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CRS Report for Congress

# Medicaid Financing

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## Summary

Combined federal and state spending on the Medicaid program currently exceeds $300 billion each year. It is the largest or second-largest item in state budgets, and is second only to Medicare in terms of federal spending on health care. This report provides background information on Medicaid financing and a discussion of current issues. Last year, Congress placed temporary moratoriums on the implementation of four controversial regulations that anticipate large reductions in federal spending for Medicaid. Legislation to further delay implementation of these and other regulations has been passed by the Senate (S. 1200) and introduced in both chambers (H.R. 4355, S. 2460, H.R. 5173, S. 2578, H.R. 5613), and deficit-neutral reserve funds have been included for this purpose in the House and Senate budget resolutions (H.Con.Res. 312 and S.Con.Res. 70). In response to the recent economic downturn, legislation that would provide state fiscal relief in the form of a temporary increase in the federal medical assistance percentage (FMAP, which determines federal share of most Medicaid costs) has also been introduced (S. 2586, H.R. 5268, S. 2620).

## Shared Responsibility

Financing for the Medicaid program is shared by the federal government and the states. States incur Medicaid costs by making payments to health care providers (e.g., for beneficiaries' doctor visits) and performing administrative activities (e.g., making eligibility determinations). They then submit quarterly expense reports in order to receive federal reimbursement for a share of these costs.[1]

[1] These quarterly expense reports are also used to repay the federal share when a state recovers some of its Medicaid costs (e.g., from a health insurer in cases where a Medicaid beneficiary also has private coverage or from the estate of a deceased beneficiary who received certain long-term care services) or discovers that it has overpaid a health care provider.

The federal share for Medicaid administrative costs does not vary by state and is generally 50%.[2] The federal share for most Medicaid service costs is determined by the federal medical assistance percentage (FMAP), which is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa).[3] FMAPs have a statutory minimum of 50% and maximum of 83%. Some Medicaid services receive a higher federal match, including those provided through an Indian Health Service facility, to certain women with breast or cervical cancer, for family planning, or under the Qualifying Individuals (QI) program that pays Medicare Part B premiums on behalf of certain Medicaid beneficiaries.[4]

Exceptions to the FMAP formula have been made for certain states and situations. For example, the District of Columbia's Medicaid FMAP is set in statute at 70%, and the territories (Puerto Rico, American Samoa, the Northern Mariana Islands, Guam, and the Virgin Islands) have FMAPs set at 50%. Under the Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L. 108-27), all states received a temporary increase in Medicaid FMAPs for the last two quarters of FY2003 and the first three quarters of FY2004 as part of a fiscal relief package. In addition, the Deficit Reduction Act of 2005 (P.L. 109-171) allowed an increase in the federal share for certain Medicaid and State Children's Health Insurance Program (SCHIP) costs in the wake of Hurricane Katrina.

One goal of the FMAP formula is to narrow differences in states' ability to fund Medicaid services, defined in some studies as a state's total taxable resources (a specific measure produced by the U.S. Department of Treasury) relative to its number of low-income people. Although the Government Accountability Office (GAO) and others have found that it does not always do so,[5] a primary obstacle to altering the FMAP formula is the potential creation of winners and losers among states that fare well under the current system and those that would do better under another.

In FY2006, Medicaid spending on services and administrative activities in the 50 states and the District of Columbia totaled $314 billion, with a federal share of $179 billion and a state share of $135 billion.[6] As with overall health care spending, Medicaid is expected to consume a growing share of the U.S. economy in the future, mostly because of increases in costs per person (driven by medical technology and other factors) and to a lesser extent because of population aging.[7]

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[2] CRS Report RS22101, *State Medicaid Program Administration: A Brief Overview*, by April Grady.

[3] CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by April Grady.

[4] There is also an enhanced FMAP for Medicaid services that are financed with federal allotments for SCHIP.

[5] GAO, *Medicaid Formula: Differences in Funding Ability among States Often Are Widened*, GAO-03-620, July 2003, at [http://www.gao.gov/new.items/d03620.pdf].

[6] Centers for Medicare and Medicaid Services, Form CMS-64 data.

