



The Medicaid Commission Report: A Dissent

By Robert B. Helms

While instructive, the Medicaid Commission's final report on reforming the program does not fully address its deficiencies, particularly the problems with the formula which allocates Medicaid funds to states. Worthwhile reforms would direct Medicaid funds to the states and populations that need them most.

In May 2005, Secretary of Health and Human Services Michael O. Leavitt established the Medicaid Commission, chartering it “to advise the Secretary on ways to modernize the Medicaid program so that it can provide high-quality health care to its beneficiaries in a financially sustainable way.”¹ The commission issued two reports. The first, submitted on September 1, 2005, provided recommendations for achieving short-term budget savings. A final report, suggesting how best to reform the program, was released on December 29, 2006.²

There were fifteen voting members and fifteen non-voting members who met on nine occasions. During these meetings the commission members were given extensive briefings and heard public testimony from health-care experts and Medicaid recipients. In many cases, the latter group consisted of disabled recipients, or the parents, spouses, and caregivers struggling to care for them. Their common refrain was, “Don’t cut our Medicaid benefits!” The public testimony was often emotional, so much so that it was sometimes difficult to see how it would help the commission address the financial and management problems presented by the experts. Still, the stories told by recipients and caregivers did affect the commission’s view of

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Medicaid’s basic problems. The public and expert testimony showed that Medicaid plays a crucial role in helping state and local governments take care of the most vulnerable people in our society. But it also reminded us that the present Medicaid program does a poor job of taking care of these individuals, and that it cannot be sustained without substantial reform. These observations delineated the basic issues that we struggled with for a year and a half.

I voted for the final report and for all of the specific proposals approved by the commission. The final recommendations provide a helpful, overdue road map to achieve useful reforms of the program. I submitted a dissent to the report, however, because I believe that the commission did not address an important aspect of the current program that is the root cause of many of Medicaid’s problems.³ This *Health Policy Outlook* is intended to provide background and a thorough rationale for my dissent.

The Origin of the Problem

Medicaid has an ill-conceived—and now outdated—method for calculating the level of federal financial support for the states. Until this issue is addressed, and a fairer and more equitable method is developed, Medicaid will continue to be plagued by problems, including:

- poor targeting of resources to help the poorest and most disadvantaged members of our communities
- uncontrolled growth of federal and state spending
- rampant fraud and abuse
- incentives for states to use questionable accounting schemes to increase federal funding
- federal subsidy formulas that are unable to sufficiently respond to changing economic conditions
- intensifying adversarial relationships between the states and the federal government that reduce the chance of political compromise on policy reforms
- enable states of varying means to provide roughly equivalent benefits to their Medicaid-eligible populations
- increase and decrease federal matching payments to states to reflect changed economic circumstances
- target states with higher concentrations of individuals in poverty⁹

Since its passage in 1965, the Medicaid program has operated as a joint effort between the federal and state governments to finance health care for a population that has grown to 55 million people.⁴ It is an open-ended entitlement program financed with both federal and state funds, with the federal government financing approximately 57 percent of Medicaid's total cost of \$301 billion in FY 2005.⁵ The amount of federal money that flows to the states is partially determined by the Federal Medical Assistance Percentage (FMAP).⁶ This formula compares each state's per-capita personal income to the national per-capita personal income and is designed to provide larger federal subsidies to states with relatively low incomes.⁷

The FMAP formula determines only the percentage rate at which the federal government matches claims submitted by the states. The total amount of federal funds flowing to each state is also a function of the number of claims that a state submits to cover the costs of providing mandatory and optional benefits for the populations the program can serve. This feature of Medicaid financing—allowing each state to determine how much it will spend and obligating the federal government to match what the state chooses to spend—has been a popular feature of the program. For the politicians who designed the original program, it met the national objective of subsidizing medical coverage for those with low incomes while allowing each state great flexibility to choose its own level of desired and affordable support, threading the twin political needles of compassion and federalism.⁸ In a recent AARP report, Vic Miller and Andy Schneider point out that the original objective of the FMAP was to:

