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Medicaid and the Current State Fiscal Crisis

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Summary

Medicaid, a health insurance program funded jointly by the federal government and the states, is facing a period of quickly escalating costs at a time when the need (as measured by the number of uninsured) among the population it serves — the low-income disabled, families and elderly — is rising. The pressures of quickly rising costs and increasing need are driving legislative attention both at the state and federal levels. Between FY2000 and FY2003, the annual growth rate of federal Medicaid expenditures was 11.3%.

States, which cannot use deficit spending, have been facing fiscal pressures from recent declines or slower growth rates for general state revenues due to the economic downturn and constraints on the states' use of creative financing mechanisms. Medicaid is frequently pointed to as a significant contributor to these fiscal pressures. This is not the first time that Medicaid has been a fiscal flash point. In the mid-nineties, the Congress passed legislation to repeal the Medicaid program and replace it with a fixed grant program. President Clinton vetoed this effort. The period of economic growth in the 1990s relieved some of the fiscal pressures. In recent years however, the fiscal pressures have returned.

The joint nature of the Medicaid program means that program policy changes can occur at either (or both) the federal and state level. For states, making significant cuts in the Medicaid program is challenging because some of the quickly growing cost items such as nursing facility care are federally required. In addition, cutting the program when unemployment is high and the number of uninsured is growing is politically unpopular. As a result, states have combined to lobby for fiscal relief from the Congress.

In the 108th Congress, the Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA, P.L. 108-027) provided temporary fiscal relief to states through a combination of grants and an increase in the federal medical assistance percentage. Alternatively, the Bush Administration has proposed various options to control Medicaid spending including waivers through the Health Insurance Flexibility and Accountability (HIFA) initiative and a Medicaid reform proposal. In addition, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) provided some fiscal relief to states by temporarily increasing disproportionate share to hospital (DSH) allotments and increasing the floor for DSH allotments for certain states. However, P.L. 108-173 also created a prescription drug benefit under the Medicare program. The prescription drug benefit, which will begin in 2006, will be partially funded by the states.

This report describes Medicaid financing mechanisms, some of the factors that contribute to the program's spending growth, how Medicaid fits into state budgets, what avenues some states are using to control Medicaid spending growth in their budgets, and federal legislative and administrative proposals aimed at affecting the program's fiscal impact. This report will be updated as legislative activities warrant.

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Medicaid and the Current State Fiscal Crisis

Medicaid

Medicaid is a health insurance program jointly funded by the federal government and the states. While states have considerable flexibility to design and administer their Medicaid programs, certain groups of individuals must be covered for certain categories of services. Generally, eligibility is limited to low-income children, pregnant women, parents of dependent children, the elderly, and people with disabilities. The federal government's share of Medicaid costs is determined by a formula included in statute; states must contribute the remaining portion of costs in order to qualify for federal funds.

In fiscal year (FY) 2004, Medicaid enrollment was estimated at 54.9 million including 25.7 million children, and 14.0 million aged, blind, or disabled individuals.[1] In FY2002,[2] total (state and federal) Medicaid (medical assistance and administration) payments were $258.2 billion. Medical assistance payments were $246.3 billion, with the four largest categories being: nursing facilities — 19.3% of the total; prepaid health care (capitation payments - managed care organizations) — 13.3%; inpatient hospital services — 12.7%; and prescription drugs — 9.5%.

The 10 largest states in terms of total medical assistance payments in FY2002 were New York, California, Texas, Pennsylvania, Florida, Ohio, Illinois, Massachusetts, New Jersey, and Michigan. They accounted for 57.1% of total Medicaid medical assistance payments. Nine of the 10 are also in the top 10 states for total population.[3]

Medicaid Financing

Medicaid is jointly funded by the states and the federal government. Generally, the federal share of Medicaid is based on a matching percentage. A state must pay its share of Medicaid program costs to receive matching federal payments. However, the simple mechanism of a federal matching percentage for Medicaid program service costs becomes more complicated when combined with two special provisions for reimbursement: (1) the required payment adjustments for hospitals

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[1] Centers for Medicare and Medicaid Services, 2004 CMS Statistics, Table 11, available at [http://www.cms.hhs.gov/researchers/pubs/CMSstatistics/2004CMSstat.pdf]. The balance of the enrollees (15.3 million) are adults. Children participating in the State Children's Health Insurance Program (SCHIP) through a Medicaid expansion are not included.

[2] Calculations by the Congressional Research Service based on Form 64 data (Financial Management Report) provided by the Centers for Medicare and Medicaid Services, Jan. 2004.

[3] Massachusetts ranks 13th in terms of population.

(disproportionate share payments to hospitals, known as DSH) that serve a large number of low-income or Medicaid patients; and (2) the upper payment limits (UPLs) for services by type of provider and provider ownership (private or public). These two financing mechanisms allowed under law made it possible for states to finance their Medicaid programs with less than their required state match, in effect increasing their federal match rate. However, these sources of financing have been restricted, just as other sources of state revenues are also decreasing.

Federal Medical Assistance Percentage. The federal government's share of a state's expenditures for Medicaid is called the Federal Medical Assistance Percentage (FMAP). The FMAP for each of the 50 states and the District of Columbia is determined annually based on a statutory formula that uses the average per capita income of each state and the United States for the three most recent calendar years for which data are available from the Department of Commerce. This formula is designed to pay a higher FMAP to states with lower per capita income relative to the national average (and vice versa for states with higher per capita incomes). FMAPs must not fall below 50% or exceed 83%.[4] There is an FMAP of 50% for administrative expenses and a higher match for certain services and administrative functions. In FY2003 and FY2004 the Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA, P.L. 108-027) provided fiscal relief to the states through a temporary increase in the FMAP for states that met certain requirements. For the last two quarters of FY2003 and the first three quarters of FY2004, eligible states were held harmless (protected) from any decline in the FMAP from FY2002 levels, and the resulting FMAPs were increased by 2.95 points for these quarters. In general a state would have been eligible for the higher FMAP if the Medicaid program eligibility was not more restrictive than their program eligibility on September 2, 2003. **Table 1** provides the FMAP for each state, the District of Columbia, and the territories for FY2002 through FY2006.

Table 1. FMAPs for FY2002 through FY2006

State	FY2002	FY2003 (first 2 quarters)	FY2003E (last 2 quarters)	FY2004E (first 3 quarters)	FY2004 (last quarter)	FY2005	FY2006
Alabama	70.45	70.60	73.55	73.70	70.75	70.83	69.51
Alaska	57.38	58.27	61.22	61.34	58.39	57.58	50.16
Arizona	64.98	67.25	70.20	70.21	67.26	67.45	66.98
Arkansas	72.64	74.28	77.23	77.62	74.67	74.75	73.77
California	51.40	50.00	54.35	52.95	50.00	50.00	50.00
Colorado	50.00	50.00	52.95	52.95	50.00	50.00	50.00
Connecticut	50.00	50.00	52.95	52.95	50.00	50.00	50.00
Delaware	50.00	50.00	52.95	52.95	50.00	50.38	50.09
District of Columbia	70.00	70.00	72.95	72.95	70.00	70.00	70.00
Florida	56.43	58.83	61.78	61.88	58.93	58.90	58.89
Georgia	59.00	59.60	62.55	62.55	59.58	60.44	60.60

[4] For the District of Columbia, the FMAP was permanently set to 70.00% starting in FY1998. For Alaska, the state percentage is calculated using the three-year average per capita income for the state divided by 1.05, for FY2001 through FY2005 only.

