CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

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Director

MEMORANDUM December 7, 1995

TO: Interested Parties

FROM: Linda Bilheimer LB

SUBJECT: Medicaid Per Capita Cap Proposals

Attached is a memorandum outlining important design and implementation issues for Medicaid per capita cap proposals. It focuses primarily on those features of per capita cap proposals that would affect Medicaid expenditures, but also addresses some other policy concerns.

Per capita cap proposals would typically limit average Medicaid expenditures per beneficiary but would not restrict the number of beneficiaries covered by the program. Thus, they would lack the tight controls on Medicaid spending offered by a block grant, but would provide more flexible financial support to states with rapidly growing low-income populations and also during periods of recession.

Alternative approaches to capping average Medicaid expenditures--that could make per capita cap proposals closer to block grants--are beyond the scope of this memorandum. An example of such a policy would be to cap each state's average Medicaid expenditures per person in poverty, rather than per Medicaid beneficiary, and compare actual expenditures per person in poverty to that limit. In theory, that approach would accommodate the needs of states with growing poverty populations. But, because of the time lag in obtaining poverty data, such states could have difficulty keeping their Medicaid expenditures within the limits. States would have stronger incentives to contain Medicaid spending than under a typical per capita cap proposal because increases in the number of Medicaid beneficiaries, as well as in spending per beneficiary, would cause Medicaid spending per person in poverty to rise relative to the capped amount.

If you have any questions about this memorandum, please call me at 6-2673.

Attachment

I. INTRODUCTION

Several proposals for restructuring Medicaid intend to slow the growth of expenditures while maintaining the program as a federal entitlement for eligible people. Typically, such proposals would place limits on the initial level and subsequent rate of growth of average Medicaid expenditures per beneficiary but would not restrict enrollment growth. Because enrollment could continue to expand unabated, the so-called "per capita cap" proposals would lack the tight controls on Medicaid spending that a block grant would offer. Those proposals could, however, partially protect states with rapidly growing low-income populations from the tight fiscal constraints that they might face under a block grant, and provide more flexible federal financial support to states facing expanded Medicaid enrollment during periods of recession.

How effective per capita cap proposals would be in constraining the growth of federal Medicaid expenditures would depend on a variety of design features and on the behavioral responses of the states. In addition to their potential effects on cost containment, the proposals raise important questions about the distribution of federal Medicaid funds among the states.

In spite of the lack of restrictions on enrollment, per capita cap proposals would not necessarily maintain a true federal entitlement to benefits for the eligible population groups. A federal entitlement would require federal financing to grow to accommodate increases in the costs of the benefits to which enrollees were entitled as well as increases in the number of enrollees. As long as proposals maintain both the current Medicaid eligibility criteria and benefit requirements, and place constraints on the rate of growth of federal payments per capita, they cannot necessarily guarantee an entitlement to the mandatory Medicaid benefits.

II. WHAT IS MEANT BY CAPPING FEDERAL MEDICAID EXPENDITURES PER PERSON?

Per capita cap proposals could use one of two basic approaches to limiting federal Medicaid payments to the states. In principle, the federal government could:

- Pay a fixed amount per Medicaid beneficiary to the states; or
- Allow federal payments per Medicaid beneficiary to vary, depending on actual average expenditures, but limit the maximum federal payment per beneficiary.

Recent proposals, however, have all adopted variants of the second approach. In addition, a per capita cap policy would have to establish to what ratio the per capita caps would apply, how the states' per capita caps would be established, and how they would be implemented.

CAPPING MEDICAID EXPENDITURES PER PERSON: COST IMPLICATIONS AND OTHER POLICY ISSUES

OUTLINE

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To What Ratio Would the Per Capita Caps Apply?

All per capita cap proposals envision limiting average Medicaid expenditures per beneficiary, but that ratio could be defined in various ways.

- **What expenditures would be capped?** Limits could be placed on all Medicaid expenditures. Alternatively, certain components of Medicaid spending, such as payments for Medicare premiums and cost-sharing or payments to disproportionate share (DSH) hospitals, could be excluded from the capped amounts. Given the expenditure base, limits could be placed on states' total matchable Medicaid expenditures or directly on their federal Medicaid payments. Capping total matchable expenditures would cause maximum federal expenditures per beneficiary to vary with changes in states' federal match rates. By contrast, if the caps were placed directly on federal expenditures, the maximum federal payment per beneficiary would be insensitive to changes in federal match rates.

- **How would the covered population be counted?** Although some proposals are unclear about whether the relevant beneficiary population would be enrollees or recipients, it is generally assumed that caps would be placed on average expenditures per Medicaid enrollee. (The remainder of this memorandum adopts that assumption.) Expenditures per enrollee would be lower than expenditures per recipient, because not every person enrolled in the Medicaid program actually uses services.

