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Medicaid Financing: The Basics

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Executive Summary

Medicaid represents $1 out of every $6 spent on health care in the US and is the major source of financing for states to provide coverage to meet the health and long-term needs of their low-income residents. Medicaid is administered by states within broad federal rules and jointly funded by states and the federal government. President-elect Trump and other GOP proposals have put forth fundamental changes in Medicaid financing. This brief examines the following 3 key Medicaid financing questions:

- **How does Medicaid financing work now?** States design their Medicaid programs within broad federal rules; in return, Medicaid provides a guarantee of federal matching payments with no pre-set limit. There are special match rates for the ACA, administration and other services. Medicaid also provides "disproportionate share hospital" payments to hospitals serving many Medicaid and uninsured patients.
- **How much does Medicaid cost and how are funds spent?** Payment to private managed care organizations (MCOs) account for 43% of Medicaid spending. Almost two-thirds of all Medicaid spending is for the elderly and persons with disabilities, who make up just one-quarter of all Medicaid enrollees. Medicaid enrollment and spending increases during recessions. Medicaid growth per enrollee has been lower than private health spending. The ACA has provided a significant amount of federal dollars to states.
- **What is the role of Medicaid in federal and state budgets?** Medicaid is the third largest domestic program in the federal budget following Medicare and Social Security. Medicaid is a spending item but also the largest source of federal revenues for state budgets. In responding to two major recessions in the last 15 years, states have adopted an array of policies to control Medicaid spending growth. Research shows that the influx of federal dollars from Medicaid spending has positive effects for state economies.

Looking ahead, proposals to fundamentally change Medicaid financing will be debated. President-elect Trump and other Republicans have proposed to transition Medicaid to a Medicaid block grant or per capita cap financing model for Medicaid. These models would fundamentally change the current structure of the program (Figure 11). These policies are typically designed to reduce federal spending and fix rates of growth to make federal spending more predictable, but could eliminate the guarantee of coverage for all who are eligible and the guarantee to states for matching funds. These proposals could be structured in a variety of ways. States could gain additional flexibility to administer their programs but reduced federal funding could shift costs and risk to beneficiaries, states, and providers.

How does Medicaid financing work under current law?

Under current law, Medicaid provides a guarantee to individuals eligible for services and to states for federal matching payments with no pre-set limit. Medicaid provides an entitlement to income eligible individuals. The federal government matches state spending for eligible beneficiaries and qualifying services based on state spending and program need without a limit. The federal share of Medicaid is determined by a formula set in statute that is based on a state's per capita income. The formula is designed so that the federal government pays a larger share of program costs in poorer states. The federal share (FMAP) varies by state from a floor of 50% to a high of 74% in 2017, and states may receive higher FMAPs for certain services or populations (Figure 1). In 2015, the federal government paid about 60% of total Medicaid costs with the states paying 40%.[1] Each quarter, states report their Medicaid costs (for qualified beneficiaries and services) to the federal government, and the federal government matches those costs at the state's matching rate.

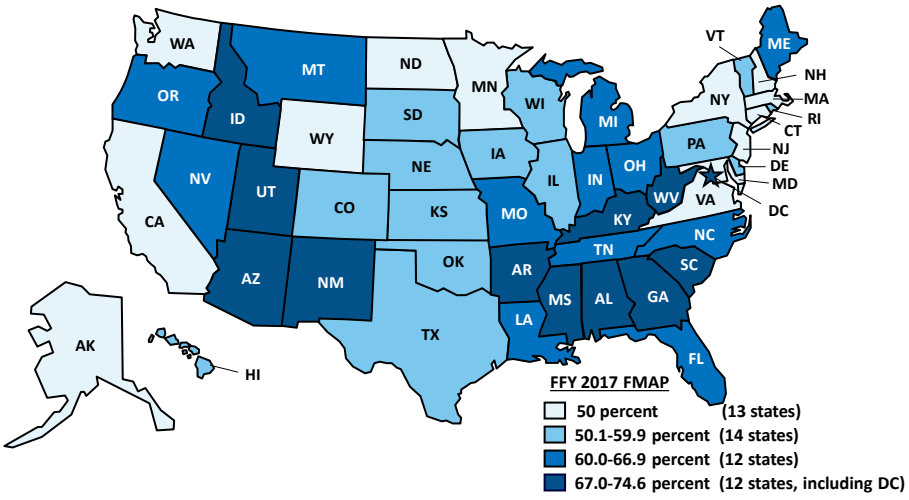
To participate in Medicaid and receive federal matching dollars, states meet core federal requirements. States must provide certain core benefits (e.g. hospital and physician and nursing home services) to core populations (e.g. poor pregnant women and children) without imposing waiting lists or enrollment caps. States may also receive federal matching funds to cover "optional" services (e.g., adult dental care) or "optional" groups (e.g., elderly with high medical expenses). States also have discretion as to how to purchase covered services (e.g., fee-for-service or managed care) and the amounts they pay providers. Based on program flexibility, spending per Medicaid enrollee varies significantly across eligibility groups and states.[2]

