth of

Kentucky. <http://chfs.ky.gov/nr/rdonlyres/dbec3c06-f397-45ad-8cbb-91f339533fae/0/351revised814web.pdf>.

Commission on Long-Term Care (CLTC). 2013. *Report to the Congress*. September 30, 2013. Washington, DC: CLTC. <https://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf>.

DC Department of Health Care Finance. 2013. *LTCSS Assessment Tool V 1.1*. Washington, DC: Department of Health Care Finance, Government of the District of Columbia. <http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Long%20Term%20Care%20Assessment%20Tool.pdf>.

Eiken, S., K. Sredl, B. Burwell, and P. Saucier. 2015. *Medicaid expenditures for long-term services and supports (LTSS) in FY 2013: Home and community-based services were a majority of LTSS Spending*. Ann Arbor, MI: Truven Health Analytics. <https://www.medicare.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf>.

Healthy & Ready to Work (HRTW) National Resource Center. 2013. *Medicaid buy-in*. Readfield, ME: HRTW.

Hendrickson, L., and G. Kyzr-Sheely. 2008. *Determining Medicaid nursing home eligibility: A survey of state level of care assessment*. New Brunswick, NJ: Rutgers Center for State Health Policy. <http://www.cshp.rutgers.edu/Downloads/7720.pdf>.

Ingram, C., A. Lind, and B. Ensslin. 2013. *Uniform assessment practices in Medicaid managed long-term services and supports*. Hamilton, NJ: Center for Health Care Strategies. <http://www.chcs.org/resource/uniform-assessment-practices-in-medicare-managed-long-term-services-and-supports-programs/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. *MACStats: Medicaid and CHIP data book*. December 2015. Washington, DC: MACPAC. <https://www.macpac.gov/publication/macstats-medicare-and-chip-data-book-2/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2014. Chapter 2: *Medicaid's role in providing assistance with long-term services and supports*. In *Report to the Congress on Medicaid and CHIP*. June 2014.

Washington, DC: MACPAC. <https://www.macpac.gov/publication/ch-2-medicoids-role-in-providing-assistance-with-long-term-services-and-supports/>.

Medicare Payment Advisory Commission (MedPAC). 2015. Chapter 7: Medicare's post-acute care: Trends and ways to rationalize payments. In *Report to the Congress: Medicare Payment Policy*. March 2015. Washington, DC: MedPAC. [http://www.medpac.gov/documents/reports/chapter-7-medicare-s-post-acute-care-trends-and-ways-to-rationalize-payments-\(march-2015-report\).pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/chapter-7-medicare-s-post-acute-care-trends-and-ways-to-rationalize-payments-(march-2015-report).pdf?sfvrsn=0).

Mission Analytics Group (MAG), Acumen, LLC, and Health Services Research Institute (HSRI). 2013. *The Balancing Incentive Program: Implementation manual*. Report to CMS, contract no. HHSM-500-2006-000061, TO #HHSM-500-T0004. Sacramento, CA: MAG. <http://www.balancingincentiveprogram.org/resources/revise-balancing-incentive-program-implementation-manual>.

Mission Analytics Group (MAG) and New Editions Consulting, Inc. (NEC). 2016. *State reflections and recommendations*. Report to CMS, contract no. HHSM-500-2013-00250G. Sacramento, CA: MAG. <http://www.balancingincentiveprogram.org/resources/state-reflections-and-recommendations-report>.

Mission Analytics Group (MAG) and New Editions Consulting, Inc. (NEC). 2015. *Balancing Incentive Program: Highlights of state activities*. Sacramento, CA: MAG. http://www.balancingincentiveprogram.org/sites/default/files/Balancing_Incentive_Program_State_Highlights.v3_508.pdf.

Office of the National Coordinator for Health Information Technology (ONC) and Centers for Medicare & Medicaid Services (CMS). 2016. Standards and Interoperability (S&I) Framework. San Francisco, CA: Tangient LLC. [http://wiki.siframework.org/electronic+Long-Term+Services+and+Supports+\(eLTSS\)](http://wiki.siframework.org/electronic+Long-Term+Services+and+Supports+(eLTSS)).

Saucier, P., J. Kasten, B. Burwell, L. Gold. 2012. *The growth of managed long-term services and supports (MLTSS) programs: A 2012 update*. Report to CMS, contract no. HHSM-500-2005-000251, TO #0002. Ann Arbor, MI: Truven Health Analytics. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf.

