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State Medicaid Program Administration: A Brief Overview

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Summary

Medicaid is jointly financed by the federal and state governments, but each state designs and administers its own program within broad federal guidelines.[1] This report provides a brief overview of Medicaid program administration at the state level and includes information on organization, responsibilities, and expenditures. It also describes issues related to program administration that have attracted recent attention.

Organization

The Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for Medicaid program administration at the federal level,[2] but individual state Medicaid agencies administer their own programs on a day-to-day basis. Federal law requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. This agency, which is usually part of a welfare, health, or umbrella human resources agency, will often contract with other public or private entities to perform various program functions.

An August 2000 survey by the American Public Human Services Association (APHSA) on operational responsibility for 16 key functions found that only five states had Medicaid agencies that administered (or shared in the administration of) all 16. However, most functions not directly administered by the Medicaid agency were handled by another state agency or department. One exception was the operation of Medicaid Management Information Systems (MMISs), which are used to process claims for payment (e.g., from doctors and other providers who serve Medicaid patients) and perform a variety of other tasks (e.g., monitor service utilization and provide data to meet federal reporting requirements). The APHSA survey found that 29 states contracted with

[1] For a program overview, see CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz.

[2] Discussion in this report excludes Medicaid administrative activities and expenditures that are exclusively federal (e.g., program oversight by HHS staff).

the private sector to administer this function.[3] Information from CMS indicates that 36 states did so as of June 15, 2007.[4]

Responsibilities

States that opt to have a Medicaid program (as all currently do) are obligated to pay for covered services that are rendered by qualified providers to eligible individuals, using methods of administration that are found to be proper and efficient by the Secretary of HHS. To this end, a state must

- allow individuals to apply for assistance and determine their eligibility;
- determine which providers are qualified to furnish covered benefits and how much they will be reimbursed;
- have a system for processing claims submitted by providers;
- monitor the quality of care provided to beneficiaries;
- maintain control mechanisms designed to minimize improper payments resulting from unintended errors, as well as fraud and abuse;
- have a system for resolving grievances by applicants, beneficiaries, and providers; and
- collect and report required program information to CMS.

Although some federal guidelines for program administration are specific (e.g., nursing facility standards, quality control requirements for monitoring eligibility determinations, data collection and reporting), states have considerable discretion in other areas (e.g., choice of optional eligibility groups and benefits, procedures for gathering information from applicants, setting provider reimbursement rates).[5]

Expenditures

The federal government pays a share of every state's spending on Medicaid services and program administration. 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). FMAPs have a statutory minimum of 50% and maximum of 83%. The federal match for administrative expenditures does not vary by state and is generally 50%, but certain administrative functions have a higher federal match. Those with a 75% federal match include

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[3] American Public Human Services Administration, "Organizing Medicaid Responsibilities: A Look at Current State Agency Structure," *Washington Memo* 12, no. 4 (July-September 2000). The other 16 functions in the survey were related to eligibility and benefits, hearings, managed care, quality assurance, provider issues, third-party liability and collections, and fraud and abuse.

[4] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *MMIS Fiscal Agent Contract Status Report*, June 15, 2007, at [http://www.cms.hhs.gov/MMIS/].

[5] For more information on state responsibilities, see Andy Schneider et al., *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured, July 2002, pp. 131-144, at [http://www.kff.org/medicaid/2236-index.cfm].

- compensation or training of skilled professional medical personnel (and their direct support staff) of the state Medicaid or other public agency;
- preadmission screening and resident review for individuals with mental illness or mental retardation who are admitted to a nursing facility;
- survey and certification of nursing facilities;
- operation of an approved MMIS for claims and information processing;
- performance of medical and utilization review activities or external independent review of managed care activities; and
- operation of a state Medicaid fraud control unit (MFCU).

In the case of MMISs and MFCUs, the federal match is 90% for certain startup expenses. There is a 100% match for the implementation and operation of immigration status verification systems.[6] Section 1903(a)(7) of the Social Security Act specifies that a 50% match is available for remaining expenditures found necessary by the Secretary of HHS for the proper and efficient administration of a state's Medicaid program.

In recent years, expenditures for state Medicaid program administration have grown at about the same rate as expenditures for services. As a result, they have remained a relatively constant share of the total. For example, between FY1999 and FY2006, administrative expenditures grew at an average annual rate of 7.8% and service expenditures grew at a rate of 7.5%. Over the same period, administrative expenditures as a share of the total grew only slightly, from 5.0% to 5.1%.[7] Detailed FY2006 expenditures are provided in **Table 1** at the end of this report.

Current Issues

Program Integrity. Discussions of Medicaid program integrity are often limited to issues of fraud and abuse by Medicaid providers (as well as beneficiaries) and efforts to curtail these problems. However, a broader view encompasses other program management issues (e.g., policy development and execution) that affect the ability of states and the federal government to ensure that beneficiaries receive quality care and that public funds are spent appropriately.[8] Partly in response to concerns about the level of resources devoted to Medicaid program integrity activities and the program's vulnerability to significant financial losses,[9] Congress provided new funding in the Deficit Reduction

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[6] Enhanced federal matches (above 50%) have also been provided on a temporary basis for certain administrative functions. For example, under Section 1903(a)(3)(D) of the Social Security Act, states could receive a 75% federal match during a quarter in 1991, 1992, or 1993 for expenditures attributable to the adoption of a required drug use review program.

