

THE BASICS

Medicaid Financing

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The Medicaid program, which provides health coverage to individuals with low incomes, is jointly funded by the federal and state governments. Each state administers its Medicaid program within broad federal guidelines.¹ In 2014, Medicaid provided coverage to an estimated 64.6 million people.² Estimated combined state and federal spending was \$498.9 billion, of which the federal government paid about 60 percent and states paid about 40 percent.³

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) created a state option to expand eligibility for Medicaid in 2014 from children, parents, the aged, and persons with disabilities to include working age adults without children.⁴ To date, 30 states and the District of Columbia have opted to expand eligibility.⁵ The number of persons covered in October 2014 is estimated to have increased approximately 9.6 percent from the prior year.⁶ The cost of these new eligibles will be paid entirely by the federal government through 2016, increasing the federal share of spending.

Medicaid is a sizeable portion of total state spending. On average, state and federal Medicaid spending accounted for 25.6 percent of total state budgets (including general state funds, other state funds, and federal funds) in 2014. It is the single largest budget item, next to elementary and secondary education, at 19.8 percent for most states.⁷

CALCULATING STATE AND FEDERAL SHARES OF MEDICAID

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, 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 determines the federal and state share of Medicaid spending in each state by comparing a state's per capita personal income with the national average per capita income.⁸ The 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.

The formula for the federal share is:

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

The formula for the state share is:

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

The 0.45 in the FMAP formula ensures that states with average per capita income receive a federal share of 55 percent. The statute 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 of 83 percent on the FMAP. For territories, federal law also sets the federal government's share at 55 percent for the cost of Medicaid items and services up to specific spending caps. The FMAP is set at 70 percent by statute 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 American Indians), or for Medicaid administrative costs is not determined using the FMAP formula and instead is specified separately under federal law.

Every November, the Secretary of the U.S. Department of Health and Human Services (HHS) publishes the FMAP for each state and territory in the *Federal Register* for the fiscal year beginning the following October. The FMAP is in effect for a one-year period. Based on the statutory

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formula, regular FMAPs for fiscal year (FY) 2016 range from the floor amount of 50 percent (in 12 states) to a high of 74.17 percent.⁹

Financing Affordable Care Act Eligibles

The ACA would have expanded Medicaid eligibility effective January 2014 to adults under age 65 with incomes up to 133 percent of the federal poverty level (FPL). The ACA required states to expand eligibility to this group to continue to receive any federal funding for their Medicaid programs. But in June 2012, the U.S. Supreme Court issued a decision in *National Federation of Independent Business v. Sebelius* that held that the federal government cannot make all federal Medicaid funding for a state's Medicaid program contingent on a state implementing the ACA Medicaid expansion in 2014.¹⁰ As a result of this decision, states may opt not to expand the program to newly eligible adults without losing their federal Medicaid funding for other eligible populations. In states that do expand eligibility to adults under age 65 with incomes up to 133 percent of the FPL, the federal government is to pay 100 percent of the costs 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 for those newly eligible for Medicaid as a result of the ACA. In a document released in December 2012, the Centers for Medicare & Medicaid Services (CMS) announced that states cannot expand to less than 133 percent of the FPL and receive 100 percent federal payment for this group. CMS stated that the law does not provide for a phased-in or partial expansion, and that the higher federal matching rate will not be available to states that partially expand coverage (such as up to 100 percent of FPL) through 2016.¹¹

HOW STATE PAYMENTS HAVE AFFECTED FEDERAL PAYMENTS

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 and have used various financing mechanisms to do so. Disproportionate hospital share (DSH) payments, upper payment limit (UPL) payments, and intergovernmental transfers (IGTs) are all permissible under law, but how they have been employed to increase states' receipt of federal funds rather than supporting Medicaid services has been a continuing concern. These

mechanisms, and the issues involved with them, are explained briefly in the following sections.

