

# Medicaid Financing: The Basics

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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 care needs of their low-income residents. Medicaid is administered by states within broad federal rules and jointly funded by states and the federal government. This brief examines the following three key Medicaid financing questions:

**How does Medicaid financing work?** Medicaid provides a guarantee of federal matching payments with no pre-set limit. The statute sets a formula to determine the share paid by the federal government (that varies based on states' relative per capita income) and also provides special match rates for the ACA Medicaid expansion, administration, and other services. The matching structure provides states with resources that automatically adjust for demographic and economic shifts, health care costs, public health emergencies, natural disasters and changing state priorities. Medicaid also provides "disproportionate share hospital" (DSH) payments to hospitals serving many Medicaid and uninsured patients.

**How much does Medicaid cost and how are funds spent?** In terms of services, payments to private managed care organizations (MCOs) account for 46% of Medicaid spending.<sup>1</sup> Almost two-thirds of all Medicaid spending is for the elderly and persons with disabilities, who make up just one in four enrollees. The Medicaid expansion, financed primarily with federal dollars, accounts for a relatively small share (14%) of total Medicaid spending. Recessions, rising costs of prescription drugs, and increasing needs for long-term care and behavioral health services are factors that put upward pressure on Medicaid spending growth. However, over time, Medicaid growth per enrollee has been lower than private health spending.

**What is the role of Medicaid in federal and state budgets?** Medicaid is the third largest mandatory program in the federal budget. For states, Medicaid is a spending item but also the largest source of federal revenues. Research shows federal dollars from Medicaid, including additional federal dollars for the ACA Medicaid expansion, has positive effects for state economies. Expansion states have greater fiscal capacity and spend more on Medicaid and education than non-expansion states.

Because Medicaid plays a large role in both federal and state budgets and is the primary source of coverage for low-income Americans, it is a constant source of debate. Efforts to repeal and replace the ACA and cap federal funding through a block grant or per capita cap were narrowly defeated in 2017, but were included in President Trump's proposed budget for FY 2020. States continue to focus on efforts to constrain Medicaid costs while federal administrative efforts may focus on providing states additional flexibility to administer their programs through waivers. These state and federal policy priorities and actions could have implications for Medicaid costs and coverage.

## How does Medicaid financing work?

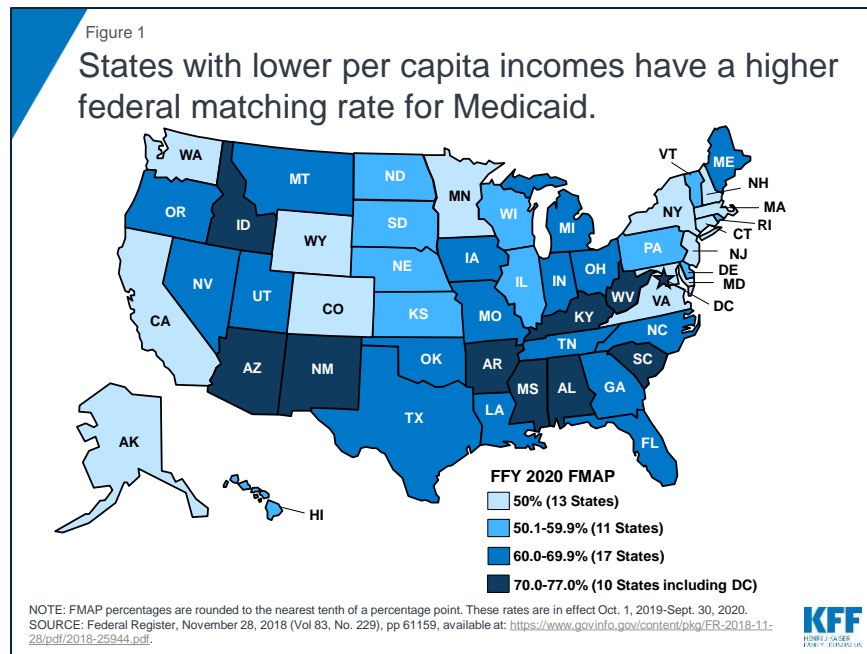
**Under current law, Medicaid provides a guarantee to individuals eligible for services and to states for federal matching payments with no pre-set limit.** Medicaid provides an entitlement to income eligible individuals. The federal government matches state spending for eligible beneficiaries and qualifying 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 percent to a high of 77 percent in 2020, and states may receive higher FMAPs for certain services or populations (Figure 1).<sup>2</sup> In 2017, the federal government paid more than 60 percent of total Medicaid costs with the states paying about 40 percent.<sup>3</sup> 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.**<sup>4</sup> States must provide certain core benefits (e.g. hospital, 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 to determine how to purchase covered services (e.g., through fee-for-service or managed care arrangements) and to set provider payment amounts. Based on program flexibility, spending per Medicaid enrollee varies significantly across eligibility groups and states.<sup>5</sup>

