

medicaid
and the uninsured

January 2004

Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds

By Victoria Wachino, Andy Schneider, and David Rousseau

Executive Summary

Medicaid, the health care program for low-income families, the elderly, and persons with disabilities, is jointly financed by the federal and state governments. Medicaid purchases health and long-term care coverage for over 50 million Americans and support tens of thousands of health care providers in urban and rural communities throughout the country. Medicaid is a major budget item for states, and at the same is also the single largest source of federal grant support to states. Understanding Medicaid's financing structure is essential to understanding this major state and federal budgetary commitment, and ultimately to understanding health care and long-term care coverage for low-income people in the United States.

Medicaid's financing structure has been in place since the Medicaid program was created in 1965. Under this structure, states and the federal government share financial responsibility for the program and federal funds for the program are provided without predetermined limits. Recently, some proposals have been advanced at the national level to change this structure. In January 2003, the Bush Administration proposed to cap all federal Medicaid spending, along with providing some modest additional funds and programmatic discretion to states. This proposal was debated by the National Governors' Association, which did not reach a position on it. In May 2003, Congress acted within the program's current structure to temporarily increase the federal share of financial responsibility for the program as part of a broader measure to provide fiscal relief to states.

This paper describes Medicaid's existing financing structure and examines its implications for the federal government, for states, and for coverage of the low-income populations Medicaid serves. Medicaid is an entitlement program, with a legal obligation on the part of the government to provide benefits to all eligible individuals. Medicaid, like any other entitlement program, is obligated to serve everyone who qualifies; its spending can therefore not be fixed in advance. Medicaid's financing structure, under which federal payments can increase when need for the program expands and decrease when need for the program falls, is fundamental to the individual entitlement that the program provides. Financing changes that cap federal matching funds would alter both the fundamental financing and entitlement structure of the program.

Medicaid's financing structure offers many benefits. It has helped the states make marked progress toward the achievement of many national health care objectives. These objectives include:

- Providing health coverage to low-income uninsured families, helping to offset increases in the number of uninsured in the United States;
- Filling in gaps in Medicare coverage, including outpatient prescription drugs and cost-sharing, for the 7 million low-income elderly and disabled individuals who are enrolled in both Medicare and Medicaid;
- Serving as the nation's principal source of coverage for long-term care, as Medicaid finances nearly half of all long-term care in the United States;
- Responding to unanticipated public health epidemics and disasters, with the HIV epidemic serving as a major example;
- Providing an essential source of financing for urban and rural providers throughout the country, accounting for almost one in every five health care dollars spent in the United States.

Moreover, Medicaid's financing structure helps both states and the federal government manage the cost and unpredictability of providing health and long-term care coverage to vulnerable low-income Americans. Health and long-term care coverage for poor families, seniors and people with disabilities entails unpredictable changes, such as changes in health care costs and economic conditions, as well as somewhat more predictable occurrences, like the long-term aging of the population. Medicaid's financing structure ensures that the federal government and the states share this risk and responsibility, with the federal government responsible for most of the expense. At the same time, the requirement that states contribute their own funds gives states an incentive to manage the program and control costs. Medicaid's open-ended federal matching structure offers other benefits to states as well. It ensures that federal Medicaid funds flow automatically to those states that are incurring health or long-term care costs; no Congressional reallocations to states that experience sudden increases or decreases in spending are necessary. Federal matching funds also facilitate the substantial discretion states have in administering the program, contribute to economic development in state and local economies, and provide significant support for other health-related programs in states' budgets.

At the same time, Medicaid's financing structure has posed a number of challenges. Although it ensures that the cost of health and long-term care coverage is shared between the federal government and the states, the cost of this coverage remains substantial for both parties and is difficult to predict. This expense and unpredictability may be an inescapable part of financing health coverage, particularly for low-income elderly and disabled populations. Spending on the other major government health program, Medicare, is also substantial, as is spending on employment-based health insurance. Another challenge is that Medicaid's matching payments do not automatically or quickly adjust to changing state economic conditions. During recessions, when many states have difficulty funding the state share of Medicaid spending, the federal share of support for the program does not necessarily increase. This means that Medicaid, despite

its substantial federal matching payments, can experience reductions in scope during economic downturns that have a negative impact on both program beneficiaries and newly uninsured low-income individuals. This dynamic is occurring now, as states are curtailing their Medicaid spending growth in the face of significant fiscal pressure. This shortcoming could be addressed within the program's existing structure, as Congressional action last year to temporarily increase the federal Medicaid matching rate demonstrates.

Finally, the Medicaid program has also faced consistent challenges to maintaining accountability for the use of federal matching funds. At a number of times in the program's history, some states have used "Medicaid maximization" arrangements that have increased federal spending in the program without comparable increases in state spending. These strategies have at times resulted in significant increases in federal spending on the program, and in the federal share of Medicaid spending. In some cases, states have applied these federal Medicaid funds to purposes other than health or long-term care for low-income individuals. The use of these strategies should be weighed against the vast majority of Medicaid spending, which has provided funds that have directly benefited low-income individuals and the health care providers that serve them. The federal government has in the past acted to curtail the use of these maximization strategies, and there is reason to believe that it could do more to limit or prevent them within the program's existing structure.

Medicaid's federal-state matching structure has been a central component of health and long-term care coverage for millions of Americans since 1965. It underpins the individual entitlement to coverage, and it makes it possible for states and the federal government to respond flexibly to changes in the health care system, to emerging public health threats, and to changes in the needs of the nation's low-income population. As the debate over Medicaid's future continues, care should be taken that any modifications to its financing structure do not jeopardize the many benefits it brings to low-income Americans, states, and the nation's health care system.