Overall, the problematic aspect of these mechanisms is the two-way transfer of funding between providers and state Medicaid programs. The norm for a Medicaid payment would be payment of federal and state funds from Medicaid to a provider with the provider retaining the funds for having delivered a service. The mechanisms to increase federal matching funds, instead, may involve first a transfer of funds from providers to the state in the form of a donation, payment of a special tax, or an IGT. The state then returns some or all of those funds, with federal matching funds added, to the provider. Alternatively, a state may initiate the payment of combined federal and state funds to a provider who then returns all or some of those funds to the state. States' use of these mechanisms to increase federal payment began in the late 1980s and led to increased federal scrutiny and legislative and regulatory actions to limit certain of these financing arrangements.

Disproportionate Share Hospital (DSH) Payments

DSH payments are required supplemental payments to hospitals that are intended to offset the costs of caring for low-income and uninsured patients. DSH payments were one of the earliest mechanisms states used to increase federal revenues in the late 1980s. Previously, few states were making any DSH payments. Several federal actions were taken to encourage them. A 1985 Health Care Financing Administration (HCFA, the predecessor to CMS) rule allowed states to receive provider donations, and OBRA (the Omnibus Budget Reconciliation Act) of 1986 allowed payments to hospitals serving large numbers of low-income patients to exceed the Medicaid Upper Payment Limit (described in more detail below).¹² DSH payments increased rapidly, growing from \$1.4 billion in 1990 to \$17.5 billion in 1992. In eight states, they represented over one-fifth of all Medicaid spending and in one state more than 40 percent.¹³ There was also evidence of some of these funds being used to increase the federal share of Medicaid spending rather than for services.¹⁴ The Congress in response took a number of actions, including banning non-bona fide donations and setting limit on the amount each state may claim from the federal government for DSH payments.

For FY 2014, the federal DSH allotment for all states and the District of Columbia is estimated to be \$11.65 billion, but the allotments to each state vary.¹⁵ These state allotments are based, in part, on historical DSH

payments. As a result, policies to control DSH spending preserved some of the differences in DSH allotments across states that some 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. Today, a state's DSH allotment for a given year is the higher of (i) its FY 2004 DSH allotment or (ii) the previous year's allotment adjusted for inflation.¹⁶ Each state's allotment also cannot be more than the higher of the prior year's allotment or 12 percent of the state's total Medicaid spending (federal and state, excluding administrative costs).

The ACA contains provisions to reduce federal DSH allotments to states as the expected number of uninsured individuals decreases due to the anticipated expansion of Medicaid eligibility and access to private insurance through exchanges beginning in 2014. The ACA directs the Secretary of HHS to reduce aggregate Medicaid DSH allotments by \$500 million in 2014, \$600 million in 2015 and in 2016, \$1.8 billion in 2017, \$5 billion in 2018, \$5.6 billion in 2019, and \$4 billion in 2020.¹⁷ In addition, the Middle Class Tax Relief and Job Creation Act of 2012 extended the 2020 reduction to 2021. However, Congress has delayed implementation of the cuts three times, first in the Bipartisan Budget Act of 2013, again in the Protecting Access to Medicare Act of 2014 (PAMA), and most recently in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA set the first reduction for FY 2018 at \$2.0 billion, extended the cuts to FY 2025, and more than doubled the magnitude of the total cuts to \$43 billion.¹⁸

The ACA requires the Secretary of HHS to allocate these aggregate reductions across the states using broad guidelines. Larger percentage DSH reductions are to be imposed on states that have the lowest share of uninsured individuals or states that do not target their DSH payments to hospitals with large numbers of Medicaid patients and high levels of uncompensated care. Smaller percentage DSH reductions are to be imposed on states with total Medicaid DSH payments of less than 3 percent of total Medicaid spending for FY 2000 (also called "low DSH" states). HHS has indicated how the postponed reductions for FY 2014 and FY 2015 would be allocated,¹⁹ but has not said if the same methodology would apply to the delayed reductions.