[7] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Form CMS-64 data. Includes federal and state shares. Excludes expenditures for MFCUs and nursing facility survey and certification (which represented 0.1% of total expenditures in FY2006), the Vaccines for Children program, the territories, and administrative activities that are exclusively federal (e.g., program oversight by HHS staff).

[8] Victoria Wachino, *The New Medicaid Integrity Program: Issues and Challenges in Ensuring Program Integrity in Medicaid*, Kaiser Commission on Medicaid and the Uninsured, June 2007, at [http://www.kff.org/medicaid/7650.cfm].

[9] U.S. Government Accountability Office, *Medicaid Program Integrity: State and Federal Efforts* (continued...)

Act of 2005 (DRA, P.L. 109-171). The DRA established a Medicaid Integrity Program with an appropriation reaching $75 million annually for audits, identification of overpayments, education with respect to payment integrity and quality of care, and other purposes. It also provided an additional $25 million in each of FY2006-FY2010 for Medicaid activities of the HHS Office of Inspector General and an appropriation reaching $60 million annually for an expanded Medicare-Medicaid data match project (referred to as Medi-Medi) that analyzes claims from both programs together in order to detect aberrant billing patterns.[10]

More recently, program integrity has been discussed in the context of controversial Medicaid regulations that would restrict the ability of states to use certain financing mechanisms and receive federal reimbursement for certain services and activities.[11] From the perspective of the Bush Administration, the regulations are aimed at strengthening the fiscal integrity of Medicaid. Others acknowledge the need to examine issues that have been raised, but also argue that the regulations in their current form will hinder the ability of states to appropriately serve the Medicaid population.[12]

Improper Payments. Under the Improper Payments Information Act of 2002 (P.L. 107-300), federal agencies are required to identify programs that are susceptible to significant improper payments, estimate the amount of overpayments, and report annually to Congress on those figures and on the steps being taken to reduce such payments. A final rule regarding Payment Error Rate Measurement (PERM) for Medicaid and the State Children's Health Insurance Program (SCHIP) was effective on October 1, 2007. Under the final rule, a subset of states are selected in a given year and are reviewed using a statistically valid random sample of claims and eligibility determinations to determine Medicaid and SCHIP error rates. States must submit a corrective action plan based on the error rate analysis, and must follow existing rules for reimbursing the federal government for its share of any overpayments. Improper payments are defined as those that should not have been made or that were made in an incorrect amount (e.g., a duplicate payment to a provider or a payment that was incorrectly denied). The payment error rate is calculated by taking the absolute (rather than net) value of overpayments and underpayments and dividing by total payments.[13]

Based on six months of data for the fee-for-service component of Medicaid (which accounts for the majority of Medicaid service expenditures), HHS estimated improper

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[9] (...continued)
to Prevent and Detect Improper Payments, GAO-04-707, July 2004, at [http://www.gao.gov/new.items/d04707.pdf].

[10] For more information, see Wachino, *The New Medicaid Integrity Program*.

[11] CRS Report RS22849, *Medicaid Financing*, by April Grady.

[12] For example, see Statement of Dennis G. Smith, Director, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services and Statement of Barbara Coulter Edwards, Interim Director, National Association of State Medicaid Directors, before U.S. Congress, House of Representatives, Committee on Energy and Commerce, April 2, 2008, at [http://energycommerce.house.gov/cmte_mtgs/110-he-hrg.040308.MedicaidSafetyNet.shtml].

[13] 42 CFR 431.950-1002.

payments of about $13 billion for FY2007.[14] In response to concerns about PERM that have been raised by states (e.g., criteria for defining what constitutes an error, the process for appealing error determinations, coordination with existing rules for eligibility errors), SCHIP reauthorization bills that were vetoed in 2007 (H.R. 976 and H.R. 3963) would have made various changes.[15]

Citizenship Documentation. Due to recent changes in federal law, individuals who declare that they are citizens for Medicaid eligibility purposes must present documentation that proves citizenship and documents personal identity. As a result of the new requirement, most states report that they are spending more time completing Medicaid applications and redeterminations, and that their administrative costs have increased. States will receive federal reimbursement for these costs using the 50% rate that applies to most Medicaid administrative functions. Because existing enrollees must present documentation at their next eligibility redetermination (a process that generally occurs at least once a year), administrative costs should peak in the year following implementation of the requirement. Costs in later years should be lower, reflecting the ongoing expense of documenting those who are new to the program. A number of bills that would modify the citizenship documentation requirement have been introduced.[16]

Allocation of Common Administrative Costs. Because of the overlap in eligible populations, states often undertake administrative activities that benefit more than one program. Under the former Aid to Families with Dependent Children (AFDC) cash welfare program, AFDC and Medicaid program eligibility were linked, and many AFDC families also qualified for food stamps. As a result, states often collected necessary eligibility information for all three programs during a single interview or performed other shared administrative tasks and charged the full amount of the cost to AFDC as a matter of convenience. Since the federal government reimbursed states for 50% of administrative expenditures for all three programs, total federal spending was not affected by the way in which states allocated the programs' common administrative costs.