- **Would all beneficiary groups be subject to the same cap?** Typically, per capita cap proposals envision different caps applying to different groups of Medicaid beneficiaries. For example, separate caps might be established for each of the four major Medicaid beneficiary groups; the elderly, the disabled, other non-disabled adults, and non-disabled children.

- **Would all states be subject to the same caps?** Caps could be set on a national basis or could be state-specific. All recent per capita cap proposals would establish state-specific caps, based on recent spending by each state.

How Would the States' Per Capita Caps be Established?

The states' base year per capita cap amounts and their annual rates of growth would both be important policy parameters, affecting cost containment and the distribution of federal Medicaid funds among the states.

- **How would the base year cap amounts be determined?** Although the base year cap amounts could be set in a variety of ways, most current proposals would base each state's caps on its own average expenditures per enrollee in recent years.

- **How would the cap amounts grow over time?** Proposals differ in their approaches to increasing the cap amounts after the base year. The most important distinction is between proposals that would adopt an entirely exogenous growth factor (such as a modified version of the Consumer Price Index) after the base year, and those that would rebase the cap amounts each year based on spending levels in the states. Without additional provisions, rebasing the cap amounts each year would essentially build states' past spending patterns--including any excess spending above the caps--into their future caps. To avoid such an outcome, the legislation could stipulate, for example, that the new base would be the lesser of the previous year(s) cap amount or the state's actual per capita expenditures for the year, indexed by an appropriate growth factor.

How Would Per Capita Caps be Implemented?

Although per capita cap proposals intend to limit per capita expenditures, their implementation would focus on constraining aggregate expenditures.

- **How would limits on per capita spending be translated into aggregate limits?** Given a state's maximum per capita amounts and projected enrollment counts in each beneficiary group, the Health Care Financing Administration (HCFA) could project aggregate federal Medicaid expenditures for the state for the quarter (or year). Once a state had drawn down that projected amount, no additional federal funds might be available for the quarter (or year) unless the state could demonstrate that actual enrollment had been higher than projected, and that actual per capita expenditures had not exceeded the cap amounts.

- **Would there be an overall aggregate expenditure limit per state, or would there be separate aggregate spending limits for each beneficiary group in a state?** Proposals differ on that question. Some would have separate limits for each beneficiary group and would not permit spending above the limit for some groups to be offset by spending below the limit for other groups. Such proposals are described as having "walls". The alternative approach, described as being "without walls", would have a single aggregate spending limit for each state and would allow offsets among groups.

- **How would a state's appropriate aggregate expenditures be determined?** Payments to the states would probably be made on a quarterly basis, as they are under current law. Consequently, a state's aggregate expenditure limits and appropriate aggregate expenditures would also be determined quarterly. A possible scenario would be as follows. After the end of the quarter, when final enrollment counts and expenditures for each beneficiary group were available, the federal government would determine what the capped aggregate federal expenditures should have been for each

state. That amount would depend on whether the per capita caps were implemented with or without "walls". In a system that operated with "walls", if the actual federal expenditures per enrollee in a beneficiary group were less than the cap amount for that group (that is, if the cap was not binding), then the appropriate aggregate federal expenditures for the group would be:

[actual federal expenditures per enrollee]
X
[full-quarter-equivalent enrollees]

If the actual federal expenditures per enrollee in a beneficiary group exceeded the cap amount for that group (that is, if the cap was binding), then the capped aggregate federal expenditures for the group would be:

[quarterly per capita cap amount]
X
[full-quarter-equivalent enrollees]

Under a proposal with walls, the overall capped aggregate federal expenditure amount would then be the sum of the appropriate aggregate expenditures for each beneficiary group. If the per capita caps were implemented "without walls", however, and some beneficiary groups exceeded their caps while others did not, then the overall capped aggregate federal expenditures would be the sum of the appropriate aggregate amounts for each beneficiary group, with inter-group offsets incorporated into those aggregate amounts.

III. HOW EFFECTIVELY WOULD PER CAPITA CAP PROPOSALS CONTROL FEDERAL MEDICAID EXPENDITURES?

The effects of per capita cap proposals on federal Medicaid expenditures would depend on several factors:

- o States' responses to the new requirements and incentives that the proposals would offer;
- o Enforcement provisions;

- Provisions affecting those Medicaid expenditures that were excluded from the caps; and

- Other provisions affecting states' ability to control Medicaid spending.