State	FY2002	FY2003 (first 2 quarters)	FY2003E (last 2 quarters)	FY2004E (first 3 quarters)	FY2004 (last quarter)	FY2005	FY2006
Hawaii	56.34	58.77	61.72	61.85	58.90	58.47	58.81
Idaho	71.02	70.96	73.97	73.91	70.46	70.62	69.91
Illinois	50.00	50.00	52.95	52.95	50.00	50.00	50.00
Indiana	62.04	61.97	64.99	65.27	62.32	62.78	62.98
Iowa	62.86	63.50	66.45	66.88	63.93	63.55	63.61
Kansas	60.20	60.15	63.15	63.77	60.82	61.01	60.41
Kentucky	69.94	69.89	72.89	73.04	70.09	69.60	69.26
Louisiana	70.30	71.28	74.23	74.58	71.63	71.04	69.79
Maine	66.58	66.22	69.53	69.17	66.01	64.89	62.90
Maryland	50.00	50.00	52.95	52.95	50.00	50.00	50.00
Massachusetts	50.00	50.00	52.95	52.95	50.00	50.00	50.00
Michigan	56.36	55.42	59.31	58.84	55.89	56.71	56.59
Minnesota	50.00	50.00	52.95	52.95	50.00	50.00	50.00
Mississippi	76.09	76.62	79.57	80.03	77.08	77.08	76.00
Missouri	61.06	61.23	64.18	64.42	61.47	61.15	61.93
Montana	72.83	72.96	75.91	75.91	72.85	71.90	70.54
Nebraska	59.55	59.52	62.50	62.84	59.89	59.64	59.68
Nevada	50.00	52.39	55.34	57.88	54.93	55.90	54.76
New Hampshire	50.00	50.00	52.95	52.95	50.00	50.00	50.00
New Jersey	50.00	50.00	52.95	52.95	50.00	50.00	50.00
New Mexico	73.04	74.56	77.51	77.80	74.85	74.30	71.15
New York	50.00	50.00	52.95	52.95	50.00	50.00	50.00
North Carolina	61.46	62.56	65.51	65.80	62.85	63.63	63.49
North Dakota	69.87	68.36	72.82	71.31	68.31	67.49	65.85
Ohio	58.78	58.83	61.78	62.18	59.23	59.68	59.88
Oklahoma	70.43	70.56	73.51	73.51	70.24	70.18	67.91
Oregon	59.20	60.16	63.11	63.76	60.81	61.12	61.57
Pennsylvania	54.65	54.69	57.64	57.71	54.76	53.84	55.05
Rhode Island	52.45	55.40	58.35	58.98	56.03	55.38	54.45
South Carolina	69.34	69.81	72.76	72.81	69.86	69.89	69.32
South Dakota	65.93	65.29	68.88	68.62	65.67	66.03	65.07
Tennessee	63.64	64.59	67.54	67.54	64.40	64.81	63.99
Texas	60.17	59.99	63.12	63.17	60.22	60.87	60.66
Utah	70.00	71.24	74.19	74.67	71.72	72.14	70.76
Vermont	63.06	62.41	66.01	65.36	61.34	60.44	58.49
Virginia	51.45	50.53	54.40	53.48	50.00	50.00	50.00
Washington	50.37	50.00	53.32	52.95	50.00	50.00	50.00
West Virginia	75.27	75.04	78.22	78.14	75.19	74.65	72.99
Wisconsin	58.57	58.43	61.52	61.38	58.41	58.32	57.65
Wyoming	61.97	61.32	64.92	64.27	59.77	57.90	54.23
America Samoa	50.00	50.00	52.95	52.95	50.00	50.00	50.00
Guam	50.00	50.00	52.95	52.95	50.00	50.00	50.00
N. Marina Islands	50.00	50.00	52.95	52.95	50.00	50.00	50.00
Puerto Rico	50.00	50.00	52.95	52.95	50.00	50.00	50.00
Virgin Islands	50.00	50.00	52.95	52.95	50.00	50.00	50.00

Source: Table prepared by the Congressional Research Service (CRS) from HHS regulations published in the *Federal Register*; letter to State Medicaid Directors SMDL #03-005, June 12, 2003.

In FY2002, total Medicaid expenditures (including administration) were $258.2 billion. The federal government share was $146.6 billion, or about 56.8%. For the period FY1992 through FY2002, the federal share of total Medicaid expenditures ranged from 56.5% to 57.4%, with the annual average share for the period being 56.7%. The temporary increase in the FMAPs provided by JGTRRA for FY2003 and FY2004 did not significantly increase the federal share. The Congressional Budget Office estimated that the temporary FMAPs changes only increased federal Medicaid expenditures in FY2003 by $4 billion or 2.5%[5].

In the 50 states and the District of Columbia, Medicaid is an individual entitlement. There are no limits on the federal payments for Medicaid as long as the state pays its share of the matching funds. In contrast, Medicaid programs in the territories are subject to federal spending caps.

Figure 1 illustrates total expenditures for Medicaid for FY1992 through FY2003. For FY2003, federal expenditures for Medicaid were $160.7 billion, with state expenditures estimated at $122.6 billion and total expenditures estimated at $283.6 billion.[6]

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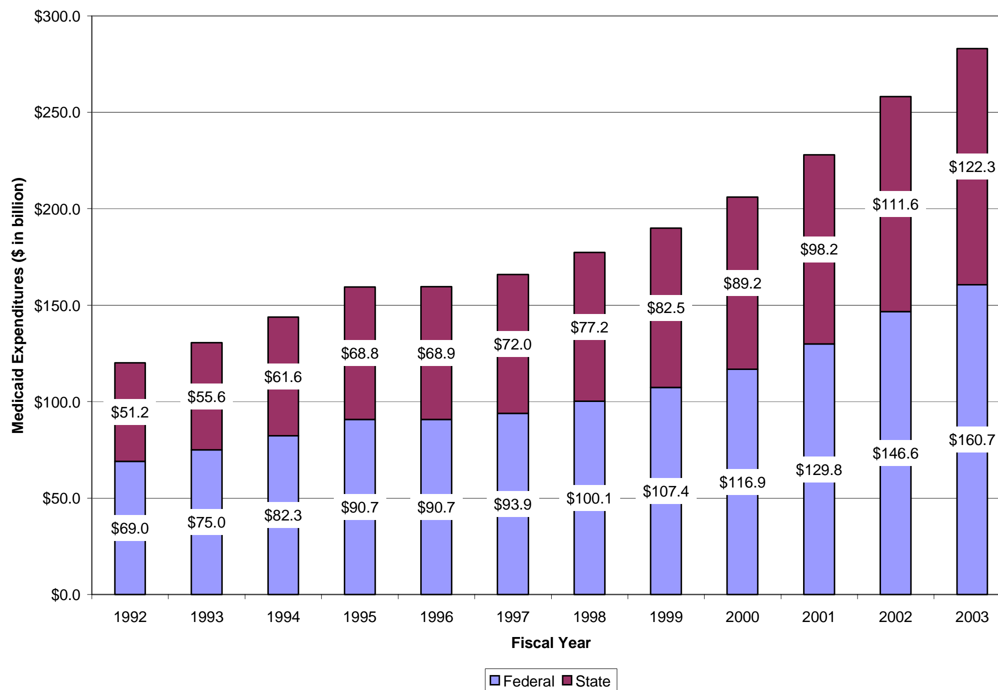
[5] *The Budget and Economic Outlook: Fiscal Years 2005 to 2014*, Congressional Budget Office, Jan. 2004, p. 59.

[6] The estimates for total and state Medicaid spending in FY2003 are based on the federal government spending of $161 billion reflecting the same share of total (56.8%) as in FY2002.

Figure 1. Federal and State Medicaid Expenditures, FY1992-FY2003



Source: Congressional Research Service based on analysis from Centers for Medicare and Medicaid Services (CMS), Form 64 for FY1992 through FY2002. The Form 64 data excludes Vaccines for Children program expenditures and includes current year expenditures, prior period adjustments, and collections. For FY2003, federal Medicaid expenditures are from the Congressional Budget Office report *The Budget and Economic Outlook: Fiscal Years 2005 to FY2014*, Jan. 2004, and state expenditures are estimated using the federal share of total expenditures in FY2002. FY2003 reflects actual federal expenditures and estimated state expenditures.

Disproportionate Share Payments and Provider Taxes.[7] The disproportionate share hospital (DSH) adjustment was established in 1981 to give states greater flexibility to use payment methods for Medicaid other than the Medicare reimbursement principles and to provide protections for hospitals, particularly those with a high level of low-income and uninsured patients. In effect, hospitals designated as DSH hospitals receive a higher reimbursement for services than other providers. A portion of the reimbursement, paid to the state by the federal government through the FMAP funding mechanism, is called the DSH adjustment. Originally, there was no upper limit placed on DSH adjustments.