However, they also point out that these objectives were not fully realized, concluding: "The FMAP formula, most analysts agree, does not adequately reflect the different fiscal capacities of the states and does not take into account the circumstances of states with high concentrations of poor citizens."¹⁰

The following data on the distribution of federal Medicaid payments illustrates how the current financing system has failed to allocate federal subsidies to the poorest people in our population. In 2004, the most recent year of available Medicaid data from the Center for Medicare & Medicaid Services (CMS), federal Medicaid payments to the states ranged from a low of \$233 million to Wyoming to a high of \$21.4 billion to New York. Since there are large differences in the population of the various states, however, federal expenditures are more easily compared when expressed on a per-population basis, independent of a state's Medicaid enrollment policies. This can be achieved by dividing federal Medicaid payments to each state by the number of poor and near-poor people in poverty (below 125 percent of the federal poverty line). These per-capita federal payments in FY 2004 ranged from \$1,736 in Nevada to \$6,780 in Maine.¹¹

As illustrated in figures 1 and 2 on the next page, data for all states reveal that there is a negative relationship between the per-capita amount of federal funds flowing to the states and the amount of poverty in the states—that is, as a general tendency, the poorer the state, the less federal money that state receives.

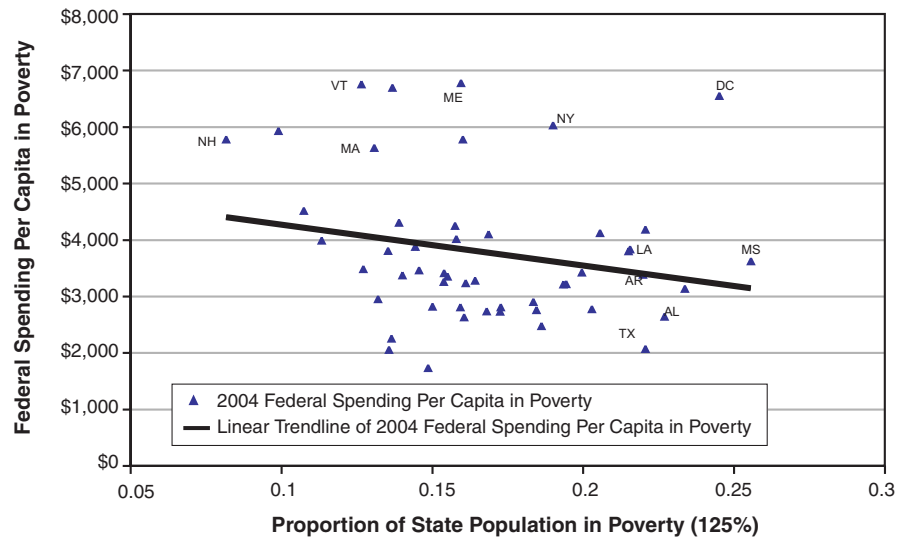
The official audited data for state Medicaid expenditures for FY 2005 have not yet been released by CMS. Preliminary data represented in figure 2, however, indicate an almost identical pattern.

Once again, there is an inverse correlation between poverty rates and federal per-capita Medicaid reimbursement. States with the highest poverty rates—such as Alabama, Louisiana, and Mississippi—received much lower Medicaid payments per-capita than did wealthier states like New York and several New England states.¹²

Not only can the wealthier states afford to spend more on Medicaid, the open-ended process of obligating the federal government to match what the state chooses to spend creates an incentive for states to increase Medicaid spending relative to all other priorities. When a state is forced to cut budget expenditures, the FMAP procedure gives the state an incentive not to cut matched expenditures relative to unmatched state expenditures. With a minimum matching rate of 50 percent, a state would have to cut total Medicaid expenditures by \$2 in order to cut state expenditures by \$1, thereby foregoing \$1 in federal funds.¹³ This incentive results in a ratchet effect in state Medicaid budgets, since Medicaid expenditures tend to rise in times of plenty but are rarely reduced when states must cut back.¹⁴