There are special match rates for the ACA, administration and other services. While the standard FMAP applies to the vast majority of Medicaid spending, there are a few exceptions that provide higher match rates for specific populations and services including family planning, some new options to expand community long-term care services, and most notably the Affordable Care Act (ACA) provided 100% federal financing for those made newly eligible by the law from 2014 to 2016 (with that match phasing down to 90% by 2020). A full list of these match rates is summarized in Appendix Table 1. In general, costs incurred by states in administering the Medicaid program are matched by the federal government at a 50 percent rate. There are, however, some types of administrative functions which are matched at higher rates such as eligibility and enrollment systems.[3] Medicaid administrative costs in general represent a relatively small portion of total Medicaid spending (5 percent or less).[4]

Medicaid also provides "disproportionate share hospital" payments to hospitals that serve a large number of Medicaid and low-income uninsured patients.[5] Federal DSH payments totaled $18.6 billion in FFY 2015.[6] While states have considerable discretion in determining the amount of DSH payments to each DSH hospital, federal DSH funds are capped for the state and also capped at the facility level. Based on the assumption of increased coverage and therefore reduced uncompensated care costs under the ACA, the law called for a reduction in federal DSH allotments starting in FFY 2014. The cuts were delayed until FFY 2018.

Figure 1

Medicaid costs are shared by the states and the federal government.



NOTE: FMAP percentages are rounded to the nearest tenth of a percentage point. These rates are in effect Oct. 1, 2016-Sept. 30, 2017. These FMAPs reflect the state's regular FMAP; they do not reflect the FMAP for newly eligibles in states that adopted the ACA Medicaid expansion.
SOURCE: Federal Register, November 25, 2015 (Vol. 80, No. 227), pp 73779-73782, available at https://www.gpo.gov/fdsys/pkg/FR-2015-11-25/pdf/2015-30050.pdf.

How much does Medicaid cost and how are funds spent?

Payment to managed care organizations (MCOs) account for 43% of Medicaid spending. In FY 2015, Medicaid spending on services totaled $532 billion. MCOs account for the largest share of Medicaid spending, about one-third of Medicaid spending is for other acute care services, 22% for fee-for-service long-term care, 3.5% for DSH and 3% for Medicaid spending for Medicare premiums and cost-sharing on behalf of dual eligible beneficiaries (Figure 2).

Almost two-thirds of all Medicaid spending for services is attributable to the elderly and persons with disabilities, who make up just one-quarter of all Medicaid enrollees (Figure 3). Dual eligible beneficiaries alone account for almost 40% of all spending, driven largely by spending for long-term care. The 5% of Medicaid beneficiaries with the highest costs drive more than half of all Medicaid spending. Their high costs are attributable to their extensive needs for acute care, long-term care, or often both.

Based on current flexibility in the Medicaid program, there is considerable variation in per enrollee costs across eligibility groups and across states. Total spending per full benefit enrollee ranged from a low of $4,010 in Nevada to $11,091 in Massachusetts in FY 2011 (Figure 4).[7] Spending for the elderly and individuals with disabilities may be more than four times the spending for an adult and more than seven times spending for an average child covered by the program.[8] In addition, even within a given state and eligibility group, per enrollee costs may vary significantly, particularly for individuals with disabilities.