In the early 1990s, the combination of a high growth rate in medical costs generally and an economic downturn resulted in states combining creative financing mechanisms, particularly provider taxes or donations, with DSH adjustments, which had no limit, to increase federal Medicaid payments. The increased federal payments, in effect, permitted the states to transfer part of the medical costs normally paid for by states (such as support for public hospitals) to the federal government.

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[7] For a more complete history and analysis of DSH payments, see CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne.

Between 1990 and 1992, DSH adjustments grew from less than $1 billion to $17.4 billion. After 1992 DSH adjustment growth slowed considerably, although the level of national DSH adjustments remains high — $15.9 billion in 2002.

Under provider taxes and donations, the state would impose a provider-specific tax or accept a "donation" from a Medicaid provider. These funds would be included as part of the state share of Medicaid funding and matched by the federal government. The providers would then have their taxes or donations returned by receiving higher payments than they would have otherwise received, including higher DSH adjustments, with any remaining funds retained by the state for other uses. Because DSH adjustments had no limit at the time and did not have to be tied to particular beneficiaries or services, they became a popular means of drawing down federal dollars. Not all states used this financing mechanism, but some states were very aggressive in their use of the mechanism with a large share of the federal payments diverted to other uses, including meeting the state's required matching rate.

An example of the financing mechanism using the provider tax would be as follows: the state Medicaid agency paid a DSH designated hospital $100 for services provided (reflecting a higher reimbursement level for a DSH adjustment), then claimed and received a $60 federal match (the state has a 60% FMAP). The hospital returned to the state, via a donation or tax, $80 of the $100 it was paid. At the end of the transaction, the hospital had been paid $20 by the state, but the federal government had reimbursed the state for $60, leaving an additional $40 the state could use for any purpose.

To curb the use of provider taxes and donations, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) restricted the use of donations to limited situations, and permitted states to impose any provider-specific taxes they wished. However, the federal match would be reduced dollar for dollar for any donations or taxes that did not meet specific requirements. Specifically, the provider-tax had to be broad-based and subject to a cap on the amount of state Medicaid program expenses the taxes could be used to support.

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 also established national and state limits on DSH adjustments. The national limit was 12% of Medicaid expenditures in any year. The state limits were based on 1992 DSH adjustment levels. States with 1992 adjustment levels greater than 12% of the state's total Medicaid expenditures would receive adjustments at the 1992 dollar levels until the adjustments became 12% of total Medicaid spending. States with 1992 adjustment levels below 12% of Medicaid expenditures could receive allotments increasing their adjustments up to a limit of 12%. In essence, states could continue to receive DSH adjustments, which are not based on actual services, up to 12% (generally) of Medicaid expenditures.

The size of total DSH adjustments and the lack of reliable data on what the adjustments accomplished focused attention on the payments, and they became a target of federal budget cutters. The Balanced Budget Act of 1997 (BBA 1997, P.L. 105-33) established specific levels of DSH adjustments for 1998 through 2002, with later years increasing by the growth in the Consumer Price Index (CPI). The annual

limits were to decline over the 1998 to 2002 period, but the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554) relaxed the levels for 2001 and 2002. In 2003 the DSH allotment returned to the levels set by BBA 1997, resulting in a decline in the allotment compared to 2002. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) provided a 16% increase in adjustments for FY2004 and altered the calculation of future adjustments. In future years, if the calculated adjustment is less than or equal to the FY2004 adjustment, the adjustment for that fiscal year will be the prior fiscal year adjustment increased by the CPI.

In FY2002, six states (New York, California, Texas, New Jersey, Louisiana, and Pennsylvania) accounted for over half of total DSH adjustments. DSH adjustments in FY2002 were $15.9 billion, or 6.2% of total Medicaid (medical assistance and administration) payments.

Upper Payment Limits (UPL) and Intergovernmental Transfers (IGT).[8] In 1987, the Secretary of HHS issued regulations establishing upper payment limits (UPL) for different types of Medicaid covered services. Interacting with this policy was a provision of Medicaid law that allows state governments to fund up to 60% of the non-federal share of Medicaid expenditures with local government funds. It is this source of intergovernmental transfers that plays a role in state accounting practices for UPL and that has drawn the attention of Congress.

In 2000, it became apparent that some states were using the combination of UPL and intergovernmental transfers to receive payments in excess of what the federal share of payments would have been based on the actual rate paid for services.[9] Those states were paying county or city service providers at rates above the usual payment rates to claim a higher federal match. The local providers would be required to return the excess payments to the state to cover part of the state Medicaid expenditures or for other purposes.

In the 1987 rules, states were allowed to pay all providers, regardless of ownership, up to 100% of the Medicare payment rate. As part of the financing mechanism, populations in private and public (city or county) hospitals were combined to determine the total expenditures for federal match, up to 100% of the Medicare rate. The private facilities were paid the normal Medicaid reimbursement rate (below 100% of the Medicare rate) with the excess (the amount that would bring total expenditures up to 100% of Medicare) going to public (city or county) facilities which were required to return the excess to the state through an IGT.

As part of the new rules imposed during the Clinton administration, public (city or county) hospital reimbursements had a UPL of 150% of the Medicare payment rate while private facilities remained at 100%. States had to treat private and public (city or county) patient populations separately in calculating total expenditures for the

[8] For a more detailed history and analysis of UPL and IGT, see CRS Report RL31021, *Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action*, by Lisa Herz.

[9] Ibid, pp. 2-3

federal match. The Bush Administration changed the rules to impose the 100% of Medicare payment rates on public facilities, a move that has reduced this source of revenue for states during the current period of budget pressures.

However, states can still claim federal Medicaid reimbursement for payments to providers at the upper payment level regardless of the provider's actual cost of services. To the extent the UPL is above actual service costs, the state will receive additional or excess revenues. Intergovernmental transfers are still permitted for use in calculating state Medicaid expenditures within the program match requirements. This is because of the nature of state and local government relations. Local governments derive their authority, including taxing authority, from the state government, and can be viewed as units of state government. Therefore, funds the local government transfers to be used for Medicaid are no different from state funds used for Medicaid.

The Administration's FY2005 budget proposal contains two provisions which would impact state Medicaid financing through the use of the UPL and intergovernmental transfers.[10] In the budget, there are two new proposed initiatives to ensure the proper use of federal Medicaid payments: (1) limiting federal reimbursement to the cost of services provided; and (2) restricting the use of certain types of intergovernmental transfers. The budget proposal does not provide specifics on the two initiatives.

Federal Medicaid Expenditure Growth

It has been noted that the history of Medicaid expenditure growth has five distinct periods.[11] These periods are defined as:

- 1965-1972. This was the period when Medicaid was introduced and states began to develop programs resulting in a growth rate for federal Medicaid spending of 53% a year. By 1972 every state except Alaska and Arizona had a program.
- 1973-1980. During this period the Supplemental Security Income (SSI) program for aged and disabled persons began and states had new options for institutional coverage. Federal Medicaid expenditures grew at a 15% annual rate.
- 1981-1989. During this period there were a number of legislative changes to Medicaid at the federal level, some to reduce costs and others to expand eligibility. The annual growth for federal Medicaid expenditures was 11%.
- 1990-1992. During this period federal Medicaid expenditures grew at a 28% annual rate reflecting the states use of creative financing

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[10] U.S. Department of Health and Human Services, Budget in Brief: FY2005, Jan. 2004, p. 6.

[11] Andy Schneider, and David Rousseau, "Medicaid Financing," The Medicaid Resource Book, The Kaiser Commission on Medicaid and the Uninsured, July 2002, Chapter 3, pp. 81-127.

mechanisms to maximize federal payments, particularly DSH payments at a time of economic downturn.

- 1993-1998. During this period reforms were made to DSH payments, welfare reform took place, and Medicaid spending restrictions were imposed on DSH, provider taxes, and provider donations to reduce federal Medicaid expenditures. The average annual rate of growth was 6%, but between 1995 and 1998 the rate of growth was only 3.7%.