Shirk, C. 2009. *Comprehensive assessments in home and community-based services*. Baltimore, MD: Hilltop Institute, University of Maryland, Baltimore County. <http://hilltop.umbc.edu/publications/ComprehensiveAssessmentInHomeAndCommunity-BasedServices-July2009.pdf>.

Smith, M., Division of Community Systems Transformation, Center for Medicaid and CHIP Services (CMCS), Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. Telephone conversation with MACPAC staff, February 19.

Stone, J. 2011. *Medicaid eligibility for persons age 65+ and individuals with disabilities: 2009 state profiles*. Washington, DC: Congressional Research Service.

Terzaghi, D. 2015. *State of the states in aging and disability: 2015 survey of state agencies*. Washington, DC.: National Association of States United for Aging and Disabilities. <http://www.nasuad.org/sites/nasuad/files/NASUAD%202015%20States%20Rpt.pdf>.

Tucker, S.M., and M.E. Kelley. 2011. *Functional assessment processes for Medicaid personal care services*. Long Beach, CA: The SCAN Foundation. http://www.thescanfoundation.org/sites/thescanfoundation.org/files/TSF_CLASS_TA_No_7_Medicaid_Assessment_Process_FINAL.pdf.

U.S. Social Security Administration (SSA). 2013. Supplemental Security Income (SSI) eligibility requirements. Washington, DC: SSA. <http://www.socialsecurity.gov/ssi/text-eligibility-ussi.htm>.

Zimmerman, D.R., S.L. Karon, g. Arling, et al. 1995. Development and testing of nursing home quality indicators. *Health Care Financing Review* 16, no. 4: 107–127.

Appendix

Authorizing Language from the Social Security Act (42 USC 1396)

Medicaid and CHIP Payment and Access Commission

- (a) ESTABLISHMENT.—There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as “MACPAC”).
- (b) DUTIES.—
- (1) REVIEW OF ACCESS POLICIES FOR ALL STATES AND ANNUAL REPORTS.—MACPAC shall—
- (A) review policies of the Medicaid program established under this title (in this section referred to as “Medicaid”) and the State Children’s Health Insurance Program established under title XXI (in this section referred to as “CHIP”) affecting access to covered items and services, including topics described in paragraph (2);
 - (B) make recommendations to Congress, the Secretary, and States concerning such access policies;
 - (C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC’s recommendations concerning such policies; and
 - (D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.
- (2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, MACPAC shall review and assess the following:
- (A) MEDICAID AND CHIP PAYMENT POLICIES.—Payment policies under Medicaid and CHIP, including—
 - (i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;
 - (ii) payment methodologies; and
 - (iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).
 - (B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

- (C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.
 - (D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.
 - (E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.
 - (F) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.
 - (G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dually eligible individuals.
 - (H) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.
- (3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—
- (A) review national and State-specific Medicaid and CHIP data; and
 - (B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.
- (4) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.
- (5) COMMENTS ON CERTAIN SECRETARIAL REPORTS AND REGULATIONS.—
- (A) CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees

of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

- (B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.
- (6) AGENDA AND ADDITIONAL REVIEWS.—
- (A) IN GENERAL.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC’s agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.
- (B) REVIEW AND REPORTS REGARDING MEDICAID DSH.—
- (i) IN GENERAL.—MACPAC shall review and submit an annual report to Congress on disproportionate share hospital payments under section 1923. Each report shall include the information specified in clause (ii).
- (ii) REQUIRED REPORT INFORMATION.—Each report required under this subparagraph shall include the following:
- (I) Data relating to changes in the number of uninsured individuals.
- (II) Data relating to the amount and sources of hospitals’ uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.
- (III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quaternary care, including the provision of trauma care and public health services.
- (IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.
- (iii) DATA.—Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1923(j), cost reports submitted under title XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.
- (iv) SUBMISSION DEADLINES.—The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.

