



THE BASICS

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Medicaid Financing

The Medicaid program, which provides health coverage to poor or disabled individuals, is jointly funded by the federal and state governments. Each state administers its Medicaid program within broad federal guidelines. In 2009, Medicaid provided coverage to an estimated 50.1 million¹ people.² Combined state and federal spending was \$380.6 billion, of which the federal government paid about 66 percent and states paid about 34 percent.³

Medicaid is a sizeable portion of total state spending. Although the share varies by state, it is the first or second largest budget item for states next to elementary and secondary education.⁴ On average, state and federal Medicaid spending accounted for 21.1 percent of total state budgets in 2009.⁵

DETERMINING THE STATE AND FEDERAL SHARE OF MEDICAID SPENDING

The federal and state governments jointly fund the Medicaid program. Because Medicaid is an entitlement program, there is no limit on the amount the federal government pays as long as the state pays its share. The federal portion of Medicaid spending in each state is called the Federal Medical Assistance Percentage and is commonly referred to as the FMAP.

The formula to calculate the FMAP was established in statute when Medicaid was authorized in 1965. The FMAP formula is designed so that the federal government pays a higher proportion of Medicaid costs in states with lower per capita income relative to the national average, such as Mississippi, and a lower proportion in states with higher per capita income relative to the national average, such as Washington. As shown below, per capita income is the key variable in the FMAP formula.⁶

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The federal formula is:

$$\text{FMAP} = 1 - 0.45 \times (\text{State Per Capita Income}^2 / \text{U.S. Per Capita Income}^2)$$

And the state formula is:

$$\text{STATE SHARE} = 0.45 \times (\text{State Per Capita Income}^2 / \text{U.S. Per Capita Income}^2)$$

The multiplier of 0.45 in the FMAP formula ensures that states with average per capita income receive a federal share of 55 percent. The statute also establishes a minimum FMAP of 50 percent for states, stipulating that no state shall bear more than 50 percent of total costs, regardless of the result of applying the formula. The statute also contains an upper limit on the regular FMAP of 83 percent. For territories federal law also sets the federal government's share at 50 percent for the cost of Medicaid items and services up to specific spending caps. The FMAP is set at 70 percent for the District of Columbia.

The FMAP applies to state expenditures for most medical services. However, the federal share for certain services (for example, family planning services and supplies), certain populations (for example, uninsured women with breast or cervical cancer and Native Americans), or Medicaid administrative costs is not determined using the FMAP formula and is instead specified separately under federal law.

The Secretary of Health and Human Services publishes the FMAPs in the *Federal Register* in November for the fiscal year beginning the following October. The FMAP is in effect for a one-year period. Based on the statutory formula, regular FMAPs for fiscal year 2010 ranged from the floor amount of 50 percent (in 11 states)⁷ to a high of 75.67 percent.⁸

Temporary FMAP Increases

The Congress has enacted temporary FMAP increases to provide for state fiscal relief during periods of economic hardship, including the most recent recession. The American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) contained a provision that provided temporary enhanced FMAP funding (an across-the-board increase of 6.2 percentage points plus an unemployment adjustment) to states through December 2010. In the first quarter of fiscal year 2010, the ARRA-enhanced FMAP raised the federal share to a low of 61.59 percent and a high of 84.86 percent.⁹

In P.L. 111-226, the Congress extended a reduced, but still higher, FMAP through June 2011. Specifically, a 3.2 percentage point increase applies through March 2011 and a 1.2 percentage point increase applies from April through June 2011.¹⁰ To be eligible for the ARRA- and ARRA extended-enhanced FMAP funding, states must maintain their Medicaid eligibility standards, methods, and procedures in effect on July 1, 2008.

To receive federal funds through the end of calendar year 2013, the Patient Protection and Affordable Care Act of 2010 (PPACA, P.L. 111-148) requires that states not make eligibility standards, methods, or procedures more restrictive than they were on March 23, 2010. States must maintain eligibility for children under 19 through fiscal year 2019. For groups newly eligible for Medicaid as a result of PPACA, the federal government is to pay 100 percent of the costs in 2014 through 2016, 95 percent of the costs in 2017, 94 percent of the costs in 2018, 93 percent of the costs in 2019, and 90 percent of the costs in 2020 and thereafter. (See also “The Basics: Medicaid Eligibility and Benefits,” National Health Policy Forum, available at www.nhpf.org/library/details.cfm/2546).

How Do Federal Matching Funds Flow to the States?