Since 1998, Medicaid costs appear to have entered a new phase of growth, particularly for certain services. While Medicaid (federal and state) fee-for-service prescription drug expenditures grew at an annual rate of 19.0% between 1998 and 2002, estimates from the Office of the Actuary at CMS[12] suggest that prescription drug expenditures will have grown by 17.0% between 2002 and 2003, and are projected to grow by 15.4% between 2003 and 2004. The projections by the Office of the Actuary also show an increase in total (public and private) expenditures for prescription drugs of 84.1% between 1998 and 2002, with the public share of prescription drug expenditures increasing over this period from 21.1% to 21.7%. The growth in Medicaid expenditures for prescription drugs therefore reflects general changes in the price and usage of prescription drugs and is not necessarily a by-product of Medicaid program rules or changes. Medicaid expenditures for nursing home care grew between 1998 and 2001 by 17.0% and are projected to grow by 8.5% in 2002 and at annual rate of about 6.0% in 2003 and 2004. The public share of total nursing home expenditures is projected to increase from 58.8% in 1998 to 64.1% in 2002. The impact of these growth rates is significant because in FY2002, prescription drugs and nursing home facilities represented 9.6% and 19.0% of net federal Medicaid assistance payments.

While the growth in total federal Medicaid expenditures was 10.4% between FY2002 and FY2003, the Congressional Budget Office (CBO) projects[13] a slower annual average growth rate of about 4.5% for the FY2004 through FY2007 period. This is because during this period the higher temporary FMAPs will expire, the Medicare prescription drug benefit program[14] will begin, and there have been changes to state programs which reduce growth in costs. After this period of slow growth, CBO projects that increasing medical prices and enrollment for Medicaid will result in an average annual rate of growth for total federal Medicaid expenditures of about 8.6% for the FY2008 through FY2014 period. **Figure 2** shows CBO actual and projected federal Medicaid expenditures for FY2003 through FY2014.

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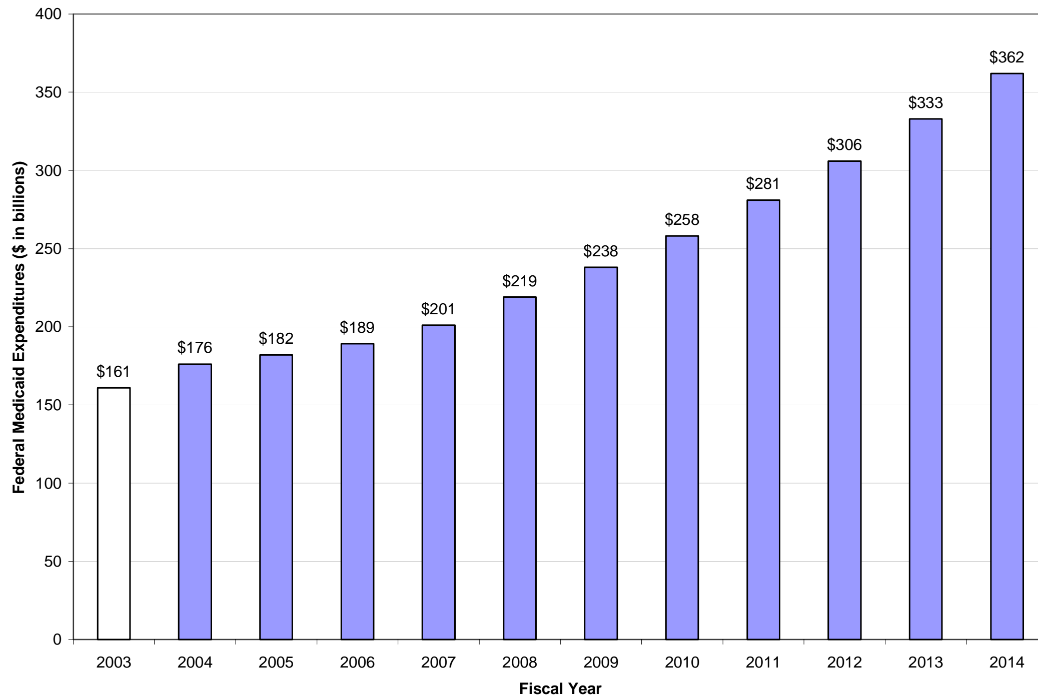
[12] Office of the Actuary, Centers for Medicare and Medicaid Services, National Health Care Expenditures Projections: 2002-2012. Available on the CMS website at [http://www.cms.hhs.gov/statistics/nhe/projections-2002/proj2002.pdf].

[13] Congressional Budget Office, *The Budget and Economic Outlook: An Update*, Sept. 2004.

[14] For more information on the new Medicare benefit, see CRS Report RL31966, *Overview of the Medicare Drug, Improvement and Modernization Act of 2003*, by Jennifer O'Sullivan, Hinda Chaikind, Sibyl Tilson, Jennifer Boulanger, and Paulette Morgan.

Figure 2. Actual and Projected Federal Medicaid Expenditures, FY2003-FY2014



Source: Congressional Research Service (CRS) based on information provided in the Congressional Budget Office Report *The Budget and Economic Outlook: An Update*, Sept. 2004.

Note: FY2003 reflects actual federal Medicaid expenditures, all other fiscal years are estimates.

Beginning in 2006, the Medicare prescription drug benefit program will shift federal expenditures for drug benefits for the Medicaid population known as "dual eligibles" — those eligible for both the Medicaid and Medicare programs — from the Medicaid program to the Medicare program. This shift from Medicaid to Medicare however does not provide significant relief to the states for Medicaid prescription drug expenditures for dual eligibles. Currently, the Medicare program does not cover prescription drugs, but state Medicaid programs do include prescription drugs as an optional benefit not required by the federal government. Under a provision of the new Medicare prescription drug benefit program known as the "claw-back", states will be required to remit funds to the federal government based on their inflation-adjusted 2003 per person Medicaid expenditures for prescription drugs for dual eligibles. While the share of this base amount that the states must pay declines over time from 90% to 75%, in effect the states will continue to pay for a share of prescription drug benefits for dual eligibles.[15]

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[15] For additional information, see CRS Report RL32440, *Implications of the Medicare Prescription Drug Benefit for State Budgets*, by April Grady and Christine Scott.

Comparing Medicaid and Medicare Growth. A common comparison is that of personal health care expenditures for Medicaid and Medicare,[16] which would show that while Medicare spending between FY1998 and FY2003 grew at an annual rate of 5.3%, Medicaid's annual spending growth for the same time period was 9.7%. However, the two programs differ in scope and coverage and are not directly comparable. The addition of the Medicare prescription drug benefit program will alter the growth rates of both programs in the future, but long term care for the elderly and disabled remains a Medicaid expenditure, and therefore partially a state responsibility.

Medicaid and State Budgets

There are two measures that can be used to assess the role of Medicaid in state budgets:

- total Medicaid expenditures as a share of total state expenditures; and
- state-funded Medicaid expenditures as a share of total state-funded expenditures.

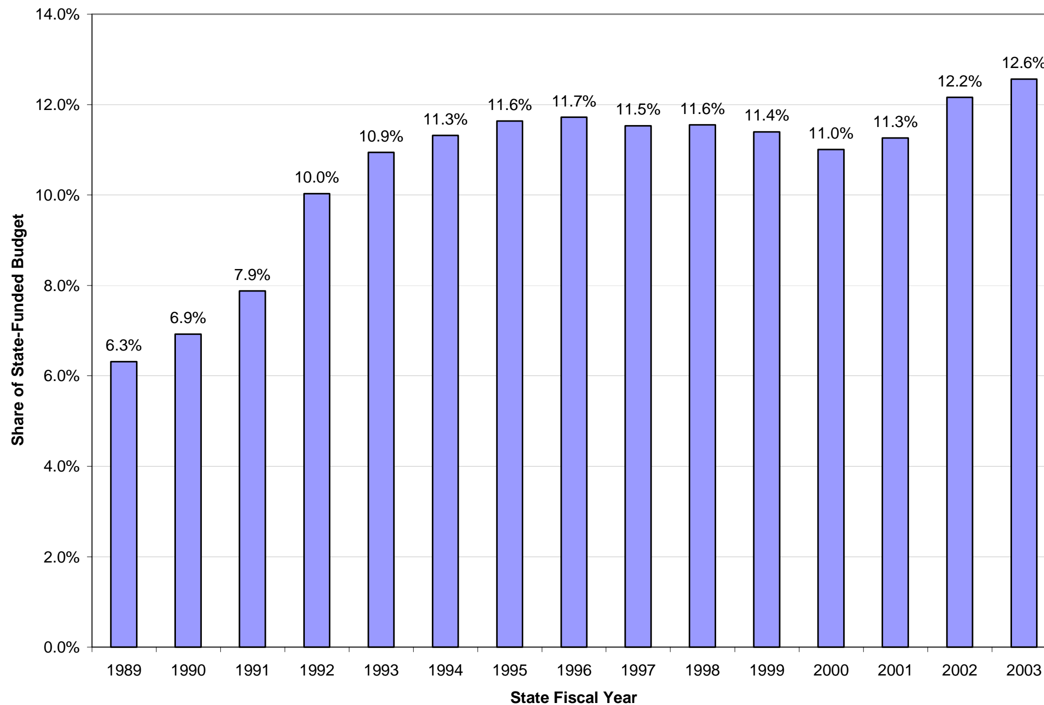
The first measure, 21.4% in state fiscal year (SFY) 2003, measures the total administrative size of the Medicaid program. Since it includes both federal and state expenditures, the fiscal responsibility of the states for Medicaid represents a smaller portion of this total.