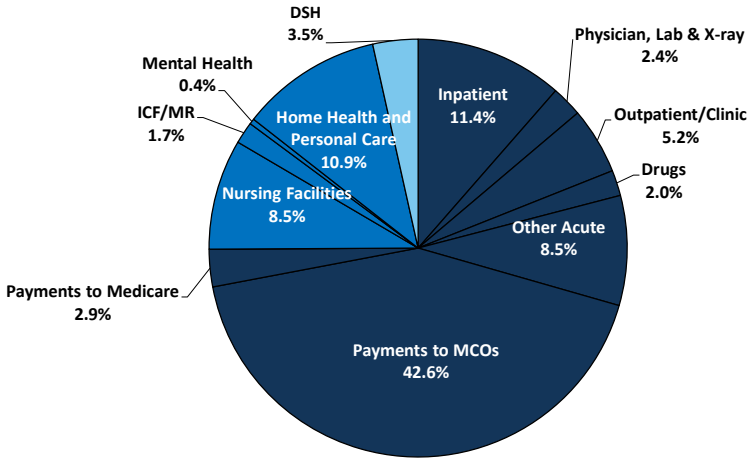
Medicaid enrollment and spending increases during recessions. Medicaid spending is driven by multiple factors, including the number and mix of enrollees, medical cost inflation, utilization, and state policy choices about benefits, provider payment rates, and other program factors. During economic downturns, enrollment in Medicaid grows, increasing state Medicaid costs at the same time that state tax revenues are declining. Figure 5 shows peaks in Medicaid spending and enrollment in 2002 and 2009 due to recessions.

Medicaid growth per enrollee has been lower than private health spending. States have incentives to constrain Medicaid spending by restricting payment rates, controlling prescription drug costs and through payment and delivery system reforms. Over the period 2007-2013, per-enrollee spending growth in Medicaid was 3.1% – on par with growth in national health expenditures per capita and medical cost inflation, and less than growth in private health insurance premiums per enrollee (Figure 6).

From January 2014 through September 2015 spending for the new adult expansion group was $105 billion, with the federal government paying $99 billion. For the new adult group, virtually all expenditures (94%) were paid for with federal funds (Figure 7).[9] This is because, under the ACA, the federal government paid for 100% of the costs of the expansion population for 2014-2016, with the federal share declining to 95% in 2017 and then gradually to 90% in 2020 and beyond. In contrast, federal funds comprised 58% of the costs for the traditional Medicaid population over the same period.

Figure 2

Medicaid Expenditures by Service, with DSH Payments and Payments to Medicare, FY 2015

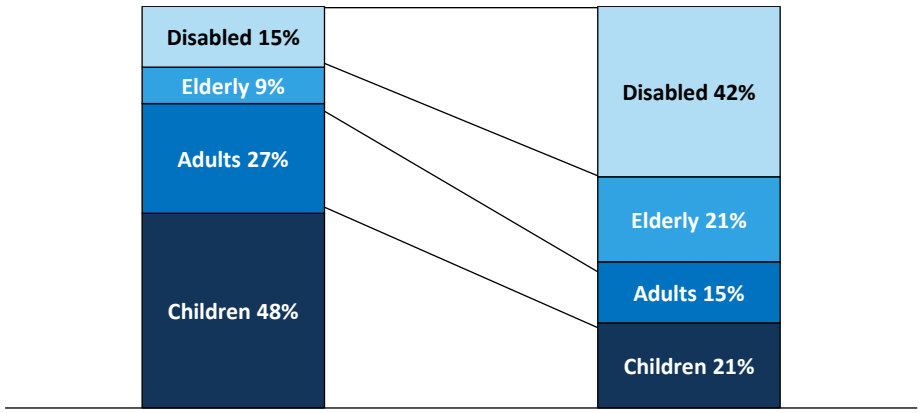


Total = $532.08 billion

NOTE: Excludes administrative spending, adjustments and payments to the territories.
SOURCE: Urban Institute estimates based on FY 2015 data from CMS (Form 64), prepared for the Kaiser Commission on Medicaid and the Uninsured.