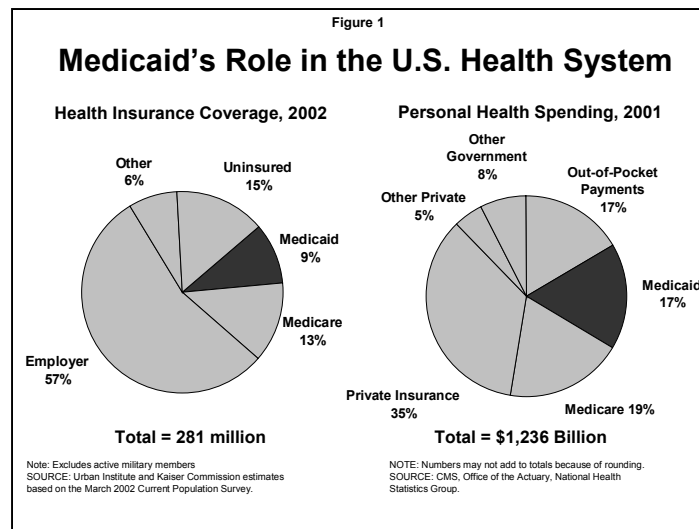
Table of Contents

Executive Summary	i
I. Introduction	1
II. Background: Medicaid’s Financing Structure and Entitlement to Coverage.....	3
<i>How the Federal Government Matches State Medicaid Spending</i>	3
<i>What is an Entitlement?</i>	4
<i>How Does Medicaid’s Financing Structure Support Its Entitlement to Coverage?</i>	5
<i>Exceptions to Federal Medicaid Matching Funds Without Predetermined Limits</i>	7
III. The Benefits of Medicaid’s Federal and State Matching Structure.....	8
<i>Progress Toward National Health Care Objectives</i>	10
<i>Helping States and the Federal Government Manage the Cost and Unpredictability of Health and Long-Term Care Coverage for Low-Income Americans</i>	16
<i>Financial Benefits to States and Support for State Discretion</i>	17
IV. The Challenges Facing Medicaid’s Federal and State Matching Structure.....	21
<i>States Bear A Large Share of the Cost and the Risk of Unpredictable Health Care Spending</i>	21
<i>Medicaid’s Financing Structure Does Not Adjust Rapidly to Changing Economic Conditions</i>	23
<i>Issues of Accountability for Federal Funds</i>	24
V. Conclusion	26
Appendix A: <i>How the Federal Medical Assistance Percentage (FMAP) Works</i>	27
Appendix B: <i>States’ Fiscal Choices and Their Impact on Medicaid</i>	29
Appendix C: <i>A Brief Summary of DSH and UPL Financing Arrangements</i>	31
Medicaid Glossary	34

I. Introduction

To understand a health care program one must understand how it is financed. Medicaid is no exception. A health insurance program administered by the states and paid for jointly by the federal and state governments, Medicaid in 2002 purchased medical and long-term care services for more than 50 million low-income children, their parents, people with disabilities, and seniors. It is the largest health care program in every state, averaging 16 percent of all state spending. Medicaid insures one-fifth of the nation's children, purchases about half the nation's nursing home care, and pays for more than half of all the costs of AIDS treatment.

Medicaid will serve 38 million children and parents in low-income families in 2004, according to the Congressional Budget Office.¹ In addition, it will serve 13 million seniors and individuals with disabilities, including 6 million Medicare beneficiaries who are also enrolled in Medicaid. For these people, Medicaid will assist with Medicare premiums and provide coverage for services, like outpatient prescription drugs, that Medicare does not cover. Nationally, Medicaid insured about 9 percent of all Americans in 2002 (Figure 1).



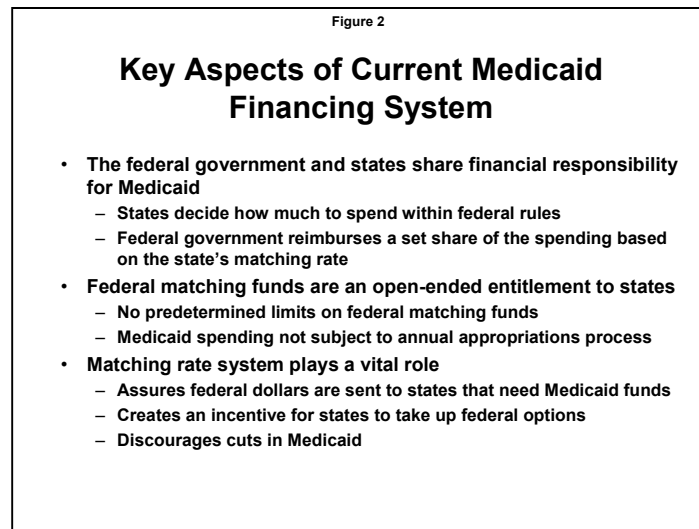
Medicaid is an entitlement program, and is financed with both federal and state funds. The federal government funds its share of the program through matching payments, which pay for more than half of all Medicaid spending. The federal government will spend \$162 billion on Medicaid in fiscal year (FY) 2003, according to the Congressional Budget Office, accounting for about 7.5 percent of all federal spending.² As a rough estimate, the states will spend over \$110 billion of their own funds during this same period, bringing total program spending to about \$270 billion.

The current economic downturn has brought Medicaid's financing structure into sharp focus. Precipitous declines in state revenues have prompted many states to reduce growth in their own spending on Medicaid, and to reduce funding for other programs as well. To address this situation, Congress earlier this year provided \$20 billion in fiscal

assistance to states, including \$10 billion in increased Medicaid matching funds during most of the FY 2003-2004 period. Earlier this year, the Bush Administration proposed a fundamental change in Medicaid's financing structure.³ The proposal would cap federal Medicaid matching payments and replace the requirement of state matching funds with a state maintenance of effort requirement. In addition, the proposal would give states additional discretion over some populations that the program covers. Because Medicaid affects millions of low-income Americans, involves billions of federal and state dollars, and plays such a large role in the nation's health care system, changes in the program's financing structure will have wide-ranging implications. The purpose of this paper is to explain Medicaid's current financing structure and to inform the debate on alternative financing approaches.