However, because total state budgets include federal revenues for transportation and other federal grant programs in addition to Medicaid, the second measure is more reflective of the fiscal exposure that states face due to Medicaid. **Figure 3** illustrates the role that Medicaid has played in state budgets for SFY1989 through SFY2003.[17] As **Figure 3** illustrates, state-funded Medicaid spending comprised 6.3% of total state-funded spending in SFY1989, and grew to 12.6% by SFY2003. The major growth period for state-funded Medicaid spending as a share of state-funded spending was in the early 1990s. The economic downturn, high growth in medical costs, and the use of DSH and other financing mechanisms (provider taxes or donations and intergovernmental transfers count as state expenditures) contributed to an increase in Medicaid's share from 6.3% in SFY1989 to 10.0% in SFY1992.

[16] Office of Budget and Management, *Historical Tables, Budget of the U.S. Government, FY2005* (Washington, DC, 2004), Table 16.1.

[17] National Association of State Budget Officers, State Expenditures Report, various years. Information was not reported for certain states in some years.

Figure 3. State-Funded Medicaid Expenditures as a Share of State-Funded Budgets, State Fiscal Years (SFY) 1989-2003



Source: Congressional Research Service (CRS) based on data collected by the National Association of State Budget Officers (NASBO). State expenditures do not include expenditures from federal revenues. The District of Columbia is not included.

During the mid to late 1990s, state-funded Medicaid spending as a share of state-funded expenditures ranged from 11.3% to 11.7%, with the share increasing to 12.6% in SFY2003. During the SFY1995 to SFY2000 period, total state-funded expenditures increased by an average annual rate of 6.5% while state-funded Medicaid expenditures increased by an average annual rate of 5.1%. As a result, the Medicaid share of total state-funded expenditures declined. During the SFY2000 to SFY2003 period this changed, and state-funded total expenditures increased by only 4.8% annually while state-funded Medicaid expenditures increased by 9.5%.

During the SFY1995 to SFY2000 period, state-funded expenditures for some functions — elementary and secondary education and corrections — increased at an annual rate higher than that of total state-funded expenditures, while state-funded expenditures for public assistance had a negative annual growth rate. For the SFY2000 to SFY2003 period, only the annual growth rates for Medicaid and other expenditures (a residual category) were higher than that of total state-funded expenditures, while the annual growth rate for public assistance was negative.

In SFY2003, the Medicaid share of total state-funded expenditures ranged from 4.8% in Hawaii to 23.0% in Ohio. Actual expenditure data for SFY2004 is not yet available, but NASBO provides estimates of expenditures by category. Based upon the NASBO expenditure estimates, Medicaid will increase to 12.7% of state-funded

total expenditures in SFY2004. The state shares for Medicaid expenditures for selected years are shown in **Table 2.**

Table 2. State-Funded Medicaid Expenditures as a Share of State-Funded Total Expenditures by State, Selected State Fiscal Years

State	1990	1995	2000	2001	2002	2003	2004 (est)
Alabama	6.2%	7.3%	8.0%	8.5%	9.7%	9.9%	8.2%
Alaska	2.8%	3.9%	N/A	N/A	5.3%	5.3%	3.8%
Arizona	6.2%	7.7%	6.1%	6.4%	8.6%	8.7%	10.0%
Arkansas	4.6%	6.1%	5.9%	6.3%	7.3%	7.3%	7.4%
California	7.2%	11.1%	9.5%	9.5%	12.1%	11.6%	10.9%
Colorado	7.2%	11.2%	10.7%	10.7%	11.8%	11.3%	12.5%
Connecticut	5.5%	9.3%	20.7%	20.6%	19.2%	20.2%	19.8%
Delaware	3.3%	6.1%	5.8%	6.0%	6.6%	7.0%	7.3%
Florida	5.6%	8.9%	9.1%	9.4%	12.6%	13.0%	13.0%
Georgia	5.9%	9.7%	9.3%	12.1%	7.6%	10.3%	10.6%
Hawaii	3.3%	5.9%	4.9%	5.0%	4.8%	4.8%	6.2%
Idaho	3.4%	5.9%	7.7%	8.5%	9.5%	10.1%	9.4%
Illinois	7.9%	16.2%	14.2%	14.5%	14.8%	17.0%	17.8%
Indiana	8.1%	9.2%	9.1%	9.9%	11.6%	11.1%	10.9%
Iowa	4.4%	7.2%	6.9%	7.9%	12.5%	9.7%	8.1%
Kansas	5.1%	5.8%	7.6%	7.9%	8.1%	8.5%	8.2%
Kentucky	4.3%	7.7%	8.3%	8.4%	9.6%	9.1%	8.4%
Louisiana	5.9%	6.2%	9.5%	10.2%	11.5%	10.4%	9.5%
Maine	6.5%	10.0%	12.4%	12.0%	12.5%	13.2%	12.5%
Maryland	6.7%	11.3%	10.7%	10.4%	9.9%	11.2%	12.1%
Massachusetts	9.7%	11.5%	11.7%	11.9%	11.6%	12.4%	12.2%
Michigan	9.3%	10.5%	11.2%	10.9%	10.9%	11.4%	12.9%
Minnesota	8.3%	12.0%	11.5%	11.5%	12.6%	13.0%	12.4%
Mississippi	4.6%	6.9%	7.3%	7.6%	9.6%	8.8%	8.4%
Missouri	5.3%	10.6%	13.4%	14.9%	16.8%	18.3%	17.1%
Montana	3.7%	6.7%	6.7%	6.3%	6.9%	6.1%	6.0%
Nebraska	4.5%	7.3%	8.6%	9.5%	10.2%	9.8%	9.0%
Nevada	N/A	6.6%	9.4%	10.3%	12.3%	14.1%	12.5%
New Hampshire	10.2%	24.3%	16.7%	18.8%	18.6%	18.9%	18.9%
New Jersey	8.6%	15.6%	12.2%	13.8%	13.0%	13.0%	12.9%
New Mexico	2.5%	4.8%	4.8%	5.5%	5.8%	6.3%	6.2%
New York	9.6%	22.2%	12.9%	12.2%	12.9%	15.1%	14.4%
North Carolina	4.8%	4.7%	9.0%	10.0%	11.8%	11.5%	11.1%
North Dakota	5.2%	6.7%	8.4%	8.5%	8.8%	9.1%	8.9%
Ohio	7.0%	20.6%	18.5%	19.7%	21.2%	23.0%	25.2%
Oklahoma	5.0%	6.3%	6.2%	6.9%	7.8%	8.1%	8.2%
Oregon	3.3%	7.6%	6.1%	7.6%	9.0%	9.6%	6.8%
Pennsylvania	8.1%	16.3%	18.4%	19.0%	18.7%	19.1%	19.2%
Rhode Island	10.9%	17.9%	16.9%	16.5%	16.4%	16.1%	15.1%
South Carolina	3.1%	8.1%	8.8%	8.9%	9.9%	9.7%	11.1%
South Dakota	6.3%	9.5%	8.4%	9.4%	6.9%	9.1%	10.2%
Tennessee	7.8%	12.1%	15.1%	17.4%	19.3%	19.7%	20.4%
Texas	6.6%	11.9%	13.2%	11.1%	12.8%	12.6%	13.8%