Figure 3

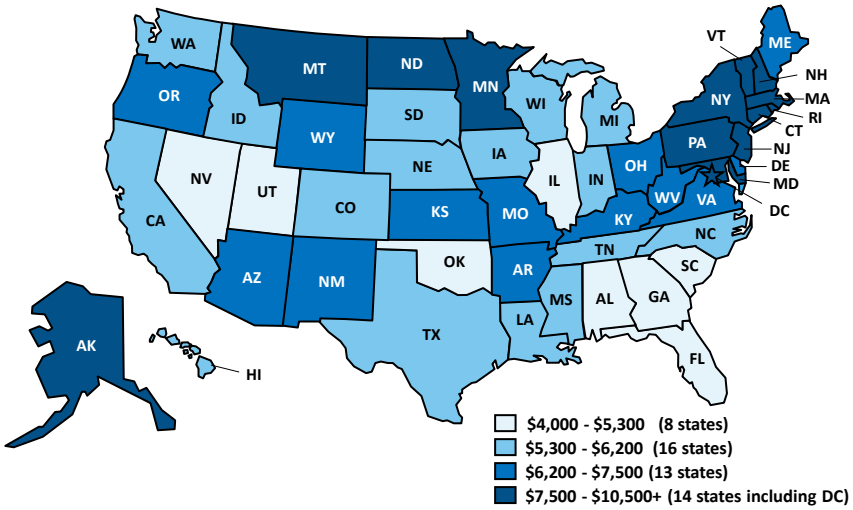
Medicaid spending is mostly for the elderly and people with disabilities, FY 2011.



SOURCE: KCMU/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT, but adjusted to 2011 CMS-64.

Figure 4

Spending per Medicaid enrollee in FY 2011 varies across states.

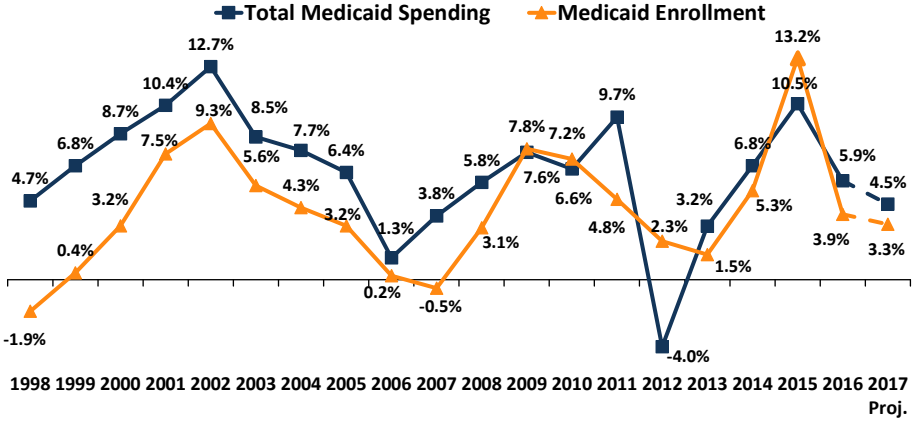


SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports. Because 2011 MSIS data were unavailable, 2010 MSIS & CMS-64 data were used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT.

Figure 5

Recessions and the implementation of the ACA resulted in peaks in total Medicaid spending and enrollment.

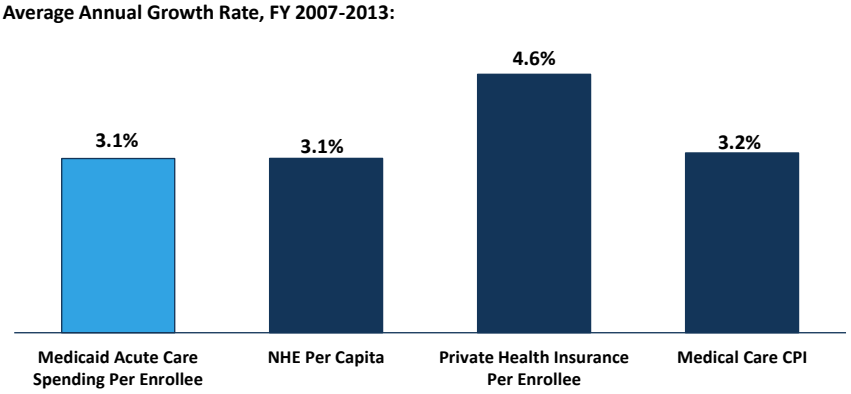
Annual Percentage Changes, FY 1998 – FY 2017



NOTE: For FY 1998-2013, enrollment percentage changes are from June to June of each year. FY 2014-2016 reflects growth in average monthly enrollment. Spending growth percentages refer to state fiscal year. FY 2017 data are projections based on enacted budgets.
SOURCE: Kaiser Family Foundation, *Medicaid Enrollment & Spending Growth: FY 2016 & FY 2017*; October 2016, available at: http://kff.org/medicaid/issue-brief/putting-medicaid-in-the-larger-budget-context-an-in-depth-look-at-four-states-in-fy-2016-and-fy-2017.