II. Background: Medicaid’s Financing Structure and Entitlement to Coverage

Medicaid’s financing structure contains two essential elements. First, Medicaid is funded with a combination of federal and state money, and federal payments are made on a matching basis that guarantees that the federal government pays more than half of all Medicaid spending.⁴ Second, these matching payments are not subject to predetermined limits. This means that they are available to pay for covered services for all eligible individuals based on those individuals’ need for health and long-term care services (Figure 2). This section discusses the manner in which the federal government matches state Medicaid spending, and how these matching payments support Medicaid’s entitlement to individuals.

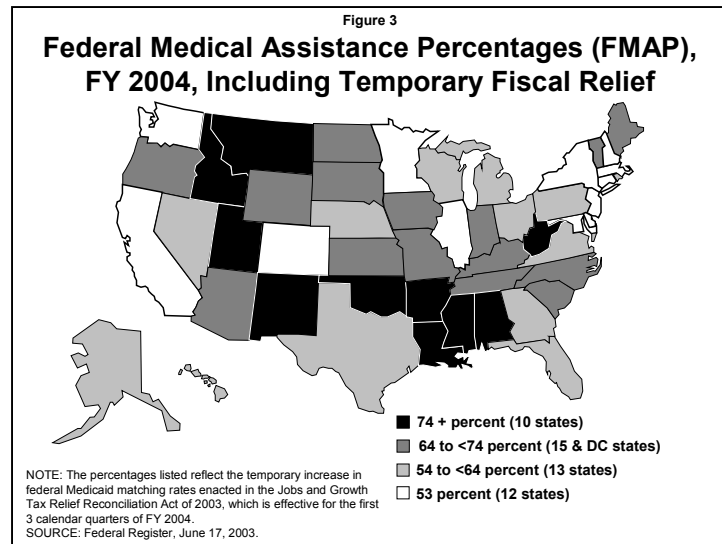


How the Federal Government Matches State Medicaid Spending

The federal government matches each state’s Medicaid spending at a set rate that varies by state. This rate is called the Federal Medical Assistance Percentage, or FMAP. Each state’s matching rate is determined by a formula set forth in the federal law that governs the Medicaid program.⁵ Under this formula, states with per capita incomes below the national average receive higher matching percentages. States with per capita incomes above the national average receive lower matching percentages. The formula is designed to try to account for variations in income across states. In law, the minimum FMAP is set at 50 percent and the maximum is set at 83 percent. Under the formula, state matching rates currently range from 50 percent to 77 percent. On average across all states, the federal government matches 57 percent of what states spend on Medicaid. Congress temporarily increased these matching rates by nearly three percent in 2003 as part of a package providing states with fiscal relief (For a detailed explanation of the FMAP, see Appendix A, “*How the Federal Medical Assistance Percentage Works*”).

Table 1 on page 13 shows each state’s matching rate for FY 2004 and FY 2005.⁶ The FY 2004 rate reflects the temporary increase in matching rates states received as part

of the “Jobs and Growth Tax Relief Reconciliation Act of 2003” in May 2003. Twelve states have federal matching rates of 53 percent in FY 2004: California, Colorado, Connecticut, Delaware, Illinois, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, and Washington. Most of these states would have lower matching rates if it were not for the statutory floor constraining the operation of the formula. At the other end of the range, 10 states have matching rates of 74 percent or more in FY 2004. As shown in Figure 3, these states are concentrated in the South and the West: Alabama, Arkansas, Idaho, Louisiana, Mississippi, Montana, New Mexico, Oklahoma, Utah, and West Virginia.



Federal matching payments are available to states for all covered services provided to covered beneficiaries. This means that the federal government shares substantially in the costs states incur in providing health and long-term care coverage to the Medicaid population. When state Medicaid spending increases, federal matching payments increase commensurately. This occurs regardless of whether spending increases take place as a result of factors beyond the state’s control (such as increases in unemployment or disability rates) or as a result of decisions states make to expand eligibility or offer additional services.

Federal matching funds apply equally to “mandatory” benefits and eligibility categories that a state must cover if it participates in the Medicaid program as well as to additional, “optional” categories of eligibility and services that a state may elect to cover.⁷ States receive the same open-ended federal matching funds, at the same matching rate, for mandatory populations and services and for optional populations and services. About two-thirds of all Medicaid spending is for “optional” services or populations.⁸

What is an Entitlement?

An entitlement program creates a legal obligation on the part of the government to provide benefits to any person, business, or other unit of government that meets the

criteria set in law. There are many federal entitlement programs; by far the biggest of these are Social Security, Medicare and Medicaid.

Medicaid encompasses two entitlements. First, it is an entitlement to individuals. Any person who meets the requirements for eligibility established by the Medicaid program in the state in which the person resides is entitled to receive the services that the state offers. The entitlement applies regardless of where in the state the eligible individual lives, the individual's health status, or how many other individuals meet the eligibility requirements. Medicaid is also an entitlement to states that participate in the program.⁹ States are entitled to receive federal matching payments for a share of all the costs they incur in paying for services furnished to Medicaid beneficiaries. Both the entitlement to individuals and the entitlement to states are legally enforceable through the courts.¹⁰

How Does Medicaid's Financing Structure Support Its Entitlement to Coverage?

Financing is fundamental to an entitlement program, because the financing structure must back up the legal obligation that the program creates. State and federal Medicaid funding is based on need, not on a fixed budget, and this is what makes the entitlement to individuals possible. It means that all individuals within a state who meet Medicaid eligibility requirements can receive all of the services that state covers.