States' Responses to New Requirements and Incentives

Under a per capita cap proposal, states would have strong incentives to have their cap amounts set as high as possible and, generally, to avoid spending above those caps. The extent to which states could affect their cap amounts would depend on how the base year cap amounts were determined and how the update factors were established. In addition, states could use a variety of methods to keep their average expenditures below the cap amounts. Some of those methods might raise, rather than lower, aggregate federal Medicaid expenditures.

- **Determining the base year amounts**. Per capita cap proposals generally assume that a state's base year cap amount for each beneficiary group would be some function of its average per capita expenditures per enrollee for the previous year or years. Thus, the initial level would depend on the accuracy of both the expenditure data in the numerator of the ratio and the enrollee data in the denominator. In order to receive their federal matching funds, states routinely report their Medicaid expenditures to the HCFA and those data are presumably fairly reliable. Little is known, however, about the accuracy of states' enrollment data, especially on a full-year-equivalent basis. If states had to estimate their full-year-equivalent enrollee counts, they would have an incentive to underestimate those counts (thereby raising the estimate of expenditures per enrollee) for purposes of determining their base year amounts. (They would have the opposite incentive, however, in calculating their current year expenditures.)

- **Establishing the update factors.** If the process for updating the per capita amounts rebased the per capita caps each year to reflect states' actual expenditures (with no upper limit), then any excess spending above the caps would be built into future cap amounts. Consequently, some states might be willing initially to absorb the costs of excess expenditures above the caps in a given year, in order to raise their caps in future years.

- **Keeping average expenditures per capita below the cap amounts.** One purpose of limiting per capita Medicaid expenditures would be to encourage states to seek more efficient ways to operate their Medicaid programs--by enrolling more beneficiaries in managed care plans, for example. But under tight spending constraints, improvements in efficiency alone would probably be insufficient to

maintain expenditures below the cap amounts. States might, therefore, reduce coverage of optional services or optional categories of beneficiaries. They might, however, use other means to stay within the per capita limits that would increase rather than reduce total federal expenditures. Possibilities include expanding enrollment to cover more low-cost enrollees or shifting enrollees from lower-cost beneficiary groups to higher-cost groups (with higher per capita caps). Both of those responses would have the effect of lowering the average expenditures per enrollee in the affected beneficiary groups but could increase total federal spending States might also increase their efforts to shift more of the costs of the elderly and the disabled to the Medicare program, likewise lowering average Medicaid expenditures per enrollee but raising total federal spending.

Enforcement Provisions

Enforcing the per capita caps would require appropriate mechanisms to maintain states' expenditures within the aggregate limits, and the availability of reliable data to determine the appropriate quarterly federal payments to each state. Enforcement mechanisms might also include provisions to constrain cost-increasing behavioral responses by the states.

- **Maintaining states' expenditures within their aggregate limits**. Under current law, states receive quarterly payments from HCFA, based on reports filed by the states projecting their Medicaid expenditures and enrollment for the quarter. Those payments are adjusted to reflect estimated overpayments or underpayments from previous quarters. After the end of the year, a full reconciliation occurs.

  Per capita cap proposals would typically use a modified version of that basic payment mechanism. Overpayments and underpayments (and, presumably, the end-of-year reconciliation process) would be based on a comparison of states' actual spending with their capped aggregate amounts. To provide additional incentives for states to stay within the caps, part of a state's quarterly payment might be withheld and, subsequently, be paid in full only if it had not breached its capped aggregate amount.

- **Ensuring the reliability of data to determine appropriate quarterly federal payments**. The enforcement process would be critically dependent on the availability of reliable, detailed, data on expenditures and enrollment. The quarterly payments to the states would be based on states' projections of expenditures and enrollment by beneficiary group. The post facto adjustments for overpayments or underpayments would require accurate data on actual enrollment and expenditures by beneficiary group. New or expanded quarterly reporting systems would be needed for both the projections and the retrospective data. Effective quality assurance mechanisms to ensure the accuracy of the data would be essential.

The reliability of the enrollee data would be of particular concern. The state and federal governments have historically collected expenditure data on a recipient rather than an enrollee basis. Currently, states submit quarterly enrollment projections by eligibility category to HCFA, but the accuracy of those enrollment projections is highly uncertain. The states report actual enrollment to HCFA only on an annual basis and the reliability of those data is, likewise, unknown. (Establishing the accuracy of data elements that are not essential for reimbursement is not a policy priority.)

The timeliness as well as the reliability of the actual expenditure and enrollee data would be critically important for an effective enforcement process. The longer the time lag between excess expenditures and the subsequent fiscal penalty, the more difficult the provisions would be to enforce.