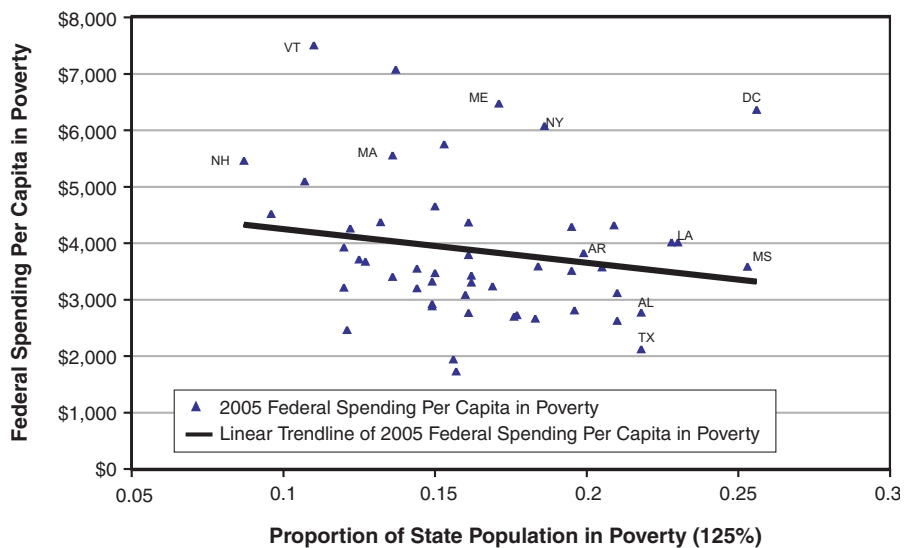
Another way to look at the effects of current Medicaid payment policy is to examine which states have increased their federal payments the most over an extended period. I obtained records of federal Medicaid payments to the states for FY 1970 and expressed them on a per capita basis using the number of people at or below 100 percent of poverty in 1970.¹⁵ Figure 3 shows the five states with the smallest increases and the five states with the largest increases for the period 1970–2005.¹⁶ Again, New York and several New England states have consistently taken greater advantage of the open-ended federal assistance formula than the poorer Southern states. Clearly, the FMAP procedure is not successfully achieving the original objective of Medicaid: targeting

FIGURE 1
2004 FEDERAL MEDICAID SPENDING PER CAPITA IN POVERTY VERSUS PERCENT OF STATE POPULATION IN POVERTY



SOURCE: Author's calculations based on CMS Medicaid data and Census Bureau poverty data. See note 11 for calculation details.

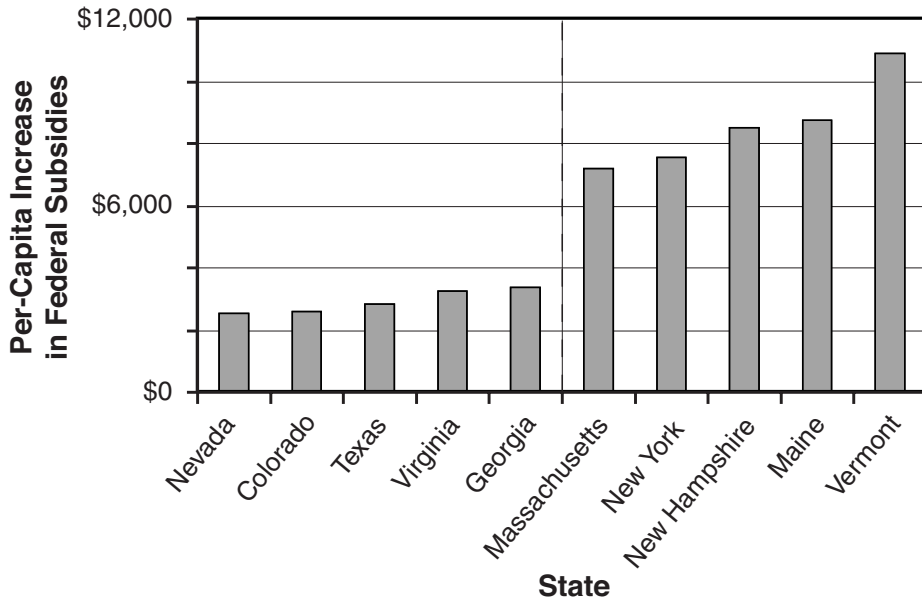
FIGURE 2
2005 FEDERAL MEDICAID SPENDING PER CAPITA IN POVERTY VERSUS PERCENT OF STATE POPULATION IN POVERTY