When Congress replaced AFDC with the Temporary Assistance for Needy Families (TANF) block grant program in 1996, the 50% federal match for expenditures related to cash welfare assistance ended and the automatic link between cash welfare and Medicaid eligibility was severed. Later, HHS clarified that states are required to allocate common administrative costs for TANF, Medicaid, and food stamps based on the relative benefits derived by each program.[17] A remaining issue of controversy stems from the fact that TANF block grants are calculated in part on the basis of pre-1996 federal welfare spending, including any amounts received by states as reimbursement for common

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[14] U.S. Government Accountability Office, *Improper Payments: Federal Executive Branch Agencies' Fiscal Year 2007 Improper Payment Estimate Reporting*, GAO-08-377R, January 23, 2008, at [http://www.gao.gov/new.items/d08377r.pdf].

[15] For example, see CRS Report RL34129, *Medicaid and SCHIP Provisions in H.R. 3162, S. 1893/H.R. 976, and Agreement*, by Evelyne P. Baumrucker et al.

[16] CRS Report RS22629, *Medicaid Citizenship Documentation*, by April Grady.

[17] States were required to comply with this policy as of the state fiscal year beginning on or after October 1, 1998. See U.S. Department of Health and Human Services, *Office of Grants and Acquisition Management (OGAM) Action Transmittal 98-2*.

administrative costs. As a result, TANF block grants are higher in many states than they would be if common administrative costs attributable to Medicaid and food stamps were excluded from block grant calculations. To compensate, Congress has permanently reduced federal reimbursement for food stamp administrative costs in most states by a flat dollar amount that reflects the administrative costs attributable to food stamps that are included in each state's TANF block grant (the annual reductions total about $200 million). Federal reimbursement for Medicaid administrative costs has not been reduced in a similar manner, but proposals to do so continue to circulate.[18]

Table 1. Expenditures for State Medicaid Program Administration and Services, FY2006 (millions)

Category	Total	Federal	State
Administration	$16,382	$9,018	$7,364
Medicaid Fraud Control Units (MFCUs)[a]	$212	$159	$53
Nursing facility survey and certification[a]	$245	$184	$61
Medicaid Management Information Systems (MMISs)[b]	$2,059	$1,523	$536
TANF-related[c]	$25	$20	$5
Other functions with a federal match greater than 50%[d]	$835	$627	$207
Functions with a federal match of 50%[e]	$13,017	$6,511	$6,506
Collections[f]	-$11	-$7	-$4
Services[g]	$298,164	$170,135	$128,029
Total	**$314,546**	**$179,153**	**$135,394**

Sources: Congressional Research Service, based on U.S. Department of Health and Human Service (HHS), Office of Inspector General, *State Medicaid Fraud Control Units Annual Report, Fiscal Year 2006* (MFCUs); HHS, Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and State Operations data (nursing facility survey and certification); and HHS, CMS, Form CMS-64 data (all other expenditures).

Note: Excludes $2 billion in federal Medicaid spending on the Vaccines for Children program (which does not require a state share and is not limited to children enrolled in Medicaid), the territories, and expenditures for administrative activities that are exclusively federal (e.g., program oversight by HHS staff).

a. Federal amounts are actual. Total and state expenditures are estimates based on a 75% federal match.
b. Includes design and development (90% federal match), operation of approved MMISs (75%), and operation of non-approved systems (50%).
c. Under Section 1931(h) of the Social Security Act, a $500 million federal fund was made available (beginning in 1997 and continuing until exhausted) to provide states with an enhanced federal match for administrative expenditures attributable to eligibility determinations that would not have been made were it not for implementation of the Temporary Assistance for Needy Families program.
d. Skilled medical professionals, immigration status verification, preadmission screening and resident review, medical and utilization review, and external independent review.
e. Excluding non-approved MMISs matched at 50%, which appear earlier in the MMIS category.
f. Offsetting amounts (e.g., donations made by a hospital to compensate for the cost of on-site stationing of state or local Medicaid agency personnel to determine eligibility or provide outreach).
g. Includes family planning (which is categorized as an administrative expenditure in CMS-64 data) and offsetting collections (e.g., amounts obtained through estate recovery).

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[18] See Congressional Budget Office, *Budget Options*, February 2007, p. 148, at [http://www.cbo.gov/doc.cfm?index=7821], and Federal Funds Information for States, *House TANF Bill Includes Possible Medicaid Cost Allocation Offset*, Issue Brief 05-13, March 24, 2005. President Bush's budget proposals have also sought legislation on this issue.