**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 percent federal financing for those made newly eligible by the law from 2014 to 2016 (with that match phasing down to 90 percent by 2020). 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.<sup>6</sup> Medicaid administrative costs in general represent a relatively small portion of total Medicaid spending (5 percent or less).<sup>7</sup>

**Medicaid also provides "disproportionate share hospital" (DSH) payments to hospitals that serve a large number of Medicaid and low-income uninsured patients.**<sup>8</sup> Federal DSH payments totaled \$15.1 billion in FFY 2017.<sup>9</sup> 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 have been delayed several times and are currently set to take effect in FFY 2020.

Unlike in the 50 states and D.C., annual federal funding for [Medicaid in the territories is subject to a statutory cap and fixed matching rate](#). Notwithstanding temporary relief funds, once a territory exhausts its capped federal funds, it no longer receives federal financial support for its Medicaid program during that fiscal year. This places additional pressure on territory resources if Medicaid spending continues beyond the federal cap – making the *effective* match rate lower than what is set in statute. The ACA included \$7.3 billion in additional funds available across all five territories under the ACA, but most of these funds expire at the end of September 2019. The ACA also increased the traditional territory FMAP from 50 percent to 55 percent (plus 2.2 percentage points for 2014 and 2015) and provided the territories with a higher matching rate for non-disabled adults without children (87 percent in 2017). Puerto Rico and United States Virgin Islands (USVI) received additional funds with 100 percent match rate after [Hurricanes Irma and Maria hit Puerto Rico and the USVI in September 2017](#). However, these funds also expire at the end of September 2019.



## How much does Medicaid cost and how are funds spent?

**Capitated payments to health plans and for other Medicaid managed care (e.g., PCCM arrangements) account for 49 percent of Medicaid spending.** In FY 2017, Medicaid spending on services totaled \$576.6 billion.<sup>10</sup> Managed care and health plans<sup>11</sup> accounted for the largest share of Medicaid spending (48.9 percent) (with the majority of that share (45.8 percent) being payments to MCOs), 24.6 percent of Medicaid spending is for fee-for-service acute care (24.6 percent), 20.6 percent for fee-for-service long-term care, 2.6 percent for DSH and 3.3 percent for Medicaid spending for Medicare premiums and cost-sharing on behalf of dual eligible beneficiaries (Figure 2).<sup>12</sup>

**Almost two-thirds of all Medicaid spending for services is attributable to the elderly and persons with disabilities, who make up less than one-quarter of all Medicaid enrollees (Figure 3).** Dual eligible beneficiaries alone account for almost 40 percent of all spending, driven largely by spending for long-term care.<sup>13</sup> The 5 percent of Medicaid beneficiaries with the highest costs drive more than half of all Medicaid spending.<sup>14</sup> Their high costs are attributable to their extensive needs for acute care, long-term care, or often both.

**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 4 shows peaks in Medicaid spending and enrollment in 2002 and 2009 due to recessions. [Enrollment and spending](#) also increased significantly following implementation of the ACA, but have moderated in more recent years. While slower caseload growth has helped to [mitigate Medicaid spending growth in recent years](#), higher costs for prescription drugs, long-term services and supports and behavioral health services, as well as state policy decisions to implement targeted provider rate increases have been recently cited as factors putting upward pressure on Medicaid spending.<sup>15</sup>

**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 \$4,003 in Nevada to \$10,721 in North Dakota in FY 2014 (Figure 5).<sup>16</sup> 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 (Figure 6).<sup>17</sup> In addition, even within a given state and eligibility group, per enrollee costs may vary significantly, particularly for individuals with disabilities.

**Medicaid growth per enrollee has been lower than private health spending.** Because states share in the financing of Medicaid and states must balance their budgets annually, there is an incentive to constrain Medicaid spending. States seek to control costs by restricting payment rates, controlling prescription drug costs, and through implementing payment and delivery system reforms. Medicaid per

enrollee spending grew slower than Medicare, national health expenditures, and private health insurance for all time periods from 2007 to 2017 (Figure 7).<sup>18</sup>

**In FY 2017, spending for the new adult expansion group was \$76 billion, with the federal government paying \$72 billion.** For the new adult expansion group, the vast majority of expenditures (94 percent) were paid for with federal funds (Figure 8).<sup>19</sup> After receiving a 100 percent federal match rate for the expansion group for CYs 2014-2016, states began paying 5 percent of the costs of the ACA Medicaid expansion group starting in January 2017 (and 6 percent beginning in January 2018). In contrast, federal funds comprised 57 percent of the costs for the traditional Medicaid population over the same period. In addition, the overall expansion group still represents a relatively small share of the total Medicaid spending (14 percent).