Figure 6

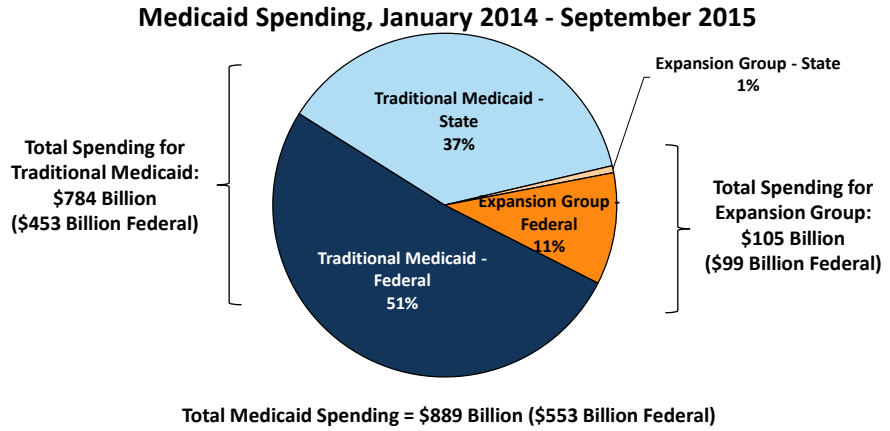
Growth in Per-Enrollee Medicaid Spending vs. Other Health Spending Benchmarks, 2007-2013



NOTE: Medicaid acute care spending includes payments to managed care organizations.
SOURCE: Medicaid estimates from Urban Institute analysis of data from the Medicaid Statistical Information System (MSIS), Medicaid Financial Management Reports (CMS Form 64), and Kaiser Commission and Health Management Associates data. NHE and private health insurance data from Centers for Medicare & Medicaid Services Office of the Actuary, National Health Statistics Group. Medical care CPI from the Bureau of Labor Statistics, Consumer Price Index Detail Report Tables.

Figure 7

From January 2014 - September 2015, spending for the expansion group totaled $105 billion ($99 billion in federal funds).



NOTES: Data for January 2014 through September 2015.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of Medicaid spending data collected from the Medicaid Budget and Expenditure System (MBES), Centers for Medicare and Medicaid Services, accessed December 2016. http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html

What is the role of Medicaid in the federal and state budgets?

Medicaid is the third largest domestic program in the federal budget following Medicare and Social Security (Figure 8). In FFY 2014, spending on Medicaid accounted for 9 percent of federal spending. Medicaid accounts for a lesser amount of federal spending compared to Medicare because program costs are shared by the federal government and the states. The Congressional Budget Office projects federal Medicaid spending and program enrollment to continue to grow over the coming decade due largely to the effects of the ACA changes such as the Medicaid expansion.

Medicaid is a spending item but also the largest source of federal revenues for state budgets. As a result of the federal matching structure, Medicaid has a unique role in state budgets as both an expenditure item and a source of federal revenue for states. In FY 2015, Medicaid accounted for 28.2 percent of total state spending for all items in the state budget, but 18.7 percent of all state general fund spending, a far second to spending on K-12 education (35.6 percent of state general fund spending).[10] Medicaid is the largest single source of federal funds for states, accounting for more than half (56.8 percent) of all federal funds for states in FY 2015 (Figure 9). Due to the match rate, as spending increases during economic downturns, so does federal funding. During these last two economic downturns, Congress has enacted legislation to temporarily increase the federal share of Medicaid spending to provide fiscal increased support for states to help fund Medicaid.

