Medicaid Financing

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Preview

- Medicaid Spending
- Financing Medicaid – federal matching percentage
- State financing issues
- Recent changes in proposed regulation
Medicaid Financing is Like Being in Hollywood

- The man in the white hat (solid public financing policies)
- The Spiral Staircase (financial incentives with unexpected twists and turns)
- Terminator (tough review from CMS and reports from GAO, HHS IG)
- Dark Shadows – regulations around the corner
Statistical Snapshot

- FY 2006 - Medicaid $316 billion ($180 billion federal share)/ Medicare $330 billion*
- FY 2004 - Medicaid enrollment of 58.2 million/Medicare 41.7 million

Federal share of Medicaid and Medicare $ from Historical Tables, Budget of the U.S. Government, Fiscal Year 2008. Total Medicaid estimated based on historical program matching shares.
Growth in Medicaid Spending

Between 1994 and 2004, total spending for Medicaid more than doubled

Spending for FY1992-2004 from HCFA/CMS 64 reports
2004 Medicaid Spending by Type of Service

- Acute Care: 31.1%
- Long-term Care: 35.7%
- Prescription Drugs: 15.3%
- Managed Care: 16.7%
- Other & Unknown: 1.2%

About two-thirds of Medicaid spending is for aged, blind or disabled individuals.

- **Blind or Disabled**: 43.3% ($111.5 billion)
- **Aged**: 23.1% ($59.5 billion)
- **Children**: 17.2% ($44.2 billion)
- **Adults**: 12.0% ($30.8 billion)
- **Unknown**: 4.5% ($11.7 billion)

Source: CRS analysis of 2004 MSIS data. Includes all 50 states and the District of Columbia.
Spending for Non-Disabled Adults and Children, FY2004

Total Medicaid Spending for All
$257.7 billion

For Non-disabled Adults and Children $75.0 billion

Source: CRS analysis of 2004 MSIS data. Includes all 50 states and the District of Columbia.
Spending for Aged and Disabled Individuals, FY 2004

Medicaid Spending for All
$257.7 billion

Spending for Aged, Disabled
$171 billion

Medicaid Financing Policy
Federal Financing for Medicaid

• Federal and state matching required for most of Medicaid
• Federal matching for
  – Medicaid services and Medicaid disproportionate share (DSH) payments varies by state at FMAP
  – Administration of state programs mostly at 50%
  – Certain other high priority items and services have higher federal matching
Disproportionate Share to Hospital (DSH) payments

- Assists hospitals serving large share of Medicaid patients or uninsured
- Subject to state- and hospital- specific limits (allotments or ceilings)
- Limits have been raised and lowered several times since originally established
Federal Medical Assistance Percentage (FMAP)

- Recognizes the relative wealth of states’ residents
- Calculated using state’s per capita personal income (PI) relative to U.S. as a whole
- A state with low per capita income will have higher FMAP
- Minimum of 50% and maximum of 83%
The State Share

- In 2006, ranged between 24% and 50%.
- No states at federal ceiling and 17 states at floor
- Can be shared with other local units of government as long as:
  - At least 60% from state funds, and
  - “Certified public expenditures”
How Do States Raise their Share of Medicaid?

• General funds (taxes, fees, etc.)
• Other special earmarks, e.g. tobacco settlement funds
  ★ IGTs
  ★ Provider-specific taxes
  ★ Provider donations (largely prohibited since 1991)
Federal Restrictions on State Financing

- Donations prohibited
- Provider taxes restricted
- Funds from other units of government must be “certified public expenditures”
- New regulations clamping down
Why all the Consternation over Raising the State Share?

• States say both sources and uses of funds are legitimate.

• Sometimes used to artificially “beef up” states’ share of Medicaid to obtain federal matching $.

• A provider transfers $ to the state (through tax or IGT) and the state repays the provider via a Medicaid payment (*Can work in reverse – state makes Medicaid payment and provider pays back some or all through tax or transfer.*)
Concerns with financing schemes

- CMS, IG, GAO concerns about recycling
- Undermine the federal and state matching requirements.
Recent Activity

• Rumors that provider taxes would be further restricted in forthcoming regulations prompted Congress to act

• Provider tax “safe harbor” reduced to 5.5% temporarily, then reverts to 6%
Proposed Regulations on Intergovernmental Transfers

- Would clarify references to “unit of government,”
- Require documentation for “CPEs”
- Establish new ceiling on reimbursements for government providers at “cost”
- Require government providers to retain all Medicaid reimbursements

CRS general distribution memorandum on regulation and CRS Reports RL31021 and 97-483 provide more detail.