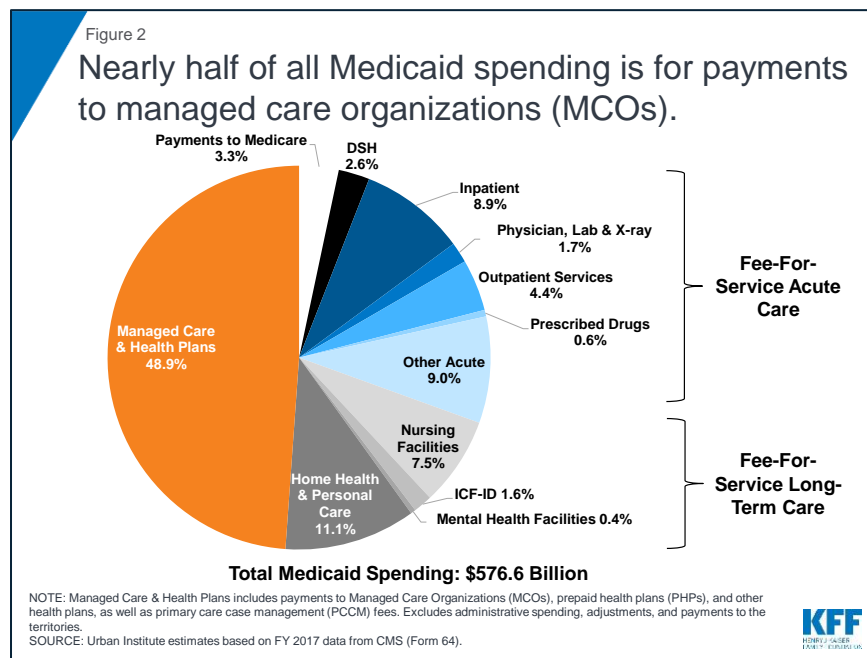
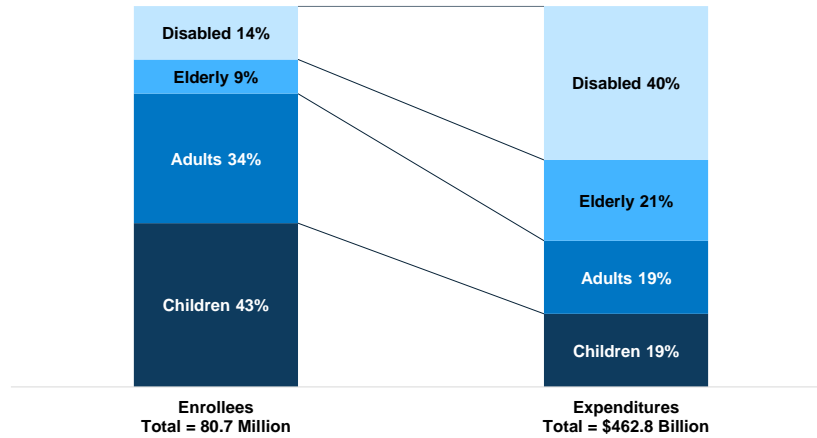


Figure 3

Medicaid spending is mostly for the elderly and people with disabilities, FY 2014.

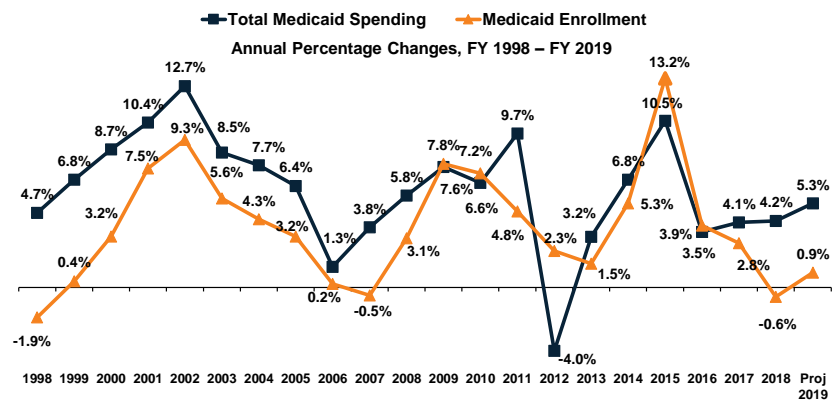


SOURCE: Kaiser Family Foundation estimates based on analysis of data from the 2014 Medicaid Statistical Information System (MSIS) and Urban Institute estimates from CMS-64 reports. Adjustments were made for the following states: AL, AK, CO, DE, DC, FL, IL, KS, KY, ME, MD, MT, NV, NH, NM, NC, ND, RI, SC, TX, and WI.