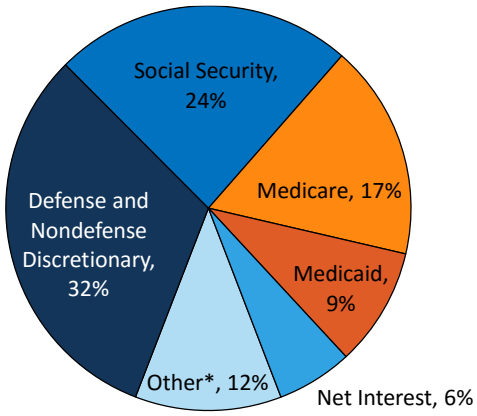
States can use provider taxes and IGTs (intergovernmental transfers) to help finance the state share of Medicaid. While federal funds have always represented the largest share of Medicaid financing (about $6 out of every $10 spent on the program), states have some flexibility to use funding from local governments or revenue collected from provider taxes and fees to help finance the state share of Medicaid. All states (except Alaska) have at least one provider tax in place and many states have more than three (Figure 10). How the non-federal share of Medicaid spending is financed continues to be a focus of federal law-makers.

In responding to two major recessions in the last 15 years, states have adopted an array of policies to control Medicaid spending growth. During economic downturns, enrollment grows but states have implemented policies to restrict provider reimbursement rates and trim benefits. Some of these restrictions are restored when the economy improves, but Medicaid payment rates tend to be below other payers. These lower payment rates have contributed to the programs relatively low costs. In addition, states have implemented an array of strategies to control the costs of prescription drugs and most states refine these policies each year. To address long-term strategies of cost control and coordinated care, more states have moved to implement a range of payment and delivery system reforms either using managed care organizations or other models.

Research shows that the influx of federal dollars from Medicaid spending has positive effects for state economies. Medicaid spending flows through a state's economy and can generate impacts greater than the original spending alone. The infusion of federal dollars into the state's economy results in a multiplier effect, directly affecting not only the providers who received Medicaid payments for the services they provide to beneficiaries, but indirectly affecting other businesses and industries as well. More recent analyses find positive effects of the Medicaid expansion on multiple economic outcomes, despite Medicaid enrollment growth initially exceeding projections in many states. Studies show that states expanding Medicaid under the ACA have realized budget savings, revenue gains, and overall economic growth.

Figure 8

Medicaid is the third largest domestic program in the federal budget.

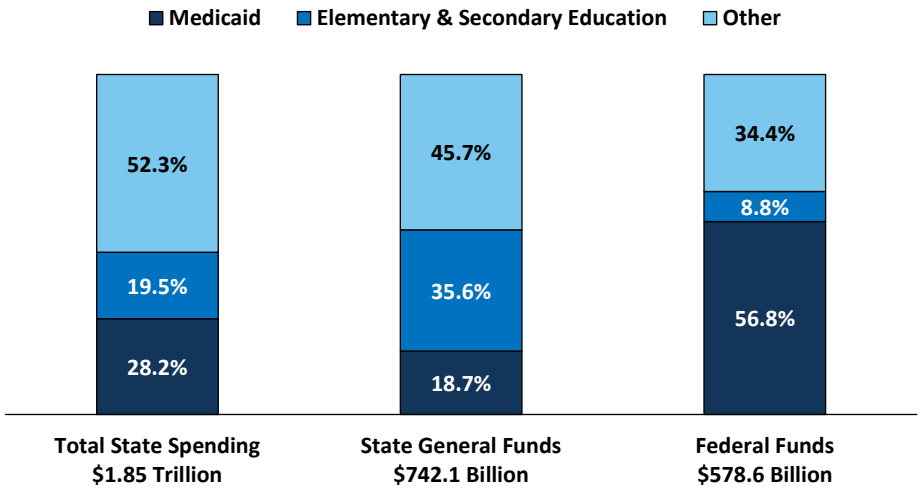


Actual FY 2015 Total Federal Outlays = $3.7 trillion

NOTE: FY is fiscal year. [1] Amount for Medicare is mandatory spending minus income from premiums and other offsetting receipts such as state contribution (clawback) payments to Medicare Part D. [2] "Other" category includes other mandatory outlays (such as CHIP and Health Insurance Marketplace premium subsidies) minus income from offsetting receipts.
SOURCE: Kaiser Family Foundation based on Congressional Budget Office, Budget and Economic Outlook Fiscal Years 2015-2025, January 2015.