- (7) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.
 - (8) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term “appropriate committees of Congress” means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.
 - (9) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.
 - (10) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.
 - (11) CONSULTATION AND COORDINATION WITH MEDPAC.—
 - (A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as “MedPAC”) established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.
 - (B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.
 - (12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC’s recommendations and reports.
 - (13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dually eligible individuals.
 - (14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.— MACPAC’s authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary’s authority to carry out Federal responsibilities with respect to Medicaid and CHIP.
- (c) MEMBERSHIP.—
- (1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) QUALIFICATIONS.—

- (A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.
- (B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dually eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.
- (C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.
- (D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

(3) TERMS.—

- (A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.
- (B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member’s predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member’s term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.
- (4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member’s regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

- (5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member’s term.
- (6) MEETINGS.—MACPAC shall meet at the call of the Chairman.
- (d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—
- (1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);
 - (2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;
 - (3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 USC 5));
 - (4) make advance, progress, and other payments which relate to the work of MACPAC;
 - (5) provide transportation and subsistence for persons serving without compensation; and
 - (6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.
- (e) POWERS.—
- (1) OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.
 - (2) DATA COLLECTION.—In order to carry out its functions, MACPAC shall—
 - (A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;
 - (B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and
 - (C) adopt procedures allowing any interested party to submit information for MACPAC’s use in making reports and recommendations.

- (3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.
 - (4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.
- (f) FUNDING.—
- (1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.
 - (2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.
 - (3) FUNDING FOR FISCAL YEAR 2010.—
 - (A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, \$9,000,000.
 - (B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, \$2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.
 - (4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

Biographies of Commissioners

Sara Rosenbaum, JD (Chair), is founding chair of the Department of Health Policy and the Harold and Jane Hirsh Professor of Health Law and Policy at The George Washington University Milken Institute School of Public Health. She also serves on the faculties of The George Washington Schools of Law and Medicine. Professor Rosenbaum's research has focused on how the law intersects with the nation's health care and public health systems, with a particular emphasis on insurance coverage, managed care, the health care safety net, health care quality, and civil rights. She is a member of the National Academy of Medicine (formerly the Institute of Medicine), and has served on the boards of numerous national organizations, including AcademyHealth. Professor Rosenbaum is a past member of the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices and also serves on the CDC Director's Advisory Committee. She has advised Congress and presidential administrations since 1977 and served on the staff of the White House Domestic Policy Council during the Clinton administration. Professor Rosenbaum is the lead author of *Law and the American Health Care System*, published by Foundation Press (2012). She received her law degree from Boston University School of Law.

Marsha Gold, ScD (Vice Chair), is an independent consultant and senior fellow emerita at Mathematica Policy Research, where she previously served as a lead investigator and project director on research in the areas of Medicare, Medicaid, managed care design, delivery system reform in both public and private health insurance, and access to care. Other prior positions include director of research and analysis at the Group Health Association of America, assistant professor with the Department of Health Policy and Administration at The University of North Carolina, and director of policy analysis and program evaluation at the Maryland Department of Health and Mental Hygiene. Dr. Gold is on the editorial

board of *Health Affairs and Health Services Research*. She received her doctorate of science in health services and evaluation research from the Harvard School of Public Health.

Brian Burwell is vice president, community living systems at Truven Health Analytics in Cambridge, Massachusetts. Mr. Burwell conducts research and provides consulting services, policy analysis, technical assistance in financing and delivery of long-term services and supports, and data analysis related to integrated care models for dually eligible beneficiaries and managed long-term services and supports. He has been with Truven Health Analytics and its predecessor companies for 30 years. Mr. Burwell received his bachelor of arts degree from Dartmouth College.

Sharon Carte, MHS, has served as executive director of the West Virginia Children's Health Insurance Program since 2001. From 1992 to 1998, Ms. Carte was deputy commissioner for the Bureau for Medical Services, overseeing West Virginia's Medicaid program. Previously, she was an administrator of skilled and intermediate-care nursing facilities and a coordinator of human resources development in the West Virginia Department of Health. Ms. Carte's experience includes work with senior centers and aging programs throughout West Virginia as well as with policy issues related to behavioral health and long-term services and supports for children. She received her master of health science from the Johns Hopkins University School of Hygiene and Public Health.