SOURCE: Author's calculations based on CMS Medicaid data and Census Bureau poverty data. See note 11 for calculation details. FY 2005 Medicaid data are preliminary and are subject to change. These data were obtained directly from CMS.

federal assistance toward the states with the greatest share of poverty. Poorer states today are falling behind as wealthier states are collecting a disproportionate share of federal Medicaid dollars.

FIGURE 3
STATES WITH SMALLEST AND LARGEST INCREASES IN FEDERAL MEDICAID
SUBSIDIES, 1970–2005



SOURCE: Author's calculations based on CMS Medicaid data and Census Bureau poverty data. See note 15 for calculation details.

The FMAP formula also poorly counteracts the effects of changes in a state's economic activity. The measurement of a state's per-capita personal income does not accurately track changes in state economic activity. The three-year averaging procedure, as well as delayed updating, results in a substantial lag in FMAP adjustments.¹⁷ If a state's economy begins to decline relative to other states, it may take from three to six years for FMAP to adjust to this change.

The FMAP procedure of Medicaid financing has been criticized by policy analysts and government agencies for decades.¹⁸ This criticism comes from analysts representing a wide spectrum of policy-oriented and philosophical approaches to health policy, proving that this debate is not just a matter of government budgets. The perverse incentives created by this method of financing would be present at any level of spending. In addition to the AARP report, a recent report from the National Academy of State Health Plans refers to the Medicaid "tug of war" and calls for steps to improve the fiscal integrity of federal financing.¹⁹ The authors of the report point out that the FMAP procedure creates strong incentives for states to engage in accounting schemes that enhance federal funding, and for the federal bureaucracy to attempt to control these schemes—hence the "tug of war." Numerous

analysts have pointed out that we have created a situation in which each governor and state Congressional delegation has a strong incentive to increase federal funding under the FMAP procedures rather than consider reforms that would be in the best interest of those Medicaid is intended to serve.

Moving Forward

How should Medicaid be reformed? The literature on reform suggests myriad approaches for using alternative population or economic variables in the formula and for making the formula more responsive to changing economic conditions in the states.²⁰ But before these approaches can be considered,

it is important to understand how the existing system affects the politics of Medicaid reform. Overcoming the political obstacles to reform is daunting. The problem is linked to the incentives created by the open-ended nature of the current payment policy and the fact that no state, regardless of its economic status, receives less than a 50 percent match from the federal government. Any state willing to spend more on expanding optional benefits or covering optional beneficiaries—including beneficiaries with higher incomes—will only incur at most half the additional cost of the expansion. This creates strong pressure for a state to increase its Medicaid program and, as argued earlier, creates disincentives to control these costs. In this situation, any discussion of a change in the FMAP formula is seen as a possible threat to the open-ended flow of federal funds to the state. Any formula based on estimates of the number of poor, disabled, or aged—or any new idea to reduce the marginal reward for additions to the program—can easily be turned into a table of winners and losers by a good number cruncher.²¹