Figure 9

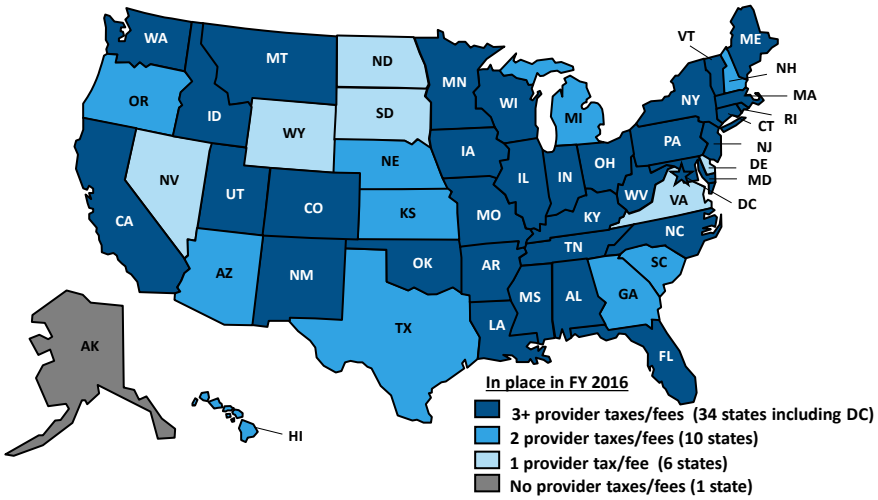
Medicaid is a budget item and a revenue item in state budgets.



SOURCE: Kaiser Commission on Medicaid and the Uninsured estimates based on the NASBO's November 2016 State Expenditure Report (data for Actual FY 2015.)

Figure 10

All states but Alaska have at least 1 provider tax and two-thirds of states have 3 or more provider taxes



NOTES: Includes Medicaid provider taxes as reported by states. States may have other taxes on health insurance premiums or health insurance claims that are not reflected here.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2016.

Looking Ahead

Looking ahead, proposals to fundamentally change Medicaid financing will be debated. President-elect Trump and other Republicans have proposed to transition Medicaid to a Medicaid block grant or per capita cap financing model for Medicaid. These models would fundamentally change the current structure of the program (Figure 11). These policies are typically designed to reduce federal spending and fix rates of growth to make federal spending more predictable, but could eliminate the guarantee of coverage for all who are eligible and the guarantee to states for matching funds. These proposals could be structured in a variety of ways. States could gain additional flexibility to administer their programs but reduced federal funding could shift costs and risk to beneficiaries, states, and providers.

Figure 11

A block grant or per capita cap would be a fundamental change to Medicaid financing.

	Current Medicaid Program	Block Grant	Per Capita Cap
Coverage	• Guaranteed coverage, no waiting list or caps	• No Guarantee (can use wait lists or caps)	• Guaranteed (maybe for certain groups)
Federal Funding	• Guaranteed, no cap • Responds to program needs (enrollment and health care costs) • Can fluctuate	• Capped • Not based on enrollment, costs or program needs • Fixed with pre-set growth	• Capped per enrollee • Not based on health care costs and needs • Fixed per enrollee
State Matching Payments	• Required to draw down federal dollars • Federal spending tied to state spending	• Unclear • Federal spending not tied to state spending beyond cap	• Unclear • Federal spending not tied to state spending beyond per enrollee cap
Core Federal Standards	• Set in law with state flexibility to expand	• Uncertain what the requirements would be to obtain federal funds	• Uncertain what the requirements would be to obtain federal funds

Appendix

Table 1: Special Federal Matching Percentages (FMAPs)		
Service/Population	**FMAP**	
Special FMAPs Enacted under the ACA		
Newly eligible, non-disabled adults under age 65 up to 138% FPL	100% 95% 94% 93% 90%	(1/14 – 12/16) (1/17 – 12/17) (1/18 – 12/18) (1/19 – 12/19) (1/20 & beyond)
Health Home Services*	90%	
State Balancing Incentive Program (BIP)**	State's FMAP + 5 or 2 percentage points	(10/11 – 9/15)
Community First Choice (CFC)***	State's FMAP + 6 percentage points	(10/11& beyond)
Clinical Preventive Services for Adults	State's FMAP + 1 percentage point	(1/13 & beyond)
Special FMAPs Predating the ACA		
Breast and Cervical Cancer Treatment	State's CHIP eFMAP rate[11]	
Family Planning Services	90%	
Indian Health Service and Tribal Facility Services[12]	100%	
Money Follows the Person Rebalancing Demo	MFP-enhanced FMAP***	