Andrea Cohen, JD, is senior vice president for program at the United Hospital Fund, a non-profit health services research and philanthropic organization with the mission to shape positive change in health care for New Yorkers. She directs the Fund's program work and oversees grant making and conference activities. From 2009 to 2014, she served as director of health services in the New York City Office of the Mayor, where she coordinated and developed strategies to

improve public health and health services. Prior professional positions include counsel with Manatt, Phelps & Phillips, LLP; senior policy counsel at the Medicare Rights Center; health and oversight counsel for the U.S. Senate Committee on Finance; and trial attorney with the U.S. Department of Justice. She received her law degree from Columbia University's School of Law.

Gustavo Cruz, DMD, MPH, is an oral health policy consultant and senior advisor to Health Equity Initiative, a professional membership organization in New York City that brings together community leaders and professionals in diverse fields to promote innovations in health equity. He also serves as resident advisor to the dental public health residency at Lutheran Medical Center and as adjunct associate professor in the Department of Epidemiology and Health Promotion at New York University College of Dentistry (NYUCD). Dr. Cruz was a Robert Wood Johnson Foundation Health Policy Fellow in 2009–2010, working in the office of the Secretary of the U.S. Department of Health and Human Services. Subsequently, he served as chief of the Oral Health Branch, Bureau of Health Professions, at the Health Resources and Services Administration. He previously served as director of public health and health promotion at NYUCD and as governing faculty of New York University's master's degree program in global public health. Dr. Cruz has conducted numerous research studies on the oral health of U.S. immigrants, oral health disparities, oral and pharyngeal cancers, and access to oral health care among underserved populations, as well as on the effects of race, ethnicity, acculturation, and culturally influenced behaviors on oral health outcomes and health services utilization. He received his degree in dentistry from the University of Puerto Rico and his master of public health from Columbia University's School of Public Health. He is a diplomate of the American Board of Dental Public Health.

Toby Douglas, MPP, MPH, is senior vice president for Medicaid solutions at Centene Corporation. Before joining Centene, he was an independent consultant

and senior advisor for Sellers Dorsey, assisting organizations involved with Medicaid, health insurance exchanges, and Medicare. Previously, Mr. Douglas was a long-standing state Medicaid official, serving for 10 years as an executive in California Medicaid. He served as director of the California Department of Health Care Services as well as California Medicaid director for six years, during which time he also served as a board member of the National Association of Medicaid Directors and as a State Children's Health Insurance Program (CHIP) director. Earlier in his career, Mr. Douglas worked for the San Mateo County Health Department in California, as a research associate at the Urban Institute, as a consultant on pharmacy utilization with Kaiser Permanente Consulting, and as a VISTA volunteer. He received his master of public policy and master of public health from the University of California, Berkeley.

Leanna George is the parent of a 13-year-old with a disability who is covered under Medicaid and a 9-year-old covered under CHIP. A resident of Benson, North Carolina, Ms. George serves on the Johnston County Consumer and Family Advisory Committee, which advises the Board of the County Mental Health Center. She also serves on the Alliance Innovations Stakeholders Group, which advises a Medicaid managed care organization and the state of North Carolina about services and coverage for developmentally disabled enrollees, and on the Client Rights Committee of the Autism Society of North Carolina, a Medicaid provider agency.

Christopher Gorton, MD, MHSA, is the president of public plans at Tufts Health Plan, a non-profit health plan in Massachusetts, Rhode Island, and New Hampshire. Previously, Dr. Gorton was chief executive officer (CEO) of a regional health plan that was acquired by the Inova Health System of Falls Church, Virginia. Other positions have included vice president for medical management and worldwide health care strategy for Hewlett Packard Enterprise Services and president and chief medical officer for APS Healthcare, a behavioral health plan and care management organization based in Silver

Spring, Maryland. After beginning his career as a practicing pediatrician in federally qualified health centers in Pennsylvania and Missouri, Dr. Gorton served as chief medical officer in the Pennsylvania Department of Public Welfare. Dr. Gorton received his degree in medicine from Columbia University's College of Physicians and Surgeons and his master of health systems administration from the College of Saint Francis in Joliet, Illinois.