This is not conducive to any serious discussion of reform. The result is a continuation of the decade-long political stalemate. As pointed out by Sonya Schwartz, Shelly Gehshan, Alan Weil, and Alice Lam,

CMS is on the defensive in trying to issue new regulations to control state-level program expansions.²² Meanwhile, Congress tries to control costs by passing new controls on payment rates to providers and suppliers.²³ This dissonance between state incentives to expand eligibility and federal attempts to control expenditures can only be expected to intensify in future years as the population ages and the cost of caring for the disabled puts more pressure on federal and state budgets.²⁴ As in any system that relies primarily on price controls and government rationing, Medicaid beneficiaries will have access to fewer providers and will experience decreases in the quality of care.

The commission was presented with ample evidence that the millions of poor, aged, and disabled people—the types of people that the commission heard from during the public testimony—were not being well-served in most states. This does not mean that some individuals with higher incomes or less-severe disabilities could not be helped by some subsidies. It only illustrates the basic problem with all welfare programs: targeting assistance to those most in need without creating incentives for others to take advantage of the program. With limited resources, how does the government target resources to the neediest? The present Medicaid program seems designed to do just the opposite, shifting resources toward citizens who live in wealthier states.

Medicaid advocacy groups and others who seem to have a near-religious belief in the concept of open-ended entitlements will not like to hear it, but I believe that Congress will eventually be forced to abandon the current funding structure and severely limit Medicaid expenditures in future years. The annual projections of the future costs of entitlements from the Congressional Budget Office show that the three largest entitlement programs (Social Security, Medicare, and Medicaid) will grow from 42.9 percent of federal spending in 2006 to 49.3 percent by 2015, and to 52.6 percent by 2020.²⁵ While these projections are driven more by Medicare than by Medicaid or Social Security, such growth in total entitlement spending will require either large tax increases or drastic reductions in all categories of discretionary spending (education, defense, and infrastructure, for example)—a highly improbable outcome. Likelier is a continuing Congressional effort to control Medicaid expenditures

by imposing more controls on payments and benefits, an approach that will only exacerbate today's access and quality problems.

The extensive literature on Medicaid reform offers a number of ideas about how to correct these perverse incentives and to ensure that the program focuses on helping the poorest and most vulnerable of our citizens. My preferred approach would be to block-grant the program and force Congress to decide how much money it wants to devote to Medicaid compared to all other budget priorities. With that amount determined, a revised formula based on the number of disabled, aged, and low-income people in each state could be used to distribute the money to the states. A relatively long transition period (at least ten years) would give the states ample time to redesign their programs. However, since block-granting any entitlement program is now out of favor, my second choice would be to reform the current FMAP formula to target the poorest and most disabled beneficiaries and to reduce the matching percentage for program extensions beyond current

mandatory coverage for those with higher incomes or for optional benefits.²⁶ The latter approach would reduce the incentive for states to game the system, and it would give them reasons to find better ways to help the neediest. Meanwhile, this approach would also leave states free to expand their own programs if they wish to do so.

In 1996, Congress reformed welfare programs when it became clear that they were not achieving their intended purposes.²⁷ It is now time to do the same for Medicaid. The Medicaid Commission's recommendations to increase state flexibility constitute a good start, but they will not correct the massive, perverse incentives now disrupting the program. Until these issues are addressed, the budgetary and policy deficiencies that led to the formation of this commission will continue to fester.

AEI research assistant Jonathan Stricks and editorial assistant Evan Sparks worked with Mr. Helms to edit and produce this Health Policy Outlook.

Notes

1. The final report, the charter, and a complete record of commission meetings can be found at <http://aspe.hhs.gov/medicaid/> (accessed December 30, 2006).

I believe that Congress will eventually be forced to abandon the current funding structure and severely limit Medicaid expenditures in future years.