* These services are matched at the enhanced rate for eight calendar quarters. After that, spending is matched at the state's standard FMAP. States can adopt multiple Health Home SPAs targeting different populations at different times.
** The BIP makes enhanced Medicaid matching funds available to certain states that meet requirements for expanding the share of LTSS spending for HCBS (and reducing the share of LTSS spending for institutional services).
*** States electing the CFC state plan option to provide Medicaid-funded home and community-based attendant services and supports will receive an FMAP increase of six percentage points for CFC services.

Endnotes

[1] Kaiser Family Foundation, State Health Facts. Federal and State Share of Medicaid Spending, FY 2015. http://kff.org/medicaid/state-indicator/federalstate-share-of-spending/.

[2] Katherine Young, Robin Rudowitz, Saman Rouhani, and Rachel Garfield, *Medicaid Per Enrollee Spending: Variation Across States* (Washington, DC: Kaiser Family Foundation, January 28, 2015), http://kff.org/medicaid/issue-brief/medicaid-per-enrollee-spending-variation-across-states/.

[3] To assist states with these investments and system upgrades, federal regulations provided for an increase in the administrative match rate - 90 percent federal funding for necessary investments in information technology, along with 75 percent federal match for operating expenses. The 90 percent match rate for initial eligibility-related IT investments was initially set to expire at the end of 2015, but CMS recently released a proposal to extend the higher federal match rate permanently. Centers for Medicare & Medicaid Services (CMS). *Notice of Proposed Rulemaking: Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10.)* (Washington, DC: Federal Register,) April 16, 2015. https://www.federalregister.gov/articles/2015/04/16/2015-08754/medicaid-program-mechanized-claims-processing-and-information-retrieval-systems-9010#h-9.

[4] Urban Institute estimates based on data from CMS (Form 64) (as of 9/16/13).

[5] To qualify as a DSH hospital a hospital must meet two minimum qualifying criteria. The first criterion is that the hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid patients (except when the hospital predominantly serves children under 18 years or the hospital does not offer obstetric services to the general public). The second criterion is that the hospital has a Medicaid inpatient utilization rate (MIUR) of at least 1 percent. A hospital is deemed as a DSH if the hospital's MIUR is at least one standard deviation above the mean MIUR in the state, or if the hospital's low-income utilization rate exceeds 25 percent.

[6] Kaiser Family Foundation, State Health Facts. Distribution of Medicaid Spending by Service, FY 2015. http://kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/.

[7] Young, Rudowitz, Rouhani, and Garfield, *op. cit.*

[8] *Ibid.*

[9] In some states that had expanded coverage to adults prior to the ACA, the new adult group includes some adults that were previously eligible through these pre-ACA expansions. These adults may be matched at a rate lower than the 100% rate for 2014-2016.

[10] Robin Rudowitz, Allison Valentine, and Vernon K. Smith, *Medicaid Enrollment & Spending Growth: FY 2016 & 2017* (Washington, DC: Kaiser Family Foundation, October 13, 2016), http://kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2016-2017/.

[11] Enhanced Federal Medical Assistance Percentages (eFMAPs) are for the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. Section 2105(b) of the Act specifies the formula for calculating Enhanced Federal Medical Assistance Percentages. For FFY 2015, the eFMAPs range from a floor of 65 percent to 81.51%. These rates do not take into account the increase included under Section 2101(a) of the Affordable Care Act amended which would increase eFMAPs by 23 percentage points (not to exceed 100 percent) this increase is scheduled to begin in FFY 2016.

State Health Facts, Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP, (Washington, DC: Kaiser Family Foundation), downloaded March 2015. http://kff.org/other/state-indicator/enhanced-federal-matching-rate-chip/.

[12] Section 402(e) of the Indian Health Care Improvement Act of 1976, P.L. 94-437.