States receive federal matching funds for expenditures on Medicaid-covered services for Medicaid-eligible beneficiaries. Each quarter, states receive a monetary advance from the Centers for Medicare & Medicaid Services (CMS) that is based on each state’s estimate of anticipated Medicaid expenditures for that quarter and a certification from the state that requisite state matching funds are or will be available for that quarter. This information is submitted to the federal government on a form called the CMS-37.

In order to officially receive federal funds, states must submit documentation of expenditures (invoices, cost reports, and eligibility records) for services and administrative costs associated with running the Medicaid program. The expenditure information is submitted electronically to CMS within 30 days of the end of the quarter, using a form called the CMS-64. CMS reviews the expenditures as reported on the CMS-64 to reconcile the states’ estimates from the CMS-37 with the actual documented expenditures to ensure that the reported expenditures are allowable under the Medicaid statute.

HOW HAVE STATES MAXIMIZED FEDERAL MATCHING FUNDS?

The shared financing of Medicaid has been a source of tension between the states and the federal government for many years. States have an incentive to maximize the federal matching funds using financing mechanisms available under the statute. Some states' use of these mechanisms to increase federal payment has led to increased federal scrutiny and legislative and regulatory actions to limit certain financing arrangements. Mechanisms for maximizing federal matching funds and policies to control their use are explained briefly in the following sections.

Disproportionate Share Hospital (DSH) Payments

DSH payments are required supplemental payments to hospitals that serve a significant number of low-income and uninsured patients. In fiscal year (FY) 2010, the preliminary federal DSH allotment is estimated to be \$11.7 billion.¹¹ All hospitals meeting the minimum criteria in federal law qualify for DSH in each state, but the criteria also allow states wide discretion in determining which hospitals receive DSH payments and how much they receive. States must define their criteria for determining DSH hospitals, as well as the payment allocation formula, in their state plans.

Significant and rapid increases in DSH spending in the late 1980s and early 1990s caused concerns about financial accountability for DSH payments. Since the early 1990s, the Congress has enacted several laws to control federal DSH spending. In 1991, "Congress capped total annual federal DSH payments at 12 percent of total Medicaid expenditures, excluding administrative costs. Out of this amount, each state was to receive its federal allotment based on a formula, which generally was capped at 12 percent of the state's total Medicaid expenditure for the federal fiscal year."¹² DSH payments to individual facilities are also limited to the hospital's costs for uncompensated care and care to Medicaid enrollees. Policies to control DSH spending have preserved wide variations across states that many regard as inequitable because the level of DSH funding a state receives is not entirely based on the care provided to low-income and uninsured patients. Concerns remain about the accuracy of the states' calculations used to allocate DSH, as well as

CMS's oversight of state DSH programs.¹³ (For additional explanation of DSH Payments see "The Basics: Medicaid Disproportionate Share Hospital (DSH) Payments," National Health Policy Forum, available at www.nhpf.org/library/details.cfm/2745).

PPACA contains provisions to reduce federal DSH allotments to states based on the lower uninsurance rates in the state as Medicaid eligibility expands and Health Insurance Exchanges become operational in 2014. Specific reductions in a state's DSH allotment are determined by formulas specified in PPACA. Until a reduction in a state's uninsurance levels is reached after FY 2012, DSH allotments will remain at the level under current law. After FY 2013, a state's DSH allotment can be no less than 50 percent of the state's FY 2012 allotment, increased by the percentage change in the CPI-U (Consumer Price Index-All Urban Consumers).¹⁴

Upper Payment Limits

Medicaid Upper Payment Limits (UPLs) establish an upper limit on Medicaid payments for which states can receive federal matching funds. UPLs are set at a reasonable estimate of what Medicare would pay a category of providers in the aggregate for comparable services. Because the limit applies in the aggregate and because states' Medicaid payment rates are typically less than Medicare rates, states were able to make large supplemental payments to a few government health facilities, receive federal matching funds, and still be under the aggregate UPL. As the Government Accountability Office (GAO) has reported, in some cases public facilities would then return the bulk of the state and federal payments to the states in the form of an intergovernmental transfer (IGT) (see next section).¹⁵ CMS issued regulations in 2001 and 2002 that significantly limited states' ability to continue using UPLs in this manner, but the GAO and others have continued to raise concerns about the use of UPLs to increase federal Medicaid expenditures and about federal oversight of these payments.¹⁶