Herman Gray, MD, MBA, is president and CEO of United Way for Southeastern Michigan. Prior to assuming this post in September 2015, he served as executive vice president for pediatric health services for the Detroit Medical Center, a position he accepted after eight years as CEO and president of the Detroit Medical Center Children's Hospital of Michigan. At Children's Hospital of Michigan, Dr. Gray also served as chief operating officer, chief of staff, and vice chief of education in the department of pediatrics. He also served as vice president for graduate medical education (GME) at the Detroit Medical Center and associate dean for GME at Wayne State University School of Medicine. Dr. Gray has served as the chief medical consultant at the Michigan Department of Public Health, Children's Special Health Care Services, as well as vice president and medical director of clinical affairs at Blue Care Network, a subsidiary of Blue Cross Blue Shield of Michigan. He has received the Michigan Hospital Association Health Care Leadership Award and *Modern Healthcare's* Top 25 Minority Executives in Healthcare Award and is a member of the board of trustees for the Skillman Foundation. He received his medical degree from the University of Michigan and his master of business administration from the University of Tennessee, and he completed his pediatrics training at the Children's Hospital of Michigan/Wayne State University.

Stacey Lampkin, FSA, MAAA, MPA, is an actuary and principal with Mercer Government Human Services Consulting, where she leads actuarial work for several state Medicaid programs. She previously served as actuary and assistant deputy secretary for Medicaid finance and analytics at

Florida's Agency for Health Care Administration and as an actuary at Milliman. She has also served as a member of the Federal Health Committee of the American Academy of Actuaries (AAA), as vice chairperson of AAA's Uninsured Work Group, and as a member of the Society of Actuaries project oversight group for research on evaluating medical management interventions. Ms. Lampkin is a fellow in the Society of Actuaries and a member of the AAA. She received her master of public administration from Florida State University.

Charles Milligan, JD, MPH, is CEO of UnitedHealthcare Community Plan of New Mexico, a Medicaid managed care organization with enrolled members in all Medicaid eligibility categories (including dually eligible beneficiaries and adults in Medicaid expansion programs) that provides somatic, behavioral, and managed long-term services and supports. Mr. Milligan is a former state Medicaid and CHIP director in New Mexico and Maryland. He also served as executive director of the Hilltop Institute, a health services research center at the University of Maryland at Baltimore County, and as vice president at The Lewin Group. Mr. Milligan directed the 2005–2006 Commission on Medicaid and has conducted Medicaid-related research projects in numerous states. He received his master of public health from the University of California, Berkeley, and his law degree from Harvard Law School.

Sheldon Retchin, MD, MSPH, is executive vice president for health sciences and CEO of The Ohio State University Wexner Medical Center in Columbus. Dr. Retchin's research and publications have addressed costs, quality, and outcomes of health care as well as workforce issues. From 2003 until his appointment at Ohio State in 2015, he served as senior vice president for health sciences at Virginia Commonwealth University (VCU) and as CEO of the VCU Health System, in Richmond, Virginia. Dr. Retchin also led a Medicaid health maintenance organization with approximately 200,000 covered lives through which, for 15 years, he and his colleagues helped manage care for 30,000 uninsured individuals in the Virginia

Coordinated Care program. Dr. Retchin received his medical degree from The University of North Carolina School of Medicine and his master of science in public health from The University of North Carolina School of Public Health.

Norma Martínez Rogers, PhD, RN, FAAN, is a professor of family nursing at The University of Texas Health Science Center at San Antonio. She has held clinical and administrative positions in psychiatric nursing and at psychiatric hospitals, including the William Beaumont Army Medical Center in Fort Bliss during Operation Desert Storm. She is dedicated to working with those who face health disparities in the health care system and is the founder and president of the National Latino Nurse Faculty Association. She has initiated a number of programs at The University of Texas Health Science Center, including a mentorship program for retention of minorities in nursing education. She was a founding board member of the Martínez Street Women's Center, a non-profit organization that provides support and educational services to women and teenage girls. Dr. Martínez Rogers is a fellow of the American Academy of Nursing and a past president of the National Association of Hispanic Nurses. She received her master of science in psychiatric nursing from The University of Texas Health Science Center at San Antonio and her doctorate in cultural foundations in education from The University of Texas at Austin.

Peter Szilagyi, MD, MPH, was recently named vice chair for clinical research in the Department of Pediatrics at the University of California, Los Angeles. Until that appointment, he served as chief of the division of general pediatrics and professor of pediatrics at the University of Rochester and as associate director of the Center for Community Health within the University of Rochester's Clinical Translational Research Institute. His research has addressed CHIP and child health insurance, access to care, quality of care, and health outcomes, including the delivery of primary care with a focus on immunization delivery, health care financing, and children with chronic disease. For the past 18

years, he was chairman of the board of the Monroe Plan for Medical Care, a large Medicaid and CHIP managed care plan in upstate New York. He is editor in chief of *Academic Pediatrics* and has served as the president of the Academic Pediatric Association. Dr. Szilagyi received his medical and public health degrees from the University of Rochester.