Because an entitlement program is legally obligated to serve all who are eligible, its spending is not fixed. Spending is broadly determined by the need for the program's services, within the constraints of the policies under which the program operates – specifically, the eligibility criteria, benefit coverage, and payment rules. At its most basic, Medicaid spending is determined by the number of people the program serves, the benefits that they use, and how much the program pays for these benefits. None of these factors is fixed; each is subject to change beyond states' control.

The financing structure of an entitlement program must have the capacity to respond to these changes. Spending on entitlement programs is inherently difficult to predict. To determine how much funding the program requires one must know in advance what the need for the program's services will be – how many people will be eligible and enroll, what services they will use, and how much must be spent to purchase those services. These two qualities – the need to serve all who are eligible, and the consequent unpredictability of spending – make any capped or predetermined limits on Medicaid spending incompatible with the entitlement nature of the program. A preset limit would either overestimate or underestimate the funding that is required for the program. An overestimate would mean that funding is provided beyond what is necessary to meet the need for the program. An underestimate would mean that the program would not be able to provide benefits to all who are eligible. Under Medicaid's financing structure, state and federal funding essentially “follows the people” to pay for the services that beneficiaries use.

The financing of entitlement programs stands in contrast with federal spending in non-entitlement, or “discretionary” programs, where funding does not match the people served, but is preset. Instead, Congress generally appropriates a set amount of funds in advance.¹¹ If the federal government provided a set amount of funding each year, as it does for “discretionary” health programs like the Ryan White CARE Act program, then that dollar amount, rather than eligibility criteria or the need for services, would determine how many people the program serves or which services those people receive.

Federal matching payments support states’ decisions to maintain health coverage. Under a capped funding structure, states would essentially face two choices when spending exceeds the cap. The state could reduce spending on its program to fit within the cap. This would likely involve limiting the number of people the program serves, limiting the benefits the program offers, or limiting how much the state pays for services. Alternatively, states could assume all of the costs of providing services to eligible individuals above this federal cap amount. This is a financial exposure that many states would be unable or unwilling to assume.

The difference between programs that provide an entitlement to individuals without a limit on federal matching funds and those that do not is illustrated by the differences between the Medicaid program and the State Children’s Health Insurance Program (SCHIP). SCHIP is a block grant to states to provide health coverage to uninsured children in families with incomes that exceed Medicaid eligibility levels.¹² Like Medicaid, SCHIP is a federal-state matching program. Like Medicaid, SCHIP entitles states to federal matching payments, although the SCHIP matching rate is more generous to states than Medicaid’s is.¹³ Unlike Medicaid, however, federal matching payments to states for SCHIP costs are capped. The total amount of federal matching funds for SCHIP is set at a specific amount each fiscal year. For example, the amount for FY 2004, which was specified in 1997, is \$3.2 billion, the same amount specified in 1997 for FY 2003.¹⁴ Within these totals, set allotments are made to individual states. Therefore, under SCHIP, a state’s spending on health services for eligible children is matched by the federal government up to certain amount each year.

The SCHIP financing structure raises a number of issues. The cap on federal payments affects decisions states make about extending health care coverage to uninsured children. States may, for example, limit the enrollment of eligible children to keep their spending below the level at which they would exhaust their allotment of federal matching payments. This means that two children with the same income level may be treated differently: one child may qualify for the program and the other may not, because of the enrollment cap and depending on the timing of the child’s application. A study of the effects of an enrollment cap imposed by North Carolina’s SCHIP program from January to October 2001 concluded that “many families faced significant hardships as a result” of the cap.¹⁵

At the same time, the levels of federal funding for SCHIP will not keep up with the numbers of children who are potentially eligible for the program. Federal SCHIP funding fell from \$4.3 billion in FY 2001 to \$3.1 billion in FY 2002 because the SCHIP

legislation contains a built-in funding dip that was designed to meet budget targets at the time of enactment. As a result of this dip, the Office of Management and Budget has estimated that over time, states will reduce the number of uninsured children the program serves by an estimated 900,000.¹⁶

Exceptions to Federal Medicaid Matching Funds Without Predetermined Limits

Although Medicaid generally does not place predetermined limits on federal matching funds to states, there are some notable exceptions to this policy. Federal matching payments for disproportionate share hospitals (DSH) are capped under federal law; these caps are discussed in Appendix C. More recently, the Centers for Medicare and Medicaid Services (CMS), which administers the Medicaid program, has increasingly been capping some federal funds to states through waivers. Waivers provide an exception for states that seek to deviate from the requirements of federal Medicaid law but wish to continue receiving federal Medicaid matching funds. Tennessee's Medicaid program, TennCare, has since 1994 operated under a waiver that limits total federal spending. More recently, CMS and several states have agreed to set caps on federal Medicaid payments for services provided to the elderly as part of "Pharmacy Plus" waivers that finance prescription drug coverage for the low-income elderly through Medicaid. Five states have received Pharmacy Plus waivers; eight additional states have waiver applications pending.¹⁷ For these states, which have foregone Medicaid's entitlement to matching funds for all elderly Medicaid beneficiaries, accepting the federal funding cap is a fundamental shift in federal financing. This growing movement toward capping federal Medicaid matching funds represents a significant departure from the traditional financing arrangements the program has offered.

III. The Benefits of Medicaid’s Federal and State Matching Structure

Medicaid’s existing federal and state financing structure has enabled states and the federal government to make measurable progress toward achieving national health and long-term care objectives. It also offers some clear benefits to states: helping states bear the cost burden of health and long-term care coverage for their low-income residents; ensuring that federal matching funds are automatically allocated to states that need them; supporting state discretion in administering the program; and providing fiscal support for state budgets and state economies. This section of the paper discusses these benefits.