Figure 4

Medicaid enrollment and spending growth peaked during economic downturns and with implementation of the ACA.

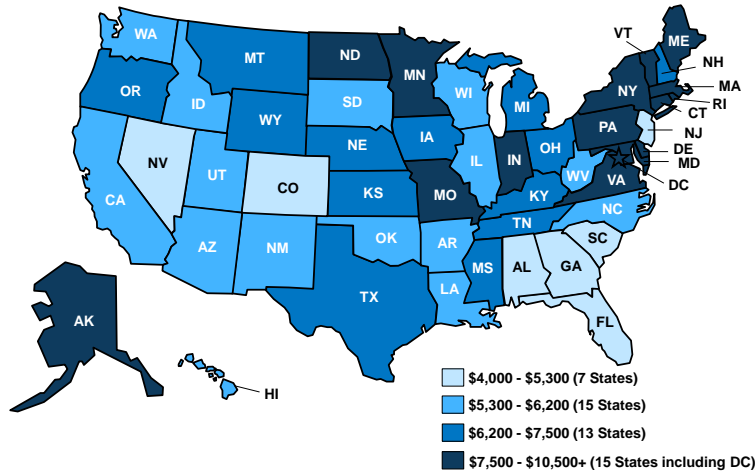


NOTE: Spending growth percentages refer to state fiscal year (FY).  
 SOURCE: FY 2018-2019 spending data and FY 2019 enrollment data are derived from the KFF survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2018; historic data from various sources including: Medicaid Enrollment June 2013 Data Snapshot, KCMU, January 2014. FY 2014-2018 are based on KFF analysis of CMS, Medicaid & CHIP Monthly Applications, Eligibility Determinations, and Enrollment Reports and from KFF Analysis of CMS Form 64 Data.



Figure 5

Medicaid spending per full-benefit enrollee in FY 2014 varies across states.

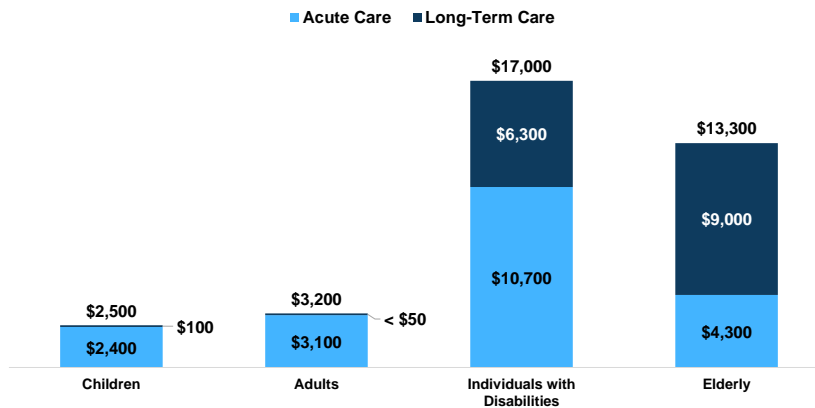


SOURCE: Kaiser Family Foundation estimates based on analysis of data from the 2014 Medicaid Statistical Information System (MSIS) and Urban Institute estimates from CMS-64 reports. Adjustments were made for the following states: AL, AK, CO, DE, DC, FL, IL, KS, KY, ME, MD, MT, NV, NH, NM, NC, ND, RI, SC, TX, and WI.



Figure 6

Medicaid per enrollee spending is significantly greater for the elderly and individuals with disabilities compared to children and adults, FY 2013.

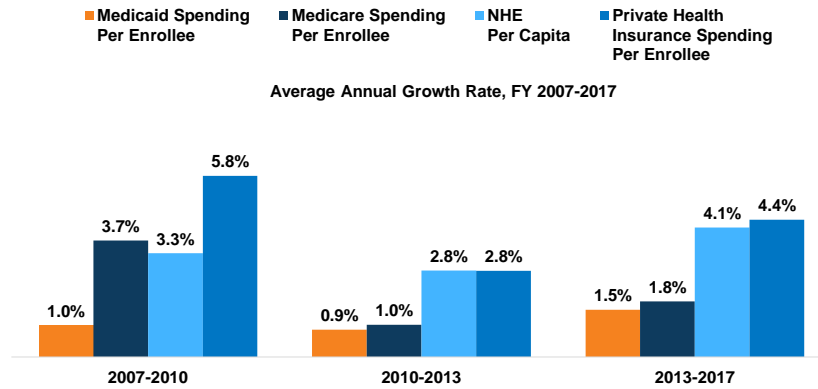


NOTE: Rounded to nearest \$100. Spending may not sum to totals due to rounding.  
 SOURCE: Kaiser Family Foundation and Urban Institute estimates based on data from FY 2013 MSIS and CMS-64 reports. Due to lack of data, does not include CO, KS, NC, or RI.