State	1990	1995	2000	2001	2002	2003	2004 (est)
Utah	2.8%	4.3%	4.8%	5.2%	5.7%	5.9%	6.0%
Vermont	6.6%	11.7%	14.1%	12.0%	12.5%	13.9%	13.9%
Virginia	4.7%	7.5%	7.1%	7.2%	9.3%	8.3%	8.3%
Washington	6.0%	9.0%	12.7%	13.3%	13.9%	13.8%	13.8%
West Virginia	4.0%	9.9%	8.2%	8.0%	3.6%	3.3%	3.4%
Wisconsin	6.9%	6.8%	4.9%	4.8%	5.5%	6.0%	8.7%
Wyoming	2.0%	3.5%	5.8%	6.9%	3.3%	3.7%	3.8%
Total	6.8%	11.6%	11.0%	11.3%	12.2%	12.6%	12.7%

Source: Congressional Research Service (CRS) based on data collected by the National Association of State Budget Officers (NASBO). State expenditures do not include expenditures from federal revenues. N/A indicates that data was not available for that fiscal year. SFY2004 is based on estimated expenditures data from NASBO. The District of Columbia is not included.

Medicaid is not the largest share of state-funded expenditures in state budgets. The share for each function of state-funded expenditures will vary across states reflecting the executive and legislative priorities in each state. Excluding the unclassified or all other category, across all states, elementary and secondary education is the largest share of state-funded expenditures followed by higher education and Medicaid. A breakdown of the share of total state funded expenditures by function for SFY2003 is shown in **Table 3**.

Table 3. Share of Total State Funded Expenditures by Function, State Fiscal Year 2003

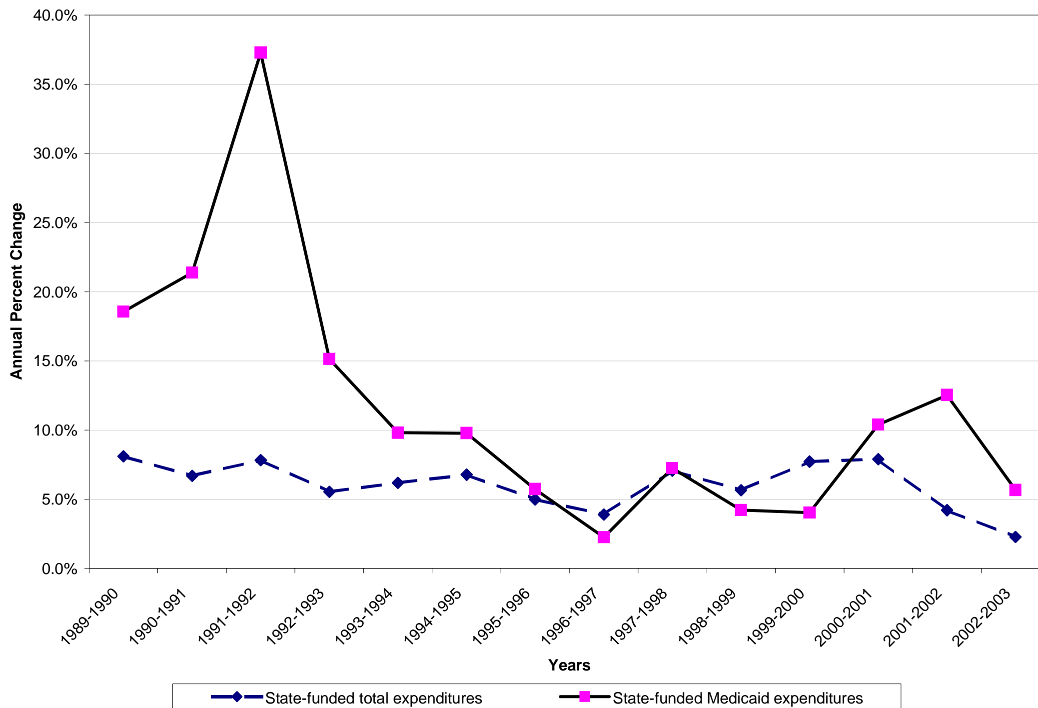
Function	% of total
Elementary and secondary education	25.9%
Higher education	13.5%
Medicaid	12.2%
Transportation	7.9%
Corrections	4.8%
Public assistance	1.5%
Other (includes public health programs, economic development, general government, etc., not categorized elsewhere)	34.1%
Total	100.0%

Source: Congressional Research Service (CRS) based on data collected by the National Association of State Budget Officers (NASBO). State expenditures do not include expenditures from federal revenues. The District of Columbia is not included. Detail may not add to total due to rounding.

A comparison of the growth rates between state-funded Medicaid expenditures and state-funded total expenditures, as in **Figure 4**, shows the impact of the economic downturn in the early 1990s and the economic boom of the late 1990s. In the early 1990s state-funded Medicaid expenditures grew at very high annual rates, partially reflecting the use of financing mechanisms (provider taxes or donations and intergovernmental transfers are counted as state expenditures) to maximize the federal payments. In the late 1990s, the rates of growth for state-funded Medicaid expenditures were generally lower than that of total state-funded expenditures reflecting the expansion of other state programs, particularly education, during the

economic boom. In the most recent period, 2000 to 2003, Medicaid expenditures have grown at a faster rate than total state-funded expenditures reflecting a combination of the faster rate of growth in Medicaid service costs and the entitlement nature of the program. However, it is not known how much of the growth in recent years is due to costs for federally mandated coverage or due to earlier expansions of state programs beyond the federal requirements.

Figure 4. Annual Growth Rate in State-Funded Total and State - Funded Medicaid Expenditures



Source: Congressional Research Service (CRS) based on data collected by the National Association of State Budget Officers (NASBO). State expenditures do not include expenditures from federal revenues. The District of Columbia is not included.

Impact of the Medicare Prescription Drug Benefit Program

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) created a Medicare Part D prescription drug benefit beginning in 2006 that will impact both state and federal financing of the Medicaid program. As of 2006, state and federal Medicaid funds can no longer be used to fund prescription drugs for the Medicaid population known as "dual eligibles".[18] Dual

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[18] Dual eligibles are those persons eligible for both Medicare and the full range of benefits (continued...)

eligibles wishing to obtain prescription drug coverage will have to enroll in the Medicare Part D program. States will be required to provide funding for the Medicare drug program based on their level of state Medicaid spending in 2003 on prescription drugs for dual eligibles.[19]

Under the Medicare prescription drug plan, states must pay a percentage (90%, declining each year to 75%) of their inflation-adjusted 2003 state Medicaid spending per dual eligible for prescription drugs, for each dual eligible person enrolled in the Medicare prescription drug program. In effect, the states will be required to continue paying for a portion of the prescription drugs for dual eligibles formerly provided through state Medicaid programs.

The ultimate impact on state budgets and Medicaid programs of the Medicare drug program cannot be determined at this time, in part because the program does not begin until 2006. There are at least three areas of concern for Medicaid programs and financing in state budgets:

- *Medicaid Drug Coverage*. Medicaid drug expenditures for dual eligibles will decline because states are prohibited from providing those drugs covered under the Medicare drug program. However, they may provide some Medicaid coverage for drugs not covered under Medicare Part D. Until the Medicare drug program coverage is defined (the specifics are determined by the private sponsors of the plans), the impact on Medicaid plans and costs for dual eligibles is unknown.
- *Medicaid Drug Prices*. There may be an impact for states on Medicaid drug prices paid by their Medicaid programs because of the change in the volume of drug purchases by the programs in the future. In addition, the Medicaid programs are not guaranteed the Medicare drug plan price (if it is lower). As a result, the impact of this provision on Medicaid drug prices for individuals continuing to receive drug benefits under Medicaid is unknown.
- *Participation*. An individual eligible for Medicare may choose not to join the Medicaid program even if the individual is eligible. Under current law, participation in Medicaid programs by dual eligibles has traditionally been low. Once MMA is implemented, an individual applying for the new drug program may also be determined eligible for Medicaid. This could increase state expenditures for two reasons: (1) utilization of Medicaid services by the new enrollees; and (2) funding for the new enrollees in the Medicare drug program

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[18] (...continued)
offered in their state's Medicaid program.