[7] For example, see Congressional Budget Office, *The Long-Term Outlook for Health Care Spending*, November 2007, at [http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf].

## Federal Funding

Federal spending levels for Medicaid are largely determined by the states, which generally receive open-ended funding as long as they operate their programs in compliance with federal law. Exceptions for which federal funding is capped include the territories, disproportionate share hospital (DSH) payments made to hospitals serving a large number of Medicaid or low-income patients, the QI program mentioned earlier, and waivers that allow states to operate outside of normal federal rules (which are subject to aggregate budget caps or cost-per-beneficiary caps).[8] The annual appropriations process also provides an opportunity for Congress to place limitations on specified activities, including the circumstances under which federal funds can be used to pay for abortions.

Unlike Medicare and Social Security, federal funding for Medicaid comes entirely from general revenues, rather than a dedicated account or trust fund within the U.S. Treasury. It represents a growing portion of the federal budget, having increased from 2% of federal outlays in FY1975 to an estimated 7% in FY2008.[9]

## State Funding

States generally control their own Medicaid spending levels by altering eligibility, covered services, cost-sharing and premiums paid by beneficiaries, health care provider reimbursement rates, and other aspects of the program within broad federal guidelines.[10] Funding for the nonfederal (i.e., state) share of Medicaid costs comes from a variety of sources, but at least 40% must be financed by the state, and up to 60% may come from local governments. In state fiscal year (SFY) 2006, states reported that about 80% of the nonfederal share of their Medicaid costs was financed by state general funds (most of which are raised from personal income, sales, and corporate income taxes). The remaining 20% was financed by other state funds (including local funds, provider taxes, fees, donations, and assessments, and tobacco settlement funds).[11]

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[8] In addition, some states have chosen to expand their Medicaid programs using capped federal allotments for SCHIP. However, this does not affect the open-ended nature of federal funding for Medicaid. Once these states have exhausted their SCHIP allotments, they revert to using Medicaid funds. See CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, by Elicia J. Herz, Chris L. Peterson, and Evelyne P. Baumrucker.

[9] U.S. Office of Management and Budget, *Historical Tables, Budget of the United States Government, Fiscal Year 2009*, Tables 8.1 and 8.5, at [http://www.whitehouse.gov/omb/budget/fy2009/].

[10] For an overview of what is mandatory and optional for states, see CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz. In terms of state control over spending, one exception relates to beneficiaries who are dually eligible for Medicare and Medicaid. Although prescription drug coverage for this population was shifted from Medicaid to Medicare Part D in 2006, states are still required to make "clawback" payments that are based on their historical Medicaid prescription drug costs. These payments are made separately to Medicare Part D and are not reported as Medicaid costs. See CRS Report RL32902, *Medicare Prescription Drug Benefit: Low-Income Provisions*, by Jennifer O'Sullivan.

[11] National Association of State Budget Officers, *2006 State Expenditure Report*, December 2007, at [http://www.nasbo.org/Publications/PDFs/fy2006er.pdf]. Some states were unable to (continued...)

Although financing for the Medicaid program is a shared responsibility, GAO and others have reported on mechanisms used by states to inappropriately increase their federal share.[12] For example, a state with a 50% FMAP might make a $10 million payment to a hospital that returns $9 million to the state, netting $1 million for the hospital and $4 million for the state at the expense of the federal government.[13] Limits have been placed on these financing mechanisms over the years, primarily through changes to DSH and upper payment limit (UPL) rules that allow states to make supplemental payments to certain providers, as well as intergovernmental transfer (IGT) and provider tax and donation rules that allow them to collect revenues from providers.