Figure 7

### Medicaid spending per-enrollee has increased slower than Medicare and private insurance.



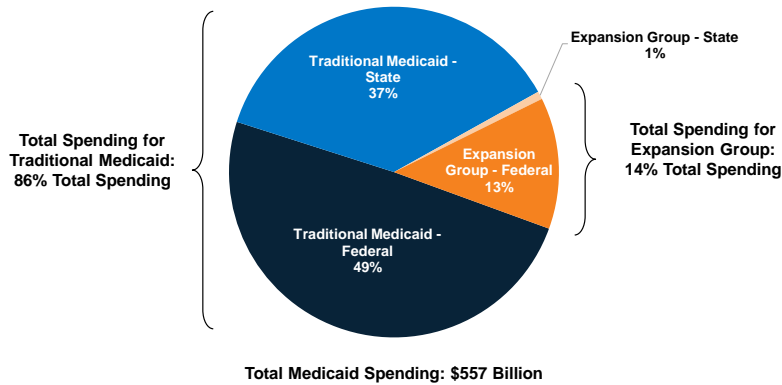
NOTE: Medicaid spending per enrollee includes both acute care and long-term care spending.  
 SOURCE: Kaiser Family Foundation estimates based on National Health Expenditure Data from the Centers for Medicare & Medicaid Services Office of the Actuary, available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html>.



Figure 8

### The Medicaid expansion accounted for 14% of overall spending in FY 2017, and is primarily federal funds.

Medicaid Spending By Traditional and Expansion Groups, FY 2017



NOTE: Totals may not sum to 100% due to rounding. These values reflect all states in FY 2017, except for NY which uses FY 2016 data, due to the large adjustments in NY in 2017.  
 SOURCE: Kaiser Family Foundation analysis of Medicaid spending data from the Centers for Medicare and Medicaid Services (CMS) Medicaid Budget and Expenditure System (MBES).





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

**Medicaid is the third largest mandatory spending program in the federal budget following Medicare and Social Security (Figure 9).** In FFY 2018, spending on Medicaid accounted for 9 percent of federal spending.<sup>20</sup> 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 (CBO) notes that growth in the elderly population is projected to increase spending for some programs including Medicaid. Overall, CBO projects Medicaid spending growth of about 4 percent per year through 2021 and 6 percent per year from 2022 through 2029; higher out-year growth rate is attributed to increases in spending per enrollee and higher projected unemployment, which would increase enrollment in the Medicaid program.<sup>21</sup>

**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 SFY 2017, Medicaid accounted for 26.5 percent of total state spending for all items in the state budget, but 14.2 percent of all state general and other fund spending,<sup>22</sup> a far second to spending on K-12 education (24.8 percent<sup>23</sup> of state general and other fund spending). Medicaid is the largest single source of federal funds for states, accounting for more than half (55.1 percent) of all federal funds for states in FY 2017 (Figure 10).<sup>24</sup> Due to the match rate, as spending increases during economic downturns, so does federal funding. During the last two economic downturns, Congress enacted legislation to temporarily increase the federal share of Medicaid spending to provide 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.** 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 11).<sup>25</sup> 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.<sup>26</sup>

**State spending on Medicaid reflects spending priorities, as well as capacity and policies, to raise revenues.** The typical expansion state had greater tax capacity whether measured by personal income, GDP, or total taxable resources (TTR) per capita. Tax capacity was about 12 percent higher for personal income and GDP in the median expansion state in 2017 and 15 percent higher for TTR in the median expansion state in 2016 compared to non-expansion states (Figure 12). Given greater tax capacity, as well as greater tax effort, expansion states are able spend more per capita on Medicaid and other services including education as shown in Figure 13.