Penny Thompson, MPA, is principal of Penny Thompson Consulting, LLC, and provides consulting services in the areas of health care delivery and payment, information technology development, and program integrity. Previously, she served as deputy director of the Center for Medicaid and CHIP Services at the Centers for Medicare & Medicaid Services (CMS). Ms. Thompson has held senior positions in management consulting at information technology companies, and she was director of health care strategy and planning for Hewlett Packard's health care business unit. She also previously served as CMS's director of program integrity and as chief of the health care branch within the Office of Inspector General at the U.S. Department of Health and Human Services. Ms. Thompson received her master of public administration from The George Washington University.

Alan Weil, JD, MPP, is editor-in-chief of *Health Affairs*, a multidisciplinary peer-reviewed health policy journal, in Bethesda, Maryland. He is an elected member of the National Academy of Medicine and served six years on its Board on Health Care Services. He is a trustee of the Consumer Health Foundation and a member of the Kaiser Commission on Medicaid and the Uninsured. He previously served as executive director of the National Academy for State Health Policy, director of the Urban Institute's Assessing the New Federalism Project, executive director of the Colorado Department of Health Care Policy and Financing, and assistant general counsel in the Massachusetts Department of Medical Security. He received a master's degree from Harvard University's John F. Kennedy School of Government and a law degree from Harvard Law School.

Biographies of Staff

Annie Andrianasolo, MBA, is the executive assistant. She previously held the position of special assistant for global health at the Public Health Institute and was a program assistant for the World Bank. Ms. Andrianasolo has a bachelor of science in economics and a master of business administration from Johns Hopkins Carey Business School.

Amy Bernstein, ScD, MHSA, is a policy director and contracting officer. She manages and provides oversight and guidance for all MACPAC research, data, and analysis projects, including statements of work, research plans, and all deliverables and products. She also directs and conducts policy analyses. Her previous positions have included director of the Analytic Studies Branch at the U.S. Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics and senior analyst positions at the Alpha Center, the Prospective Payment Assessment Commission, the National Cancer Institute, and the Agency for Healthcare Research and Quality (AHRQ). Dr. Bernstein earned a master of health services administration from the University of Michigan School of Public Health and a doctor of science from the School of Hygiene and Public Health at Johns Hopkins University.

Kirstin Blom, MIPA, is a principal analyst. Before joining MACPAC, Ms. Blom was an analyst in health care financing at the Congressional Research Service (CRS). Before that, Ms. Blom worked as a principal analyst at the Congressional Budget Office, where she estimated the cost of proposed legislation on the Medicaid program. Ms. Blom has also been an analyst for the Medicaid program in Wisconsin and for the U.S. Government Accountability Office (GAO). She holds a master of international public affairs from the University of Wisconsin, Madison.

James Boissonnault, MA, is chief information officer. Prior to joining MACPAC, he was the information technology (IT) director and security

officer for OnPoint Consulting. At OnPoint, he worked on several federal government projects, including projects for the Missile Defense Agency, the U.S. Department of the Treasury, and the U.S. Department of Agriculture. He has nearly two decades of IT and communications experience. Mr. Boissonnault holds a master of arts in Slavic languages and literatures from The University of North Carolina and a bachelor of arts in Russian from the University of Massachusetts.

Madeline Britvec is MACPAC's research assistant. Prior to joining MACPAC, she held internships at the U.S. Chamber of Commerce, International Bridges to Justice, and CBS Detroit. Ms. Britvec holds a bachelor of arts in economics and applied statistics from Smith College.

Kacey Buderl, MPA, is an analyst. Prior to joining MACPAC, she worked in the Center for Congressional and Presidential Studies at American University and completed internships in the office of U.S. Senator Ed Markey and at the U.S. Department of Health and Human Services (HHS). Ms. Buderl holds a master of public administration and a bachelor of arts in political science, both from American University.