- **Constraining states' behavioral responses.** Legislation could include a variety of provisions to constrain unintended behavioral responses by the states, but the effectiveness of such measures would be highly uncertain. Some people have suggested, for example, that if states enrolled new groups of low-cost beneficiaries in order to keep average expenditures within the cap amounts, HCFA could establish a separate per capita cap for such groups. Conversely, if states cut back on the enrollment of high-cost beneficiaries, the per capita expenditure limits could be lowered.

  Any such actions by the states, however, would probably be subtle and extremely difficult to track. States would not have to define new eligibility groups in order to enroll lower-cost beneficiaries. Older children, for example, typically cost less than infants, so increasing the ratio of older children to infants in the program could lower per capita expenditures for children. Enrollee group "creep" would also be difficult to monitor. Children with mild learning disabilities, for example, could be classified as disabled. Shifting such children from the children's group to the disabled group would put them in a group with a much higher expenditure cap and would also lower actual average expenditures among the disabled.

Provisions Affecting Medicaid Expenditures Excluded from the Caps

Proposals to limit per capita Medicaid expenditures would typically exclude some expenditures from the cap amounts. Two categories of payments, in particular, would probably be excluded:

- Payments made on behalf of qualified Medicare beneficiaries to cover Medicare's premiums and cost-sharing amounts; and

- Payments to disproportionate share hospitals.

How those excluded expenditures would be handled, and whether they would be subject to alternative spending constraints, has important implications for total Medicaid spending.

Other Provisions Affecting the Ability of States to Control Medicaid Spending

Per capita cap provisions are generally incorporated into broader legislative proposals that would affect states' Medicaid programs in several ways. Some provisions would increase the ability of the states to develop innovative approaches to cost containment: others would continue or expand current restrictions on states' operations. The following questions are of particular concern when assessing the overall effects of proposals on Medicaid spending.

- Would the proposal maintain the current federal mandatory and optional eligibility groups and covered services? (In particular, would states be given more flexibility to require cost-sharing by beneficiaries and to limit treatment services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program?)

- Would the proposal maintain the Boren Amendment's provisions affecting states' payments to hospitals and nursing homes; the payment requirements for physicians; and the restrictions on the use of provider taxes and donations to generate state matching funds?

- How much flexibility would states be given to enroll Medicaid beneficiaries in managed care programs?

- Would there be special requirements for payments to federally qualified health centers?

- Would restrictions be placed on states' abilities to expand Medicaid eligibility under section 1902(r)(2) of the Social Security Act?

- Would there be special provisions for states operating their Medicaid programs under waivers?

IV. HOW WOULD PER CAPITA CAP PROPOSALS AFFECT THE DISTRIBUTION OF FEDERAL MEDICAID FUNDS AMONG THE STATES?

Per capita cap proposals would raise some of the same equity questions as block grants concerning the distribution of federal Medicaid funds among the states. Typically, states' per capita caps would be based on their historical expenditure patterns. Consequently, states with high expenditures per beneficiary would be able to lock in higher caps than states with low expenditures per beneficiary. For some of the low-cost states experiencing rapid beneficiary growth, some of the negative effects

of low per capita caps might be mitigated by the fact that enrollment would not be constrained. For other low-cost states, however, basing the per capita caps on the existing wide discrepancies among the states would be more problematic.

V. WHAT WOULD THE INDIVIDUAL ENTITLEMENT TO MEDICAID SERVICES MEAN?

Some advocates of per capita cap proposals endorse the concept as a means to control Medicaid spending while maintaining an individual federal entitlement to Medicaid services. How that entitlement would be interpreted in practice, however, is uncertain, and the actual legislative language would be extremely important. The law establishing a federal entitlement program must describe who is eligible and the benefits to which they are entitled, as well as assuring that federal funds accommodate changes in enrollment and in the cost of benefits. A program that capped federal expenditures per enrollee probably could not meet all of those criteria. The consequences of the constraints on program growth are unclear, but those constraints would probably have different effects on optional and mandatory beneficiary groups and covered services.

- **Populations and services covered under current law at states' option.** There would be no guarantee that all populations currently covered by the Medicaid program would continue to be eligible. Nor would covered services necessarily stay the same. States might cut back on coverage of high-cost optional groups--the medically needy, for example--or eliminate some optional services, in order to keep expenditures below the cap amounts. Such cutbacks are allowed under current federal law and would, presumably, continue to be so.

- **Restrictions on access to covered services for entitled populations.** It is much less clear, however, what would happen if the caps were sufficiently constraining in some states that access to covered services for entitled populations was seriously limited. Whether beneficiaries could sue the state and/or federal governments under those circumstances, and the resulting implications for Medicaid expenditures, would depend critically on whether and how the individual entitlement was defined in the law.