2. U.S. Department of Health and Human Services, Medicaid Commission, *Final Report and Recommendations: Medicaid Commission*, December 29, 2006, available at <http://aspe.hhs.gov/medicaid/122906rpt.pdf> (accessed January 3, 2007).

3. *Ibid.*, 28–29.

4. For an historical account of the passage of Medicaid in 1965 and its early years, see Robert Stevens and Rosemary Stevens, *Welfare Medicine in America: A Case Study of Medicaid* (New York: Free Press, 1974).

5. U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, preliminary Form CMS-64 data (FY 2005) on federal and state total net expenditures.

6. For a more complete description of the FMAP formula and procedures, see Vic Miller and Andy Schneider, “The Medicaid Matching Formula: Policy Considerations and Options for Modification” (research report 2004-09, Public Policy Institute, AARP, Washington, DC, September 2004), available at http://assets.aarp.org/rgcenter/health/2004_09_formula.pdf (accessed December 30, 2006).

7. The formula for each state is: FMAP equals 100 percent – the state’s share. The state’s share equals $0.45 \times (\text{state's per-capita income} \div \text{national per-capita income})^2$. Multiplying by 0.45 was to ensure that a state with per-capita income near the national average received a 55 percent federal subsidy. The ratio of a state’s per-capita income to national per-capita income was squared as a way of providing a larger federal subsidy to the poorest states. The calculation each year uses state and national per-capita income over a three-year period. Congress has established special matching rates for Alaska and the District of Columbia. No state receives less than a 50 percent matching rate, a rule that protected thirteen states and the District of Columbia in FY 2004. See Vic Miller and Andy Schneider, “The Medicaid Matching Formula,” 9. Congress has also provided enhanced matching rates for limited periods of time and for specific purposes.

8. Thomas W. Grannemann and Mark V. Pauly, *Controlling Medicaid Costs: Federalism, Competition, and Choice* (Washington, DC: AEI Press, 1983), 30–41.

9. Vic Miller and Andy Schneider, “The Medicaid Matching Formula,” 16.

10. *Ibid.*, 17. See especially the authors’ list of studies backing up this conclusion in their note 40.

11. The calculations were made by the author based on data from two government sources. Federal Medicaid payments to the states is from CMS, Form CMS-64 data (FY 2004), available at www.cms.hhs.gov/MedicaidBudgetExpendSystem/02_CMS64.asp#TopOfPage (accessed December 30, 2006); the number of people at or below 125 percent of poverty in each state, and the percent of poverty in each state, is from the

Census Bureau, CPS, 2004, available at http://pubdb3.census.gov/macro/032005/pov/new46_100125_01.htm (accessed December 30, 2006).

12. New York, Massachusetts, Vermont, Connecticut, and New Hampshire received average per-capita federal payments of \$5,848 in FY 2004; Texas, Alabama, Louisiana, Arkansas, and Mississippi received average per-capita payments of \$2,585.

13. Vic Miller and Andy Schneider, “The Medicaid Matching Formula,” 3–4. The higher the federal matching rate, the greater the penalty for cutting a matched expenditure. A state with a 70 percent match would have to reduce total Medicaid spending by \$3.33 in order to save the state \$1.

14. The FMAP procedure also affects a state’s incentive to fight fraud and abuse in Medicaid since it affects the relative return from controlling fraud and abuse in matched—versus unmatched—state programs. If a state saves \$1 by investing in fraud and abuse control in Medicaid, it must share 50 percent or more (depending on the state’s matching rate) of the savings with the federal government. If a state saves \$1 by reducing fraud and abuse in an unmatched program, all of the \$1 savings accrue to the state.

15. With the help of John Klemm in the CMS Office of the Actuary, we obtained records of FY 1970 federal medical assistance payments for the forty-eight states (Alaska and Arizona had no such payments in 1970) from the Medicaid Financial Management Reports (Form OA-41). We then computed per-capita federal expenditures by dividing by the number of people at or below 100 percent of poverty in those states in FY 1970 and FY 2005. The mean absolute increase in per-capita federal payments for all forty-eight states was \$5,075. Arkansas (\$5,502) was the only Southern state with an increase above the mean.