[19] For more specific information on individuals eligible for the new Medicare drug program, see CRS Report RL31966, *Overview of the Medicare Drug, Improvement and Modernization Act of 2003*, by Jennifer O'Sullivan, Hinda Chaikind, Sibyl Tilson, Jennifer Boulanger, and Paulette Morgan; and CRS Report RS21837, *Implications of the Medicare Prescription Drug Benefit for Dual Eligibles and State Medicaid Programs*, by Karen Tritz.

is partially paid by the state (even if the person would never have otherwise joined the Medicaid program).

In contrast to these unknowns, there is one impact on state Medicaid budgets that is certain: because every state will pay based on their 2003 per capita spending, a state that had a more generous Medicaid drug benefit (in 2003) will pay more per person from the state's budget than a state that had a less generous Medicaid drug benefit (in 2003) for the same Medicare drug benefit in FY2006.

At the federal level, the new Medicare drug benefit may result in some funds shifting from the Medicaid program to the Medicare program. The CBO forecast for Medicaid reflects a lower growth rate (about 4.5%) in Medicaid spending for FY2004 through FY2007 reflecting the end of the temporary FMAP increases, the new Medicare drug program, and recent reductions in state Medicaid programs. The CBO forecast however, expects rising prices and greater consumption of services to raise the growth rate for federal Medicaid spending to about 8.8% a year beginning after FY2007.

The Current State Fiscal Crisis

Forty-nine states have some form of a balanced budget requirement which is either a constitutional, statutory or traditional interpretation.[20] These requirements can take one of the following forms:

- the governor's proposed budget must be balanced;
- the enacted budget must be balanced; or
- the budget must be balanced at the end of the fiscal year or biennium.

During the latter portion of the 1990s, states were experiencing a growth period in revenues. Revenues associated with a growing economy such as income taxes, and in particular capital gains, grew faster than official state predictions.[21] A survey of states by the National Conference of State Legislatures (NCSL) reported 30 states for SFY1998, and 24 for SFY1999 with revenues exceeding expectations, mostly from sales and income taxes. In addition, states negotiated with the tobacco manufacturers a settlement that allocates funds to states based on several factors including Medicaid expenditures and the smoking rate. The tobacco companies are estimated to pay states that are part of the settlement approximately $200 billion between 1998 and 2023.[22]

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[20] Vermont has no constitutional or statutory requirement for a balanced budget. The District of Columbia is not included in this discussion of the current state fiscal crisis due to the lack of data.

[21] National Conference of State Legislatures, State Fiscal Outlook for 1998, Jan. 1998. National Conference on State Legislatures, State Fiscal Outlook for 1999, Jan. 1999.

[22] Four states (Mississippi, Florida, Texas, and Minnesota) are not part of the national settlement as they reached separate settlements with the tobacco companies. The annual payment to the settlement parties (46 states, the District of Columbia, Puerto Rico, and the (continued...)

As the economy has declined in recent years, so has the growth in the associated revenue streams. From a combination of the economic decline and tax cuts, some states may see an actual reduction in tax collections rather than a slowing of the growth rate in collections. In addition, expenditures for social and health services, such as Medicaid, have increased due to growth in enrollments and inflation. A 2003 NCSL survey[23] reported that 16 states had revenues below forecasted levels for SFY2004 by November 2003 and that 22 states reported expenditures exceeding budgeted levels for some portion of the budget. In the survey, 13 of the 22 states reported that Medicaid or other health programs were over budget. The cumulative budget gap for SFY2004 was $2.8 billion by November 2003, compared to a budget gap (for SFY2003) a year earlier of $17.5 billion and 30 states reporting revenues below forecasted levels. By April 2004, states were estimated to have a budget gap of $720 million compared to $21.5 billion a year earlier. In addition, by April 2004, 32 states were forecasting a surplus at the end of SFY2004. This indicates that the fiscal pressures faced by states may not be as strong as a year ago.

State and Federal Responses to the Current State Fiscal Crisis

States. To close a budget gap a state must either reduce expenditures, increase revenues, or both. Reducing expenditures for programs or general government operations will be based upon state priorities as determined by the governor and legislature. To the extent that states determine that other programs, such as education, are a higher priority than Medicaid, Medicaid expenditures may be reduced (through changes such as limiting eligibility or benefits). Prior to cutting programs, states generally use administrative and other tools to reduce program costs and eliminate any fraud or waste in the program. The federal changes beginning in the 1990s to restrict the use of certain financing mechanisms and limit federal cost increases closed off one avenue of relief states used in the fiscal crisis of the early 1990s.

A recent survey by the National Association of State Budget Officers[24] showed that in SFY2003 through SFY2005, states had undertaken a number of actions, including across-the board program cuts, to close the projected budget gaps for SFY2003 through SFY2005. **Table 4** shows by type of action taken for SFY2003 through SFY2005, the number of states choosing to undertake that action.

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[22] (...continued)
territories) is $6.5 billion in 2003 and $8 billion in 2004 through 2007 before adjustments for inflation and consumption changes.

[23] "State Budget Update: Nov. 2003," National Conference of State Legislatures, Nov. 19, 2003.

[24] "The Fiscal Survey of States," National Association of State Budget Officers, Dec. 2003.

Table 4. Actions Taken by States to Close Budget Gaps in SFY2003,SFY2004, and SFY2005

Action	Number of States		
	SFY2003	SFY2004	SFY2005
Across-the-board percentage cuts	32	11	8
Rainy Day Fund usage	29	6	4
Fee changes	16	8	5
Layoffs	16	10	6
Early retirement	13	3	3
Reorganization of programs	13	9	4
Reduction in local aid	11	8	6
Furloughs	9	1	2
Privatization	0	0	0
Other (not categorized above)	29	11	15

Source: Table prepared by the Congressional Research Service. Original data is provided by the National Association of State Budget Officers in The Fiscal Survey of States, Dec. 2003 and Apr. 2004 .

Another recent survey[25] of state Medicaid administrators by the Kaiser Commission on Medicaid and the Uninsured showed that in FY2004 and FY2005 almost all of the jurisdictions (50 states plus the District of Columbia) included provider payment changes as a cost containment action in FY2004 and FY2005 The other cost containment strategy used by a majority of jurisdictions in FY2003 through FY2005 is pharmacy controls. **Table 5** shows, by type of Medicaid cost containment action taken for SFY2003 through SFY2005, the number of states choosing to under take that kind of action. Examples of some of the benefit actions most frequently proposed or undertaken by states to reduce Medicaid costs or programs for SFY2003 through SFY2005 are shown in **Table 6**.

[25] "States Respond to Fiscal Pressure: State Medicaid Spending Growth, and Cost Containment in Fiscal Years 2003 and 2004, Results from a 50 State Survey," Kaiser Commission on Medicaid and the Uninsured, Sept. 2003.

Table 5. Medicaid Cost Containment Actions Taken by States in SFY2003, SFY2004, and SFY2005

Action	Number of States		
	SFY2003	SFY2004	SFY2005
Provider payments	50	49	47
Pharmacy controls	46	44	43
Eligibility cuts	25	18	14
Fraud and abuse	19	19	21
Benefit reductions	18	20	9
Co-pays	17	21	9
Disease/case management	13	18	28
Long term care	10	5	17
Managed care expansions	6	11	14

Source: Table prepared by the Congressional Research Service (CRS) from information provided in *States Respond to Fiscal Pressure: State Medicaid Spending Growth, and Cost Containment in Fiscal Years 2003 and 2004, Results from a 50-State Survey*, Kaiser Commission on Medicaid and the Uninsured, Sept. 2003, and *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005: Results from a 50-State Survey*, Kaiser Commission on Medicaid and the Uninsured, Oct. 2004.