Concerns about the equity of federal and state DSH policy, the accuracy of the states' calculations used to distribute their DSH allocations to hospitals, and CMS's oversight of state DSH programs have been longstanding and persist today.²⁰ Since 2010, CMS has required states

to submit annual audits and reports on DSH payments. The U.S. Government Accountability Office (GAO) analysis of these audits found that states will need to make changes to their DSH payments to comply with federal law.²¹ GAO also concluded that information from audits will provide useful information to guide the Secretary's required reduction in DSH payments starting in 2014.

Upper Payment Limits (UPLs)

Medicaid Upper Payment Limits (UPLs) are the ceiling on Medicaid payment amounts 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, such as nursing facility services or inpatient or outpatient hospital services. Because states' Medicaid payment rates are typically less than Medicare rates, states may make supplemental payments to some hospitals or other providers in addition to standard Medicaid payments and DSH payments, receive federal matching funds, and still be under the aggregate UPL for a given category of services. GAO had documented instances of local government-operated facilities receiving such supplemental payments and returning all or some to the state through IGTs.²² Congress in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) required separate UPLs for local public and private providers to limit the potential impact of such arrangements.²³ In a 2012 report, the GAO reviewed its longstanding problems with oversight of UPL payments, which it saw as in need of improved accountability and transparency. Specifically, the GAO cited the need for more thorough CMS review of states' payment arrangements "to ensure that payments were for Medicaid purposes"; the need for better guidance to states about calculating UPLs and payment amounts; and the "need for improved transparency for non-DSH payments, which are often large and made to small numbers of providers, through facility-specific reporting of these payments."²⁴ GAO reiterated these concerns in a report published July 29, 2014, on Medicaid and state financing methods and payments to providers.²⁵

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. Federal 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 came under federal scrutiny when they were used in conjunction with supplemental payments to increase the federal share of Medicaid spending.

Provider Taxes

States may use taxes (sometime called fees or assessments) on health care providers to generate funds needed to finance the state share of their Medicaid costs. States' provider tax structures must comply with federal requirements. After several years of aggressive use of provider taxes by some states,²⁶ Congress passed a law in 1991 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.²⁷ States can comply with the hold harmless provision by limiting the taxes to a federally defined safe harbor amount of less than 6 percent of a provider's net patient revenues.²⁸ Provider taxes cannot exceed 25 percent of a state's share of Medicaid spending. For FY 2014, 49 states and the District of Columbia had at least one Medicaid provider tax, up from 41 states in 2006.²⁹ The only state without a provider tax is Alaska.³⁰

ENDNOTES

1. For more detail, see "The Basics: Medicaid Eligibility and Benefits," National Health Policy Forum, January 5, 2015, www.nhpf.org/library/details.cfm/2546.
2. 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 at a point in time, or "person year equivalents," was 58.9 million in 2013, as estimated by the CMS Office of the Actuary. An estimated 72.5 million people were enrolled in Medicaid for at least one month in 2013. Christopher J. Truffer *et al.*, "2014 Actuarial Report on the Financial Outlook for Medicaid," U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary, 2014, pp. ii–iii, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2014.pdf>.
3. Truffer *et al.*, "2014 Actuarial Report on the Financial Outlook for Medicaid," p. ii.

4. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) would have expanded Medicaid eligibility effective January 2014 to adults under age 65 with incomes up to 133 percent of the federal poverty level (FPL). A U.S. Supreme Court decision in June 2012 made the expansion optional. See Alison Mitchell, "Medicaid Financing and Expenditures," Congressional Research Service, Report R42640, July 30, 2012, p. 17.
5. National Academy for State Health Policy, StateReform.org, "Map: Where States Stand on Medicaid Expansion Decisions," updated December 29, 2015, <https://www.statereform.org/Medicaid-Expansion-Decisions-Map>.
6. Truffer *et al.*, "2014 Actuarial Report on the Financial Outlook for Medicaid," p. ii.
7. National Association of State Budget Officers (NASBO), "State Expenditure Report: Examining Fiscal 2013-2015 State Spending," November 19, 2015, p. 6, www.nasbo.org/sites/default/files/State%20Expenditure%20Report%20%28Fiscal%202013-2015%29S.pdf.
8. The incomes used in the formula are rolling three-year average per capita incomes for each state and the United States, produced by the U.S. 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.
9. FMAPs for FY 2016 can be seen at Office of the Assistant Secretary for Planning and Evaluation, "ASPE FMAP 2016 Report: Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2015 through September 30, 2016," U.S. Department of Health and Human Services, December 2, 2014, <http://aspe.hhs.gov/basic-report/fy2016-federal-medical-assistance-percentages>.
10. Mitchell, "Medicaid Financing and Expenditures."
11. Centers for Medicare & Medicaid Services (CMS), "Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid," December 10, 2012, p. 12, www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf.
12. Teresa A Coughlin and David Liska, "The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues," The Urban Institute, October 1997, www.urban.org/research/publication/medicaid-disproportionate-share-hospital-payment-program.
13. Coughlin and Liska, "The Medicaid Disproportionate Share Hospital Payment Program."
14. U.S. General Accounting Office (GAO), "Medicaid: States Use Illusory Approaches to Shift Costs to the Federal Government," HEHS 94-133, August 1, 1994, www.gao.gov/assets/230/220257.pdf.
15. KFF, "State Health Facts: Federal Medicaid Disproportionate Share Hospital (DSH) Allotments" FY 2014 data, accessed January 4, 2016, <http://kff.org/medicaid/state-indicator/federal-dsh-allotments/>.
16. The only state that received its FY 2004 DSH allotment in FY 2012 is Louisiana. See Alison Mitchell, "Medicaid Disproportionate Share Hospital Payments," Congressional Research Service, Report R42865, December 2, 2013, p. 5.

17. Mitchell, "Medicaid Disproportionate Share Hospital Payments."
18. "Medicare Access and CHIP Reauthorization Act of 2015," P.L. 114-10, April 16, 2015, p. 162, <https://www.congress.gov/114/plaws/publ10/PLAW-114publ10.pdf>.
19. *Federal Register*, "Medicaid Program; Preliminary Disproportionate Share Hospital Allotments (DSH) for Fiscal Year (FY) 2014," CMS-2389-N, 79, no. 40, February 28, 2014, p. 11441, www.gpo.gov/fdsys/pkg/FR-2014-02-28/pdf/2014-04032.pdf.
20. U.S. Government Accountability Office (GAO), "Medicaid: Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs Is Warranted," GAO-10-69, November 2009, www.gao.gov/assets/300/298754.pdf.
21. GAO, "Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed," GAO-13-48, November 26, 2012, www.gao.gov/assets/660/650322.pdf.
22. GAO, "Medicaid: State Financing Schemes Again Drive Up Federal Payments," HEHS-00-193, September 6, 2000, www.gao.gov/assets/110/108615.pdf.
23. Elicia J. Herz, "Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action," Congressional Research Service, Report RL31021, updated April 24, 2002.
24. GAO, "Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed," pp. 10 and 11.
25. GAO, "Medicaid: Completed and Preliminary Work Indicate that Transparency around State Financing Methods and Payments to Providers Is Still Needed for Oversight," GAO-14-817T, July 29, 2014, www.gao.gov/products/GAO-14-817T.
26. For the history of states' uses of provider taxes see Alison Mitchell, "Medicaid Provider Taxes," Congressional Research Service, Report RS22843, March 15, 2012.
27. Federal legal requirements for provider taxes can be found in section 1903(w) (3)-(7) of the Social Security Act, www.ssa.gov/OP_Home/ssact/title19/1903.htm.
28. From January 1, 2008, through September 30, 2011, the threshold was 5.5 percent. The threshold reverted back to 6 percent on October 1, 2011.
29. National Conference of State Legislators (NCSL), "Health Care Provider and Industry Taxes and Fees," July 10, 2014, www.ncsl.org/issues-research/health/health-provider-and-industry-state-taxes-and-fees.aspx.
30. NCSL, "Health Care Provider and Industry Taxes and Fees."