Medicaid is the largest or second-largest item in state budgets, depending on how it is measured. Looking at SFY2006 expenditures from *all* revenue sources (including federal funds), Medicaid made up the largest share (21.5%), closely followed by elementary and secondary education (21.4%). Looking only at SFY2006 expenditures from *state* revenue sources (general, other state, and bond funds), elementary and secondary education made up the largest share (24.9%), followed by Medicaid (13.0%).[14] State-funded Medicaid spending as a share of state-funded total spending has more than doubled since SFY1989 (when it was 6.3%), with major growth in the early 1990s fueled by an economic downturn, high growth in medical costs, and the use of financing mechanisms described earlier that can effectively recycle federal funds into state funds.[15]

## Current Issues

A number of controversial regulations affecting Medicaid financing and federal funding have been proposed or finalized over the past year, including some that would[16]

- restrict the use of IGTs between state governments and public providers for purposes of Medicaid, as well as UPL payments to these providers;[17]
- align the Medicaid definition of outpatient hospital services more closely to the Medicare definition for purposes of calculating Medicaid UPLs;

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[11] (...continued)
report state general funds and other state funds separately for Medicaid.

[12] U.S. Government Accountability Office, *Medicaid Financing: Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight*, testimony of Marjorie Kanof before the U.S. Congress, House of Representatives, Committee on Oversight and Government Reform, GAO-08-255T, November 1, 2007, at [http://www.gao.gov/new.items/d08255t.pdf].

[13] $10 million payment = $5 million federal share + $5 million state share; hospital net = $10 million payment - $9 million returned; state net = $9 million returned - $5 million state share.

[14] National Association of State Budget Officers, *2006 State Expenditure Report*.

[15] CRS Report RL31773, *Medicaid and the State Fiscal Crisis of 2000-2003*, by Christine Scott.

[16] Additional CRS reports are forthcoming on these issues. Also see Kaiser Commission on Medicaid and the Uninsured, *Medicaid: Overview and Impact of New Regulations*, January 2008, available at [http://www.kff.org/medicaid/7739.cfm].

[17] CRS Report RS22848, *Medicaid Regulation of Governmental Providers*, by Jean Hearne.

- implement Medicaid provider tax provisions in P.L. 109-171 and P.L. 109-432 and clarify rules for approving these taxes;[18]
- clarify that graduate medical education payments are not federally reimbursable under Medicaid;[19]
- implement a Medicaid targeted case management provision in P.L. 109-171 and clarify rules for claiming these services;[20]
- restrict federal reimbursement under Medicaid for certain school-based administrative activities and transportation services;[21]
- clarify what may be claimed as Medicaid rehabilitation services; and
- implement Medicaid prescription drug provisions in P.L. 109-171.[22]

Some of these regulations anticipate large reductions in federal spending for Medicaid. For example, the final rule on IGTs alone is expected to result in federal savings of $3.87 billion over five years by restricting states' use of certain financing mechanisms.[23] In four cases (IGTs, graduate medical education, school-based administration and transportation, rehabilitation), Congress placed temporary moratoriums on implementation that will expire in May or June of 2008. Legislation to further delay implementation of these and other regulations has been passed by the Senate (S. 1200) and introduced in both chambers (H.R. 4355, S. 2460, H.R. 5173, S. 2578, H.R. 5613), and deficit-neutral reserve funds have been included for this purpose in the House and Senate budget resolutions (H.Con.Res. 312 and S.Con.Res. 70).

Another area of concern is the recent economic downturn, which has the potential to increase Medicaid enrollment at a time when state revenues might be stagnant or falling. Several bills that would provide state fiscal relief in the form of a temporary FMAP increase have been introduced (S. 2586, H.R. 5268, S. 2620). Such an increase would reduce the amount of state funding that is required to maintain a given level of Medicaid services. For states that are contemplating cuts to Medicaid (which can take many forms), increased federal funding could enable them to avoid those cuts. For others, the state savings that result from an FMAP increase could be used for a variety of purposes that are not limited to Medicaid.[24]

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[18] CRS Report RS22843, *Medicaid Provider Taxes*, by Jean Hearne.

[19] CRS Report RS22842, *Medicaid and Graduate Medical Education*, by Elicia J. Herz and Sibyl Tilson.

[20] CRS Report RL34426, *Medicaid Targeted Case Management (TCM) Benefits*, by Cliff Binder.

[21] CRS Report RS22397, *Medicaid and Schools*, by Elicia J. Herz.

[22] CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne.

[23] Based on the regulatory impact analysis provided in the final rule. The Congressional Budget Office and the House Committee on Oversight and Government Reform have released their own estimates for various regulations.

[24] See CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP).*