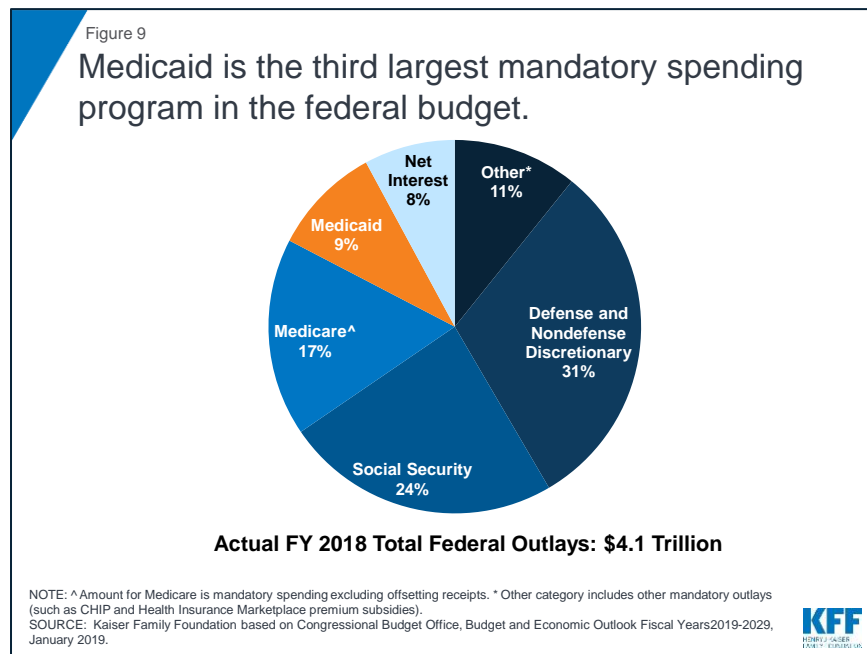
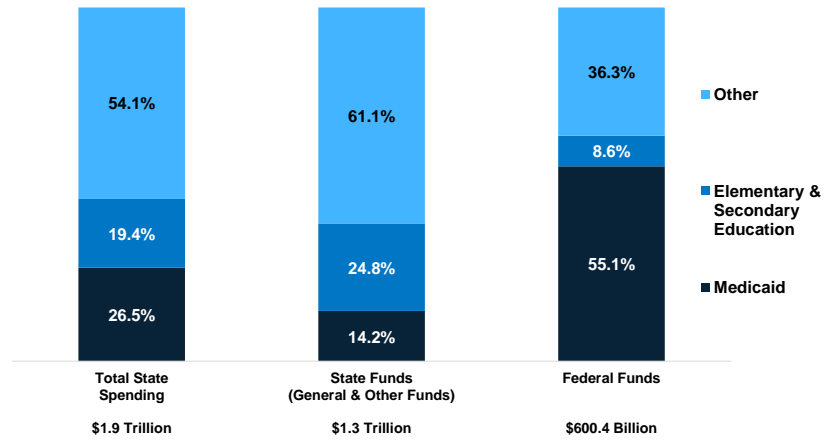


Figure 10

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

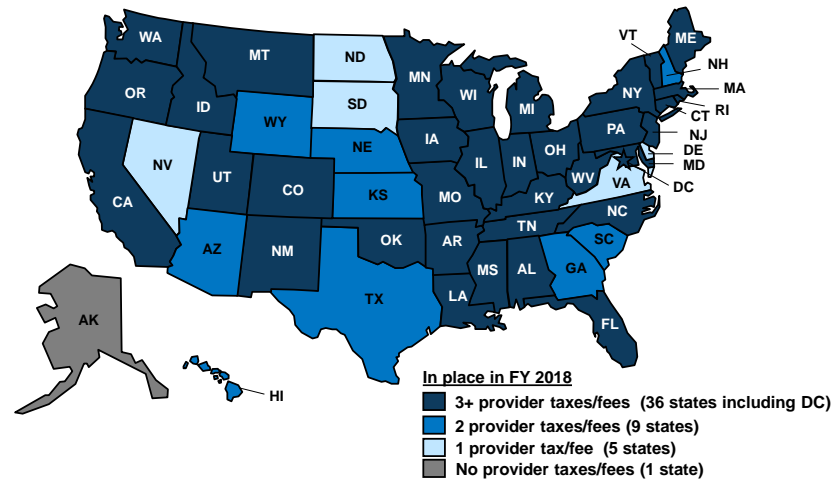


SOURCE: Kaiser Family Foundation estimates based on the National Association of State Budget Officers (NASBO) 2018 State Expenditure Report: Fiscal Years 2016-2018 (data for Actual SFY 2017).