16. The District of Columbia’s matching rate is set by Congress at 70 percent, and therefore is not based on the FMAP formula. Excluding the District from the five states with the largest increases moves Massachusetts into the top five states.

17. Vic Miller and Andy Schneider, “The Medicaid Matching Formula,” 4. See also their references to studies of the impact of Medicaid on state economic activity in their note 9.

18. Thomas W. Grannemann and Mark V. Pauly, *Controlling Medicaid Costs*. Miller and Schneider list the following Government Accounting Office (GAO) studies: GAO, *Changing Medicaid Formula Can Improve Distribution of Funds to States*, GAO/GGD-83-27, March 9, 1983; GAO, *Medicaid Matching Formula’s Performance and Potential Modifications*, GAO/T-HEHS-95-226, July 27, 1995; GAO, “Medicaid Formula: Effects of Proposed Formula on Federal Shares of State Spending,” memo to Senator Daniel Patrick Moynihan (D-N.Y.), GAO-HEHS-99-29R, February 19, 1999; and GAO,

“Medicaid Formula: Differences in Funding Ability among States Often Are Widened,” GAO-03-620, July 2003. For more recent criticisms, see John R. Graham, “Taming the Medicaid Monster,” *Health Policy Prescriptions* 4, no. 8 (August 2006); Tommy G. Thompson, *Medicaid Makeover: Four Challenges and Potential Solutions on the Road to Reform*, (Washington, DC: Medicaid Makeover, 2006), available at www.medicaidmakeover.org/MedicaidMakeoverPlan.pdf (accessed December 29, 2006); and Pamela Villarreal, “Federal Medicaid Funding Reform” (brief analysis 566, National Center for Policy Analysis, Dallas, TX, July 31, 2006, available at www.ncpa.org/pub/ba/ba566/ (accessed December 29, 2006).

19. Sonya Schwartz, Shelly Gehshan, Alan Weil, and Alice Lam, *Moving beyond the Tug of War: Improving Medicaid Fiscal Integrity* (Portland, ME: National Academy for State Health Policy, 2006), available at www.nashp.org/Files/Medicaid_Fiscal_Integrity.pdf (accessed December 29, 2006).

20. See Vic Miller and Andy Schneider, “The Medicaid Matching Formula”; and the references in note 18 of this *Health Policy Outlook*.

21. For examples, see Vic Miller and Andy Schneider, “The Medicaid Matching Formula,” tables 6 and 8–14; GAO, *Medicaid: Strategies to Help States Address Increased Expenditures during Economic Downturns*, GAO-07-97, October 2006; and Donald

B. Marron, “Medicaid Spending Growth and Options for Controlling Costs” (statement of the CBO acting director before the U.S. Senate Special Committee on Aging, Washington, DC, July 13, 2006).

22. Sonya Schwartz *et al.*, *Moving beyond the Tug of War*, 6.

23. See Andy Schneider, “Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33” (Center on Budget and Policy Priorities, Washington, DC, September 8, 1997), available at www.cbpp.org/908mcaid.htm (accessed December 29, 2006).

24. See Donald B. Marron, “Medicaid Spending Growth and Options for Controlling Costs,” especially at table 4.

25. Congressional Budget Office, *The Long-Term Budget Outlook*, December 2005, scenario 1, calculated from data in supporting tables.

26. Medicaid Commission, *Final Report and Recommendations*, viii. The “scaled match” that the commission recommends be studied in recommendation C-3 would be a step in this direction.

27. See Douglas J. Besharov and Peter Germanis, “Welfare Reform and the Caseload Decline,” in *Family and Child Well-Being after Welfare Reform*, ed. Douglas J. Besharov (New Brunswick, NJ: Transaction, 2003), 35–65, available at www.aei.org/book431/.