Intergovernmental Transfers

IGTs are transfers of public funds between government entities, such as from counties to states or between state agencies. For example, many states require their counties to transfer certain local tax revenues to help fund the state's Medicaid program. Fed-

eral law allows states to collect up to 60 percent of its Medicaid share from local governments for purposes of receiving Medicaid matching funds. Although IGTs are permissible, states' use of them has come under federal scrutiny when they have been used in conjunction with supplemental payments to increase the federal share of Medicaid spending. As the GAO has reported, an example of this is when states (i) make large payments in excess of the Medicaid rate to certain providers operated by local governments, (ii) claim federal match on the payments, and (iii) require the local government-operated provider to return all or much of the payment back to the state via an IGT, effectively increasing the federal payment for services.¹⁷

Provider Taxes

Provider taxes are a mechanism states have used to generate the state matching funds needed to receive federal financial participation in Medicaid funding. Beginning in the mid-1980s, states began using revenues from fees, assessments, and other taxes on health care providers to generate the state match. In 1991, the Congress passed a law to limit the overt recycling of money collected from providers that was then used to obtain federal match and paid back to those same providers. The law required that provider taxes be imposed uniformly on all providers in a class (for example, inpatient hospitals, nursing facilities, and managed care organizations) and generally prohibits states from guaranteeing that a portion of the tax amount (referred to as "hold harmless") will be returned after the federal matching funds are received. States can comply with the hold harmless provision by limiting the taxes to a federally defined safe harbor amount of 5.5 percent of a provider's revenues.¹⁸ Provider taxes cannot exceed 25 percent of a state's share of Medicaid funding. In fiscal years 2009 and 2010, 44 states and the District of Columbia had at least one Medicaid provider tax.¹⁹

ENDNOTES

1. Enrollment can be measured in two ways that differ because an individual's Medicaid eligibility status can change during the course of the year. The average number of enrollees over the year, or "person year equivalents," is 50.1 million, as estimated by the CMS Office of the Actuary. An estimated 62.9 million people were enrolled for any period during the same year.

2. Christopher J. Truffer *et al.*, “2010 Actuarial Report on the Financial Outlook for Medicaid,” U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary, December 21, 2010; available at www.cms.gov/ActuarialStudies/downloads/MedicaidReport2010.pdf.
3. Truffer *et al.*, “2010 Actuarial Report on the Financial Outlook for Medicaid.”
4. National Association of State Budget Officers (NASBO), “Fiscal Year 2009 State Expenditure Report,” December 2010, pp. 17 and 48; available at www.nasbo.org/Publications/StateExpenditureReport/tabid/79/Default.aspx.
5. This share factors in all state expenditures for Medicaid from all funding sources including state general funds, other states funds, and federal funds. NASBO, “Fiscal Year 2009 State Expenditure Report,” p. 8.
6. The incomes used in the formula are rolling three-year average per capita incomes for each state and the United States, produced by the Department of Commerce’s Bureau of Economic Analysis. The FMAPs are based on income data from three to six years earlier because of the time lag for data collection and calculation.
7. Four additional states had FMAPs between 50 and 51 percent in FY 2010.
8. Evelyne Baumrucker, “Medicaid: The Federal Medical Assistance Percentage (FMAP),” Congressional Research Service, order code RL32950, September 24, 2010.
9. Baumrucker, “Medicaid: The Federal Medical Assistance Percentage (FMAP).”
10. For additional information about the enhanced FMAP see Baumrucker, “Medicaid: The Federal Medical Assistance Percentage (FMAP).”
11. *Federal Register*, vol. 75, no. 78, April 23, 2010, pp. 21314–21329; available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2010_register&docid=fr23ap10-82.pdf.
12. Government Accountability Office (GAO), “Medicaid: Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs Is Warranted,” GAO-10-69, November 2009, p. 11; available at www.gao.gov/new.items/d1069.pdf.
13. GAO, “Medicaid: Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs Is Warranted.”
14. For specific information about the DSH allotment changes in PPACA see Evelyne P. Baumrucker *et al.*, “Medicaid and CHIP: Changes Made by the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152) to the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148),” Congressional Research Service, order code R41125, April 1, 2010.
15. For additional information on UPLs and other supplemental payments, see GAO, “Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments,” GAO-08-614, May 2008; available at www.gao.gov/new.items/d08614.pdf.

16. GAO, "Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments."
17. GAO, "Medicaid: Intergovernmental Transfer Have Facilitated State Financing Schemes," GAO-04-574T, statement of Kathryn G. Allen before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives, March 18, 2004; available at www.gao.gov/new.items/d04574t.pdf.
18. The applicable safe harbor amount from January 2008 through September 2011 is 5.5 percent of revenues. The amount reverts to 6 percent in October 2012.
19. National Conference of State Legislators, "Health Care Provider and Industry Taxes/Fees," updated October 2010; available at www.ncsl.org/default.aspx?tabid=14359.