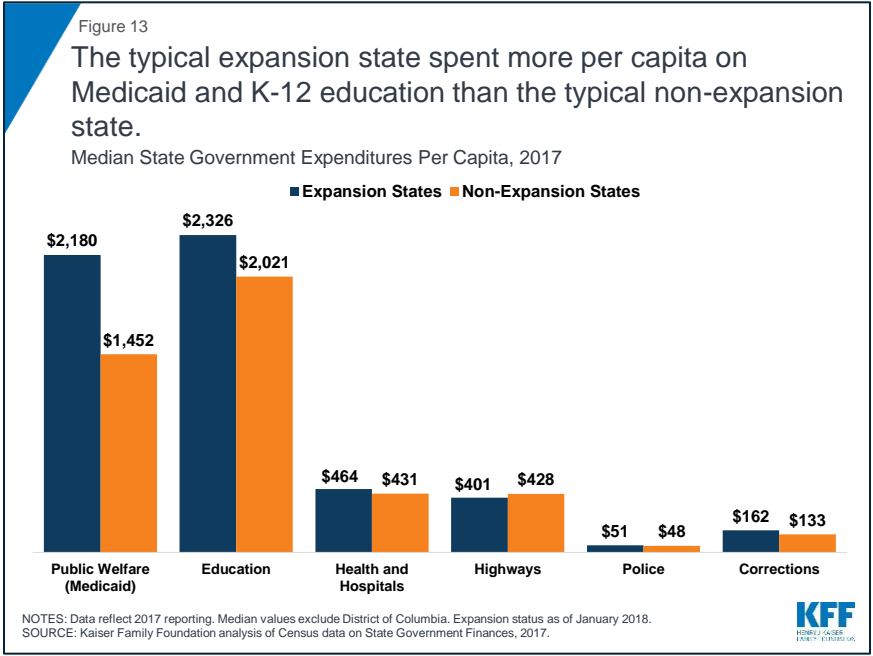
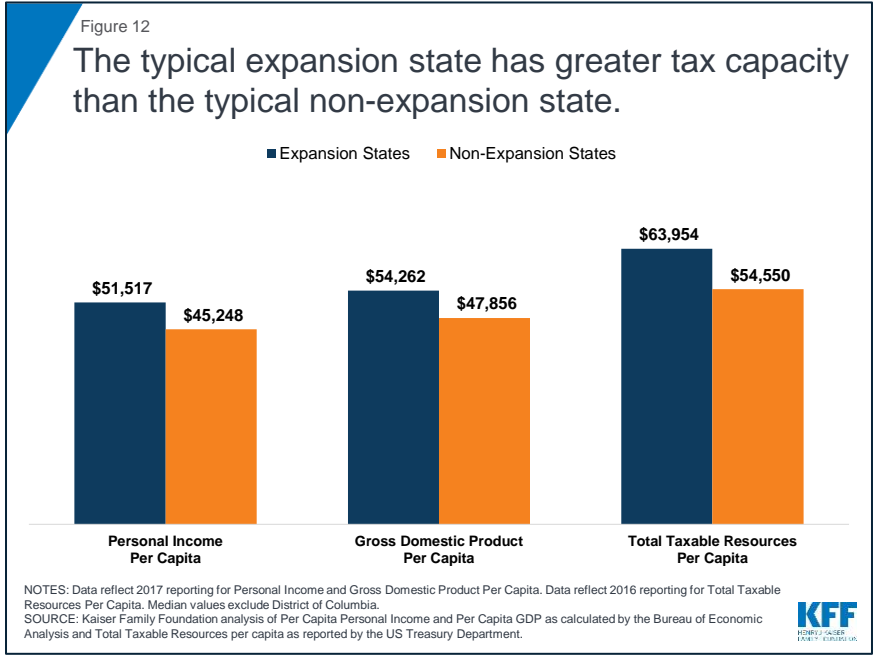
Figure 11

All states but Alaska have at least one provider tax and two-thirds of states have three 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: Kaiser Family Foundation survey of Medicaid officials in 50 states and DC conducted by HMA, October 2018.





## Looking Ahead

Because Medicaid plays a large role in both federal and state budgets and is the primary source of coverage for low-income Americans, it is a constant source of debate. Efforts to repeal and replace the ACA and cap federal funding through a block grant or per capita cap were narrowly defeated in 2017, but were included in President Trump's proposed budget for FY 2020. States continue to focus on efforts to constrain Medicaid costs while federal administrative efforts may focus on providing states additional flexibility to administer their programs through waivers. As a result, Medicaid financing and the cost pressures at both the federal and state levels remain central to the ongoing policy debates, with implications for the future structure and role of Medicaid.