Kathryn Ceja is director of communications. Previously, she served as lead spokesperson for Medicare issues in the Centers for Medicare & Medicaid Services (CMS) press office. Prior to her tenure in the press office, Ms. Ceja was a speechwriter for the Secretary of HHS as well as the speechwriter for a series of CMS administrators. Ms. Ceja holds a bachelor of arts in international studies from American University.

Veronica Daher, JD, is a senior analyst. Previously, she was a health policy analyst for the Health Safety Net program at the Massachusetts Executive Office of Health and Human Services, where she focused on developing policy in response to the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). Her work now focuses on how the ACA will affect Medicaid

and the State Children's Health Insurance Program (CHIP). Ms. Daher received her law degree from the University of Richmond and received her bachelor of arts degree from the University of Virginia.

Benjamin Finder, MPH, is a senior analyst. His work focuses on benefits and payment policy. Prior to joining MACPAC, he served as an associate director in the Health Care Policy and Research Administration at the District of Columbia Department of Health Care Finance, and as an analyst at the Henry J. Kaiser Family Foundation. Mr. Finder holds a master of public health from The George Washington University, where he concentrated in health policy and health economics.

Moira Forbes, MBA, is a policy director focusing on payment policy and the design, implementation, and effectiveness of program integrity activities in Medicaid and CHIP. Previously, she served as director of the division of health and social service programs in the Office of Executive Program Information at HHS and as a vice president in the Medicaid practice at The Lewin Group. At Lewin, Ms. Forbes worked with every state Medicaid and CHIP program on issues relating to program integrity and eligibility quality control. She has extensive experience with federal and state policy analysis, Medicaid program operations, and delivery system design. Ms. Forbes has a master of business administration from The George Washington University and a bachelor's degree in Russian and political science from Bryn Mawr College.

Martha Heberlein, MA, is a principal analyst. Prior to joining MACPAC, she was the research manager at the Georgetown University Center for Children and Families, where she oversaw a national survey on Medicaid and CHIP eligibility, enrollment, and renewal procedures. Ms. Heberlein received a master of arts in public policy with a concentration in philosophy and social policy from The George Washington University and a bachelor of science in psychology from James Madison University.

Kayla Holgash, MPH, is an analyst focusing on payment policy. Prior to joining MACPAC, Ms. Holgash worked as a senior research assistant in the Department of Health Policy and Management at The George Washington University and as a health policy legislative intern for U.S. Senator Charles Grassley. Before that, she served as the executive manager of the Health and Wellness Network for the Homewood Children's Village, a non-profit organization in Pittsburgh, Pennsylvania. Ms. Holgash holds a master of public health from The George Washington University and a bachelor of science in public and community health from the University of Maryland.

Joanne Jee, MPH, is a principal analyst focusing on CHIP and children's coverage. Prior to joining MACPAC, she was a program director at the National Academy for State Health Policy, where she focused on children's coverage issues. Ms. Jee also has been a senior analyst at GAO, a program manager at The Lewin Group, and a legislative analyst in the HHS Office of Legislation. Ms. Jee has a master of public health from the University of California, Los Angeles, and bachelor of science in human development from the University of California, Davis.

Allissa Jones is the administrative assistant. Prior to joining MACPAC, she worked as an intern for Kaiser Permanente, where she helped coordinate health and wellness events in the Washington, DC, area. Ms. Jones holds a bachelor of science with a concentration in health management from Howard University.

Sarah Melecki, MPAff, is a senior analyst focusing on a variety of issues, including Medicaid expansion, behavioral health services, the integration of Medicaid and other social programs, and dental coverage. Prior to joining MACPAC, she worked on ACA implementation and health care cost drivers at Consumers Union. Ms. Melecki also has served as district director to Texas state representative Jessica Farrar, and as a research assistant at the University of Nebraska Public

Policy Center. She holds a master of public affairs from the LBJ School of Public Affairs at The University of Texas at Austin and a bachelor of arts in political science from the University of Nebraska at Lincoln.

Jessica Morris, MPA, is a principal analyst focusing on Medicaid data and program integrity. Previously, she was a senior analyst at GAO with a focus on Medicaid data systems. She also was a management analyst at the Department of Veterans Affairs, a presidential management fellow at the Pittsburgh VA Medical Center, and a legislative correspondent in the U.S. Senate. Ms. Morris has a master of public administration from The George Washington University and a bachelor of arts in political science and communications from the State University of New York at Cortland.