Table 6. Examples of State Benefit Changes to Reduce Medicaid Costs in SFY2003, SFY2004, and SFY2005

Type of Action	States
Restriction or elimination of some (or all) dental service (including orthodontia and dentures) benefits for some (or all) Medicaid populations	California, Florida, Georgia, Indiana, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Dakota, Oklahoma, Oregon, Utah, Vermont, Washington
Restrict or eliminate certain services: chiropractic, naturopathic, occupational therapy, physical therapy, speech therapy, or psychology for some (or all) Medicaid populations	Connecticut, Massachusetts, Michigan, New Jersey, North Dakota, Ohio, Pennsylvania, Texas, Utah, Vermont,
Restrict or eliminate vision services for some (or all) Medicaid populations	Florida, Mississippi, Montana, Nebraska, Pennsylvania, Oregon, Texas, Utah, Vermont
Restrict eligibility, including changes to income limitations and eliminating continuous eligibility - for some (or all) Medicaid populations	Alaska, Connecticut, Florida, Indiana, Minnesota, Missouri, Nebraska, Texas, Washington

Source: Table prepared by the Congressional Research Service (CRS) from information provided in *States Respond to Fiscal Pressure: State Medicaid Spending Growth, and Cost Containment in Fiscal Years 2003 and 2004, Results from a 50-State Survey*, Kaiser Commission on Medicaid and the Uninsured, Sept. 2003, and *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005: Results from a 50-State Survey*, Kaiser Commission on Medicaid and the Uninsured, Oct. 2004.

States have also undertaken a number of actions that would have an impact on SFY2004 and SFY2005 revenues. States may have made more than one change for a specific revenue source, or made changes for more than one revenue source. **Table 7** shows the total revenue change enacted in states by revenue source, and the state or states with the single largest change (positive and negative) for SFY2005. Note that in **Table 7,** a state may be listed with the largest single negative and still have an overall positive change because: (1) revenues were shifted from one source to one or more others; or (2) there were offsetting increases.

Table 7. Total Revenue Changes Enacted by States By Type of Revenue, SFY2005
($ in millions)

Type of Revenue	Total Revenue Change Among All States	State(s) with Single Largest Negative Revenue Change Enacted	State(s) with Single Largest Positive Revenue Change Enacted
Sales Taxes	$1,411.0	Virginia (-$101.2) Pennsylvania (-$70.2)	Virginia ($727.1) New York ($400.0) Iowa ($144.9)
Personal Income Taxes	$64.0	Virginia (-$54.7) Virginia (-$29.3)	Kansas ($97.5) Virginia ($96.6)
Corporate Income Taxes	$399.6	Virginia (-$11.2)	Illinois ($223.0) Missouri ($48.8)
Cigarette and Tobacco Taxes	$1,411.7	None	Michigan ($295.1) Missouri ($222.4) Oklahoma ($175.8)
Alcoholic Beverages	$20.8	None	Nevada ($16.4)
Motor Fuels Taxes	$74.0	None	Illinois ($74.0)
Other Taxes	$524.8	Florida (-$90.9) Pennsylvania (-$66.3)	Nevada ($345.5) Michigan ($94.4)
Fees	$1,493.5	None	California ($306.0) New York ($230.4) New York (183.4)

Source: Table prepared by the Congressional Research Service. Based on information contained in the National Association of State Budget Officers in *Fiscal Survey of the States*, Apr. 2004.

In addition to adjusting state expenditures and revenues, states can encourage the federal government to increase federal transfers to states for programs such as Medicaid.

Federal. During the 107th Congress, the Senate passed legislation (S. 812) to provide fiscal relief to the states through a temporary increase in the federal government's share of Medicaid program costs by increasing each state's FMAP. The Senate-passed bill would have maintained a state's FY2002 FMAP for FY2003 if the FY2003 FMAP was lower ("hold-harmless"). In addition, each state would have received an increase in its FMAP of 1.35 percentage points for FY2003. Although bills were introduced in the House to also provide a temporary increase in the FMAP, no further action occurred. Other proposals were considered that would have provided grants to states for general fiscal relief but did not specify that funds would be for Medicaid purposes.

In the 108th Congress, a number of bills were introduced which would change the FMAPs by providing specific percentage point increases in the FMAPs.[26] JGTRRA (P.L. 108-027), provided temporary fiscal relief to states through a combination of grants and an increase in the FMAP. The FMAPs for the last two quarters of FY2003 and the first three quarters of FY2004 were held harmless for declines from the prior year, and 2.95 percentage points were added to the FMAPs. In addition, the spending caps for the territories were raised by 5.9% for the last two quarters of FY2003 and first three quarters of FY2004. JGTRRA also provided $5 billion in grants to the states (including the District of Columbia, Puerto Rico, and the territories)in both FY2003 and FY2004 based on population. The grant funds had to be used for improving education or job training, health care services, transportation or other infrastructure, law enforcement or public safety, and maintaining essential government services.

The Bush Administration Medicaid Reform Proposal.[27] As part of the FY2004 budget, the Bush Administration proposed Medicaid reform. Under the Medicaid reform proposal, states would have the option of operating their Medicaid programs under current rules with the current financing system, or under alternative rules with a federal allotment system of financing. Under the alternative, states would be required to provide comprehensive benefits for those individuals considered mandatory beneficiaries by the federal government, and this portion of the program would continue to be financed under FMAP rules. States would be granted flexibility to design benefits for individuals and services considered optional by the federal government. Based on the information provided in press releases by the Secretary of HHS, it is not clear exactly what limits would be placed on the flexibility being granted states. No legislation for the proposal has been introduced in the 108th session of Congress.

For the portion of the program related to optional beneficiaries, the administration proposal would have replaced the current entitlement to states for federal financing support with annual federal allotments for the Medicaid and SCHIP programs. There would be two annual allotments, one for acute care health insurance and one for long-term care and community services. States would be able to transfer funds between the two allotments. For FY2004, the allotments for each state for the portion of the program for optional beneficiaries would be based on the state's spending for Medicaid and SCHIP in 2002. The FY2004 allotment would be higher than what would be expected under the current Medicaid financing structure. The allotments would increase or decrease in future years based on an unspecified formula. For seven years, the allotments would be higher than the states would have received under current financing, but would be lower in the next three years and thereafter.

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[26] For more information on legislation related to the FMAPs, see CRS Report RS21262, *Federal Medical Assistance Percentage (FMAP) for Medicaid*, by Christine Scott.

[27] For more information on the impact of the reform proposal, see CRS Report RL32020, *The Bush Administration's Medicaid Reform Proposal: Using Data to Estimate Mandatory and Optional Beneficiaries and Expenditures*, by Karen Tritz and Evelyne Baumrucker.

Other Recent Proposed Federal Initiatives. The Administration's FY2005 budget proposal contained two provisions which would have impacted state Medicaid financing through the use of the UPL and intergovernmental transfers.[28] In the budget, there were two new proposed initiatives to ensure the proper use of federal Medicaid payments: (1) limiting federal reimbursement to the cost of services provided; and (2) restricting the use of certain types of intergovernmental transfers. The budget proposal did not provide specifics on the two initiatives.

In addition to the budget proposals, on January 7, 2004, CMS issued a notification of changes to Form CMS-37, the Medicaid Program Budget Report.[29] States must currently submit to CMS a quarterly financial statement, the Form CMS-37, containing funding requirements for the state Medicaid program and certifying that the necessary state and local funds will be available for the quarter. CMS then provides a grant to the state authorizing federal funding for the quarter. As part of the filing of the CMS-37 form, the state must provide the assumptions used by the state in developing their fiscal year budget for Medicaid expenditures. Under the proposed form changes, beginning in FY2005, states would have had to provide (with the Form-37 filing) documentation supporting the assumptions used in developing the fiscal year budget and Medicaid expenditures prior to the beginning of the fiscal year. The purpose of the changes was to identify and correct and funding or expenditure issues before the fiscal year began and Medicaid expenses have been incurred. Implementation of the proposed form changes was delayed while CMS discussed the changes with the states.

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[28] U.S. Department of Health and Human Services, Budget in Brief: FY2005, Jan. 2004, p. 6.

[29] 69 *Federal Register* 923, Jan. 7, 2004, vol. 69, no. 4.