## Endnotes

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- <sup>1</sup> Kaiser Family Foundation, State Health Facts. Total Medicaid MCO Spending, FY 2017. <https://www.kff.org/other/state-indicator/total-medicaid-mco-spending/>.
- <sup>2</sup> Federal Register, November 28, 2018 (Vol 83, No. 229), pp 61159, available at: <https://www.govinfo.gov/content/pkg/FR-2018-11-28/pdf/2018-25944.pdf>.
- <sup>3</sup> Kaiser Family Foundation, State Health Facts. Federal and State Share of Medicaid Spending, FY 2017. <http://kff.org/medicaid/state-indicator/federalstate-share-of-spending/>.
- <sup>4</sup> Samantha Artiga, Elizabeth Hinton, Robin Rudowitz, and MaryBeth Musumeci, *Current Flexibility in Medicaid: An Overview of Federal Standards and State Options*, (Washington, DC: Kaiser Family Foundation, January 31, 2017), <https://www.kff.org/medicaid/issue-brief/current-flexibility-in-medicaid-an-overview-of-federal-standards-and-state-options/>.
- <sup>5</sup> Kaiser Family Foundation, State Health Facts. Medicaid Spending Per Full-Benefit Enrollee, FY 2014. <https://www.kff.org/medicaid/state-indicator/medicaid-spending-per-full-benefit-enrollee/>.
- <sup>6</sup> 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>.
- <sup>7</sup> Urban Institute estimates based on data from CMS (Form 64), FY 2017.
- <sup>8</sup> 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.
- <sup>9</sup> Kaiser Family Foundation, State Health Facts. Distribution of Medicaid Spending by Service, FY 2017. <http://kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/>.
- <sup>10</sup> Kaiser Family Foundation, State Health Facts. Total Medicaid Spending, FY 2017. <https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/>.
- <sup>11</sup> Managed care and health plans includes payments to Managed Care Organizations (MCOs), prepaid health plans (PHPs), and other health plans, as well as primary care case management (PCCM) fees.
- <sup>12</sup> Urban Institute estimates based on data from CMS (Form 64), as of August 2018.
- <sup>13</sup> Kaiser Family Foundation, State Health Facts. Dual Eligibles' Share of Medicaid Spending. <https://www.kff.org/medicaid/state-indicator/duals-share-of-medicaid-spending/>.
- <sup>14</sup> Kaiser Family Foundation estimates based on data from FY 2013 MSIS and CMS-64.
- <sup>15</sup> Robin Rudowitz, Elizabeth Hinton, and Larisa Antonisse, *Medicaid Enrollment & Spending Growth: FY 2018 & 2019* (Washington, DC: Kaiser Family Foundation, October 25, 2018), <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2018-2019/>.
- <sup>16</sup> Kaiser Family Foundation, State Health Facts. Medicaid Spending Per Full-Benefit Enrollee, FY 2014. <https://www.kff.org/medicaid/state-indicator/medicaid-spending-per-full-benefit-enrollee/>.
- <sup>17</sup> *Ibid.*

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<sup>18</sup> Medicaid spending per enrollee includes long-term care spending, while Medicare and private health insurance generally cover and pay for very limited long-term care. [Previous analysis](#) has suggested that Medicaid acute care per enrollee spending has typically increased more quickly than long-term care per enrollee spending. Without recent administrative data, we cannot analyze the current effects of long-term care being included in Medicaid per enrollee spending growth, but it is possible that inclusion of such spending has contributed to overall low Medicaid growth in recent years.

<sup>19</sup> 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.

<sup>20</sup> Kaiser Family Foundation based on Congressional Budget Office, Budget and Economic Outlook Fiscal Years 2019-2029, January 2019.

<sup>21</sup> Congressional Budget Office, *The Budget and Economic Outlook: 2019 to 2029* (Washington, D.C.: Congress of the United States, January 2019), <https://www.cbo.gov/system/files?file=2019-01/54918-Outlook.pdf>.

<sup>22</sup> Kaiser Family Foundation, State Health Facts. Medicaid Expenditures as a Percent of Total State Expenditures by Fund, SFY 2017. <https://www.kff.org/medicaid/state-indicator/medicaid-expenditures-as-a-percent-of-total-state-expenditures-by-fund/>.

<sup>23</sup> Kaiser Family Foundation, State Health Facts. Distribution of State Expenditures (Percent). <https://www.kff.org/other/state-indicator/distribution-of-state-spending/>.

<sup>24</sup> Kaiser Family Foundation estimates based on the National Association of State Budget Officers (NASBO) 2018 State Expenditure Report: Fiscal Years 2016-2018 (data for Actual FY 2017).

<sup>25</sup> Kaiser Family Foundation survey of Medicaid officials in 50 states and DC conducted by HMA, October 2018.

<sup>26</sup> Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Samantha Artiga, *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review* (Washington, D.C.: Kaiser Family Foundation, March 2018), <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicare-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/>.