Table 1: Federal Medical Assistance Percentages (FMAP)

State	FY 2004 FMAP	FY 2005 FMAP
Alabama	73.7%	70.8%
Alaska	61.3%	57.6%
Arizona	70.2%	67.5%
Arkansas	77.6%	74.8%
California	53.0%	50.0%
Colorado	53.0%	50.0%
Connecticut	53.0%	50.0%
Delaware	53.0%	50.4%
District of Columbia	73.0%	70.0%
Florida	61.9%	58.9%
Georgia	62.6%	60.4%
Hawaii	61.9%	58.5%
Idaho	73.9%	70.6%
Illinois	53.0%	50.0%
Indiana	65.3%	62.8%
Iowa	66.9%	63.6%
Kansas	63.8%	61.0%
Kentucky	73.0%	69.6%
Louisiana	74.6%	71.0%
Maine	69.2%	64.9%
Maryland	53.0%	50.0%
Massachusetts	53.0%	50.0%
Michigan	58.8%	56.7%
Minnesota	53.0%	50.0%
Mississippi	80.0%	77.1%
Missouri	64.4%	61.2%
Montana	75.9%	71.9%
Nebraska	62.8%	59.6%
Nevada	57.9%	55.9%
New Hampshire	53.0%	50.0%
New Jersey	53.0%	50.0%
New Mexico	77.8%	74.3%
New York	53.0%	50.0%
North Carolina	65.8%	63.6%
North Dakota	71.3%	67.5%
Ohio	62.2%	59.7%
Oklahoma	73.5%	70.2%
Oregon	63.8%	61.1%
Pennsylvania	57.7%	53.5%
Rhode Island	59.0%	55.4%
South Carolina	72.8%	69.9%
South Dakota	68.6%	66.0%
Tennessee	67.5%	64.8%
Texas	63.2%	60.9%
Utah	74.7%	72.1%
Vermont	65.4%	60.1%
Virginia	53.5%	50.5%
Washington	53.0%	50.0%
West Virginia	78.1%	74.7%
Wisconsin	61.4%	58.3%
Wyoming	64.3%	57.9%

Source: <http://aspe.hhs.gov/search/health/fmap.htm>

Note: FY 2004 rates include 2.95% temporary increase in FMAP Congress provided. FY 2005 rates do not.

Underpinning the progress made toward national objectives is the incentive that federal matching payments create for states to offer coverage to their low-income populations. Medicaid’s matching formula is simple. In a state with a 50 percent matching rate, if the state spends \$100 million for covered services that have been provided to Medicaid beneficiaries, the federal government will pay the state \$50 million to match 50 percent of the state’s \$100 million in expenditures. This means that the state effectively contributes only \$50 million of its own funds to provide \$100 million in Medicaid services. In a state with a 70 percent matching rate, the federal government will match \$70 million of the state’s \$100 million in Medicaid expenditures, meaning that the state contributes only \$30 million to provide \$100 million in Medicaid services.

These straightforward matching arrangements create powerful financial incentives for states. States that seek to expand coverage to low-income groups through Medicaid know that, depending on the state, between 50 and 77 percent of the cost of this expansion will be borne by the federal government (See Table 1 and Figure 3). The higher the matching rate, the stronger the incentives. For example, the “return on investment” of the state with the 70 percent matching rate— i.e., federal

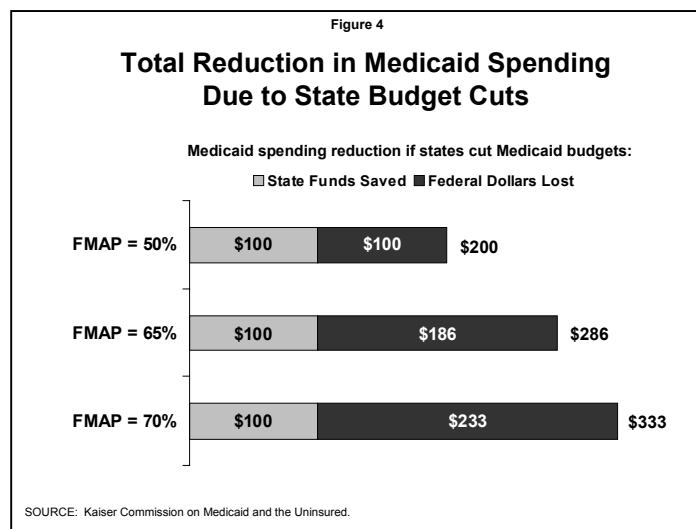
funds flowing into its economy as the result of state spending on Medicaid – is 233 percent. For every \$1 that state spends, it receives \$2.33 in federal matching funds. These ratios are shown in Table 2.

Table 2: Federal Matching Funds Provided for Each Dollar of State Medicaid Spending, FY 2004