Robert Nelb, MPH, is a senior analyst focusing on issues related to Medicaid payment and delivery system reform. Prior to joining MACPAC, he served as a health insurance specialist at CMS, leading projects related to CHIP and Medicaid Section 1115 demonstrations. Mr. Nelb has a master of public health and a bachelor's degree in ethics, politics, and economics from Yale University.

Kevin Ochieng is MACPAC's IT specialist. Before joining MACPAC, Mr. Ochieng was a systems analyst and desk-side support specialist at American Institutes for Research, and prior to that, an IT consultant at Robert Half Technology, where he focused on IT system administration, user support, network support, and PC deployment. Previously, he served as an academic program specialist at the University of Maryland University College. Mr. Ochieng has a bachelor of science in computer science and mathematics from Washington Adventist University.

Chris Park, MS, is a principal analyst. He focuses on issues related to managed care payment and Medicaid drug policy and has lead responsibility for MACStats. Prior to joining MACPAC, he was a senior consultant at The Lewin Group, where

he provided quantitative analysis and technical assistance on Medicaid policy issues, including managed care capitation rate-setting and pharmacy-reimbursement and cost-containment initiatives. Mr. Park holds a master of science in health policy and management from the Harvard School of Public Health and a bachelor of science in chemistry from the University of Virginia.

Chris Peterson, MPP, is a principal analyst. Prior to joining MACPAC, he was a specialist in health care financing at CRS, where he worked on major health legislation. Previously, he worked for AHRQ and the National Bipartisan Commission on the Future of Medicare. Mr. Peterson has a master of public policy from Georgetown University and a bachelor of science in mathematics from Missouri Western State University.

Ken Pezzella is chief financial officer. He has more than 10 years of federal financial management and accounting experience in both the public and private sectors. Mr. Pezzella also has broad operations and business experience, and is a veteran of the U.S. Coast Guard. He holds a bachelor of science in accounting from Strayer University.

Brian Robinson is MACPAC's financial analyst. Prior to joining MACPAC, he worked as a business intern at the Joint Global Climate Change Research Institute, a partnership between the University of Maryland and Pacific Northwest National Laboratory. Mr. Robinson holds a bachelor of science in accounting from the University of Maryland.

Anne L. Schwartz, PhD, is executive director. She previously served as deputy editor at *Health Affairs*; vice president at Grantmakers In Health, a national organization providing strategic advice and educational programs for foundations and corporate giving programs working on health issues; and special assistant to the executive director and senior analyst at the Physician Payment Review Commission, a precursor to

the Medicare Payment Advisory Commission (MedPAC). Earlier, she held positions on committee and personal staff for the U.S. House of Representatives. Dr. Schwartz earned a doctorate in health policy from the School of Hygiene and Public Health at Johns Hopkins University.

Kristal Vardaman, MSPH, is a principal analyst focused on long-term services and supports and on high-cost, high-need populations. Previously, she was a senior analyst at GAO and a consultant at Avalere Health. Ms. Vardaman holds a master of science in public health from The University of North Carolina at Chapel Hill and a bachelor of science from the University of Michigan. She currently is pursuing a doctorate in public policy from The George Washington University.

Ricardo Villeta, MBA, is deputy director of operations, finance, and management with overall responsibility for operations related to financial management and budget, procurement, human resources, and IT. Previously, he was the senior vice president and chief management officer for the Academy for Educational Development, a private non-profit educational organization that provided training, education, and technical assistance throughout the United States and in more than 50 countries. Mr. Villeta holds a master of business administration from The George Washington University and a bachelor of science from Georgetown University.

Katie Weider, MPH, is a senior analyst. She focuses on issues related to individuals who are eligible for both Medicaid and Medicare. Prior to joining MACPAC, she served as a senior research assistant at The George Washington University and as a health policy intern for U.S. Senator Charles Grassley. Ms. Weider received a master of public health from The George Washington University and a bachelor's degree in health science and public health from Boston University.

Eileen Wilkie is the administrative officer and is responsible for coordinating human resources, office maintenance, travel, and Commission meetings. Previously, she held similar roles at National Public Radio and the National Endowment for Democracy. Ms. Wilkie has a bachelor's degree in political science from the University of Notre Dame.




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MACPAC

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1800 M Street NW
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