State	FY 2004 FMAP	Federal Funds Sent to State for Each Dollar in State Medicaid Spending
Alabama	73.7%	\$2.80
Alaska	61.3%	\$1.59
Arizona	70.2%	\$2.36
Arkansas	77.6%	\$3.47
California	53.0%	\$1.13
Colorado	53.0%	\$1.13
Connecticut	53.0%	\$1.13
Delaware	53.0%	\$1.13
District of Columbia	73.0%	\$2.70
Florida	61.9%	\$1.62
Georgia	62.6%	\$1.67
Hawaii	61.9%	\$1.62
Idaho	73.9%	\$2.83
Illinois	53.0%	\$1.13
Indiana	65.3%	\$1.88
Iowa	66.9%	\$2.02
Kansas	63.8%	\$1.76
Kentucky	73.0%	\$2.71
Louisiana	74.6%	\$2.93
Maine	69.2%	\$2.24
Maryland	53.0%	\$1.13
Massachusetts	53.0%	\$1.13
Michigan	58.8%	\$1.43
Minnesota	53.0%	\$1.13
Mississippi	80.0%	\$4.01
Missouri	64.4%	\$1.81
Montana	75.9%	\$3.15
Nebraska	62.8%	\$1.69
Nevada	57.9%	\$1.37
New Hampshire	53.0%	\$1.13
New Jersey	53.0%	\$1.13
New Mexico	77.8%	\$3.50
New York	53.0%	\$1.13
North Carolina	65.8%	\$1.92
North Dakota	71.3%	\$2.49
Ohio	62.2%	\$1.64
Oklahoma	73.5%	\$2.78
Oregon	63.8%	\$1.76
Pennsylvania	57.7%	\$1.36
Rhode Island	59.0%	\$1.44
South Carolina	72.8%	\$2.68
South Dakota	68.6%	\$2.19
Tennessee	67.5%	\$2.08
Texas	63.2%	\$1.72
Utah	74.7%	\$2.95
Vermont	65.4%	\$1.89
Virginia	53.5%	\$1.15
Washington	53.0%	\$1.13
West Virginia	78.1%	\$3.57
Wisconsin	61.4%	\$1.59
Wyoming	64.3%	\$1.80

Source: Kaiser Commission on Medicaid and the Uninsured estimates based on FFY 2004 FMAPs as published at <http://aspe.hhs.gov/search/health/FMAP03-04temporaryincrease.html>
 Note: FY 2004 rates include temporary fiscal relief.

Conversely, the current matching arrangements create a disincentive to cut Medicaid eligibility or benefits, because states face a loss of federal matching funds when they reduce their own spending on Medicaid. For example, in order to save \$1 in state funds, a state with a 70 percent matching rate must reduce its Medicaid spending by \$3.33, foregoing \$2.33 in federal matching funds. In contrast, when a state with a 50 percent matching rate wants to save \$1 in state funds, it must reduce its Medicaid program spending by \$2, foregoing \$1 in federal matching funds (Figure 4). From a budgetary perspective, enhanced federal matching rates such as those under SCHIP provide even more powerful incentives to invest in health care coverage.¹⁸ Of course, these financial incentives do not necessarily determine state policymaking. States facing revenue shortfalls or competing budget priorities do reduce their own Medicaid spending notwithstanding the resulting loss of federal funds.

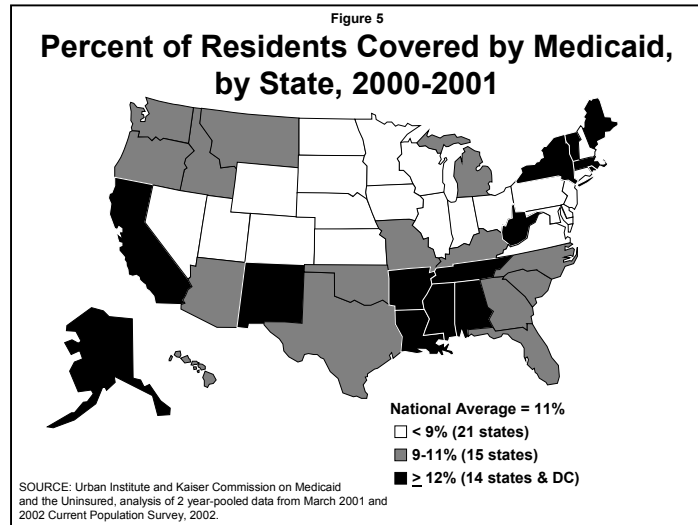


Progress Toward National Health Care Objectives

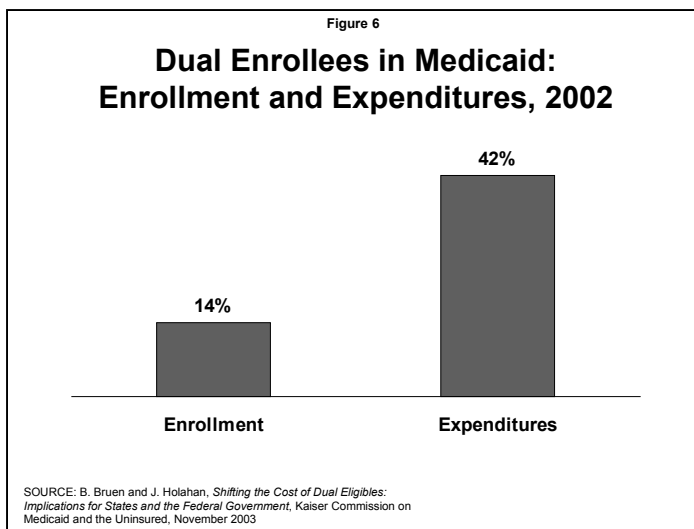
Medicaid helps to fulfill many policy objectives, which range from providing basic health coverage to low-income families and reducing the number of uninsured Americans to serving as the major provider of long-term care. The progress states have made toward these objectives would not have been possible without a firm federal commitment to share substantially in all the costs entailed in meeting them. Federal funding for Medicaid is derived from revenues that the federal government receives from taxpayers across the country. This gives the federal government a strong interest in ensuring that the program works toward achieving national goals. This section outlines the implications of Medicaid’s financing structure for progress toward five major health care goals: covering the low-income uninsured; supplementing Medicare for low-income seniors; serving as the nation’s principal source of financing for long-term care; responding to public health epidemics; and supporting health care providers, particularly those that make up the nation’s safety net.

Improving health coverage of the low-income population. From the time of its enactment in 1965, one of Medicaid’s central purposes has been the financing of basic health care coverage for low-income Americans. As historians have noted, Medicaid was originally an explicit effort on the part of the federal government to encourage states to provide health care coverage to low-income families with dependent children, the elderly, and individuals with disabilities.¹⁹ The federal government absorbs at least half – and in the majority of states, significantly more than half – of the costs of insuring the low-income uninsured through Medicaid. This gives states substantial flexibility in covering large numbers of their uninsured residents through Medicaid, and means that the federal government shares in the additional costs associated with state expansions of coverage to most categories of uninsured low-income individuals.²⁰ This structure has enabled states to use Medicaid to cover many low-income uninsured Americans, although the extent to which they have done so varies (Figure 5). Medicaid is the single largest source of coverage for this population, reaching about 40 percent of the nonelderly below poverty

and 23 percent of the near-poor (those with family incomes between 100 and 200 percent of the federal poverty level) in 2001.²¹ Over time, Medicaid’s coverage of low-income families has contributed substantially to decreases in the number of uninsured Americans in the country. More recently, Medicaid coverage has prevented the increase in the number of uninsured from growing even larger, and has helped maintain the number of children in the U.S. with insurance.



Medicaid also plays a significant role for pregnant women, funding over one out of every three births in the U.S. each year. Because low-income women are at greater risk for low birthweight births, and because Medicaid covers all pregnant women with incomes below 133 percent of the federal poverty level (\$11,940 per year in 2003), Medicaid is the most important source of financing for cost of care for preterm infants. At the same time, Medicaid also accounts for about half of the financing for publicly-funded family planning programs. Medicaid increases access to prenatal care and neonatal intensive care, helping to reduce the number of low birthweight births and avoidable birth defects, and infant mortality.



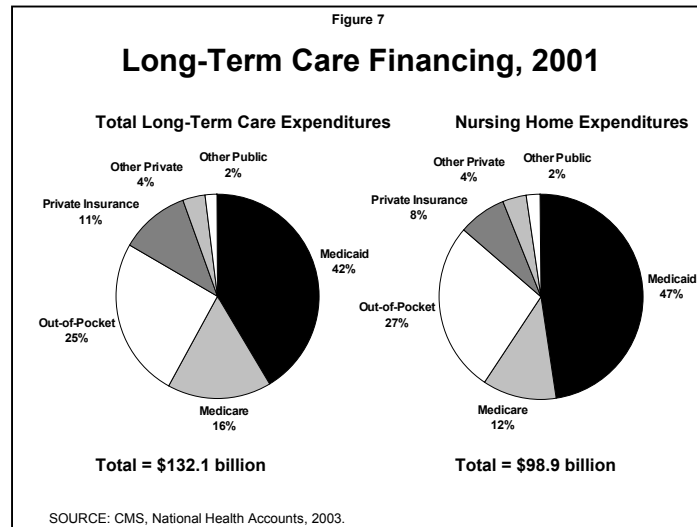
Supplementing Medicare for the low-income elderly. Over 7 million of Medicaid's nearly 51 million beneficiaries are "dual enrollees," low-income elderly or disabled individuals who are enrolled in both Medicaid and Medicare.²² Most of these individuals have substantial health needs, which means they require many different health and long-term care services and are expensive to cover. As shown in Figure 6, although dual enrollees represented 14 percent of all Medicaid enrollees in 2002, they accounted for more than 40 percent of total Medicaid spending that year.

Medicaid plays a significant role for these dual enrollees by paying for Medicare premiums and cost sharing, and for covering services Medicare does not. Medicare requires beneficiaries to pay out-of-pocket costs, including premiums, deductibles, and a 20 percent coinsurance requirement on most covered services.²³ These out-of-pocket costs, which apply to all beneficiaries regardless of income, can be quite substantial for low-income elderly and disabled Medicare beneficiaries. To reduce this financial burden, the Medicaid program finances the cost of Part B premiums and, in some cases, Medicare cost-sharing for low-income Medicare beneficiaries. These costs are shared between the states and the federal government on the same open-ended basis, using the same matching rate, as are the costs of covered services.²⁴

Medicaid also covers services Medicare does not. Most notably, as discussed below, Medicare does not cover most long-term care services. Moreover, Medicare currently does not cover outpatient prescription drugs, leaving Medicaid as the sole source of outpatient prescription drug coverage for the low-income elderly and disabled. This policy will change when the new Medicare drug benefit is implemented. Effective January 2006, no federal Medicaid matching funds will be available for the prescription drug costs of any dual enrollee; instead, the new Medicare Part D program will have sole responsibility for furnishing prescription drugs to this population.²⁵ At the same time, states will be required to send to the federal government, on a monthly basis, most of the projected savings to state Medicaid programs resulting from the termination of the Medicaid prescription drug benefit for dual enrollees. The amounts at issue are large: CBO estimates that, over 10 years, state Medicaid spending on prescription drugs will drop by \$115 billion; of this amount, states will be required to return \$88.5 billion to the Medicare program.²⁶

In sum, Medicaid fills in the gaps in Medicare coverage ensuring that 7 million low-income Medicare enrollees have comprehensive coverage. Medicaid coverage of long-term care, prescription drugs, and payment of Medicare cost sharing for low-income beneficiaries also allows the federal government to broaden the scope of Medicaid coverage while only bearing slightly more than half the cost of doing so. The cost of covering these individuals is substantial, costing the federal and state governments \$91 billion in 2002. Demographic changes, especially the aging of the population and a growth in the number of low-income aged and disabled individuals, are likely to mean significantly increased state spending on this group of Medicaid beneficiaries over time. Federal matching payments will help states respond to these demographic challenges.

Serving as the nation’s primary source of long-term care coverage. Because Medicare’s coverage of long-term care services is limited and because private long-term care insurance is either unaffordable or inaccessible for most Americans, Medicaid is the primary source of long-term care coverage in the United States. Medicaid pays for nearly half of all nursing home care (Figure 7). Medicaid also purchases a range of home-and community-based services that Medicare does not cover, including home health aide and personal care services. These differences are the reason that, while 40 percent of Medicaid spending on benefits on 2001 was devoted to long-term care, only about 16 percent of Medicare benefit payments that same year went toward long-term care services.



The single most expensive long-term care service, nursing home care, averaged \$56,000 per year in 2000.²⁷ This expense means that relatively small changes in the number of poor elderly people in a state who enter nursing homes can have a large impact on a state’s Medicaid budget. States vary in the number and proportion of individuals who are 75 or older, who are at greatest risk for nursing home care. In 2001, six percent of all Americans, some 17 million people, were 75 or older.²⁸ These demographic differences underlie significant differences in states’ fiscal exposure to long-term care costs. States also vary in the degree to which they offer Medicaid eligibility to populations at risk of long-term care. The current Medicaid financing structure automatically adjusts to these demographic and policy differences among states. Regardless of the number of low-income elderly individuals requiring and covered for nursing home care in a state, the federal government will match the costs incurred by the state in purchasing services for its eligible residents at the state’s statutory matching rate.

Responding to public health epidemics or disasters. New viruses with potentially serious health effects emerge regularly. The nation experiences catastrophes both natural (such as hurricanes) and man-made (such as terrorist attacks), and must respond immediately to the health effects of these events. Such events are likely to affect some areas and states more than others. They often generate high demand for health care services and coverage in the affected jurisdictions. Medicaid’s current financing

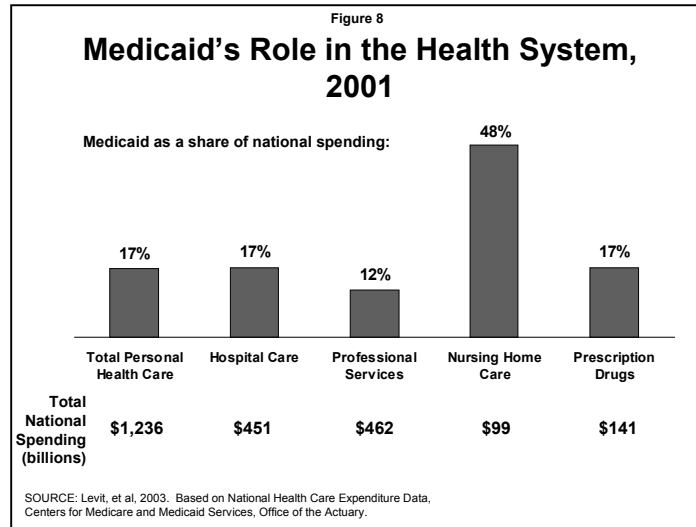
structure allows state officials to respond immediately to the health consequences of emerging diseases and events, without the need to request new federal authority, funding, or an emergency designation.

One example of the way in which Medicaid has responded flexibly to an emerging public health threat is the HIV pandemic, which disproportionately affects low-income individuals.²⁹ An estimated 850,000 to 950,000 individuals in this country are living with HIV infection or with AIDS, and many of them have low incomes. For the first 15 years of Medicaid's existence, HIV/AIDS, and the antiretroviral therapies developed to treat it, were not only unknown but unimagined. Today, at the beginning of the epidemic's third decade in this country, Medicaid is the single largest public source of coverage for persons with HIV/AIDS, and is also the federal government's largest source of funding for treating this disease. Federal spending on HIV/AIDS care in FY 2002 was estimated at \$8.7 billion; of this, nearly half was federal Medicaid funds.³⁰

The prevalence of HIV infection varies greatly from state to state. Seventy percent of all AIDS cases in 2001 were concentrated in only 10 states (New York, California, Florida, Texas, New Jersey, Pennsylvania, Maryland, Georgia, Illinois, and Massachusetts) and the District of Columbia.³¹ Medicaid's financing structure has helped these states to pay the costs of treating low-income residents with AIDS. Regardless of the number of AIDS cases in a state, and regardless of the costs of treatment, which are substantial, federal Medicaid matching funds are available to states for covered services furnished to eligible individuals on an open-ended basis. Because the federal matching payments are open-ended, these state Medicaid programs do not face the same dilemma as some state AIDS Drug Assistance (ADAP) programs, which must impose waiting lists for life-saving antiretroviral drugs in order to allocate capped federal funding.³²

Another example of how Medicaid has helped states respond to public health emergencies is New York's "Disaster Relief Medicaid" program. After the September 11, 2001 attack on the World Trade Center damaged New York City's computer systems and made it difficult to process Medicaid applications, New York State created a short-term program that used a simplified and expedited enrollment process to extend Medicaid coverage to the low-income uninsured. Nearly 350,000 New Yorkers enrolled in a four-month time period.³³ In this case, Medicaid's financing structure automatically made federal funds available to help New York respond rapidly to an unpredictable catastrophic event.

Supporting health care providers, particularly "safety net" providers. Medicaid is not simply a health care entitlement for individuals and a source of federal funds for states. It also provides financial support to health care providers like hospitals and clinics that treat program beneficiaries, playing an important role in financing the health care system. In 2001, Medicaid accounted for more than one out of every six dollars spent on health care in the United States. It paid for 17 percent of all hospital care, 17 percent of all prescription drugs, and almost half of all nursing home care in the United States (Figure 8).



More than 5,000 community hospitals, 17,000 nursing facilities, 7,000 group homes and other institutions for the mentally retarded, 748 community health centers, and 535 managed care plans participated in the Medicaid program in 2002. These facilities and plans employed millions of workers. Medicaid supports these providers and their workers through the payments Medicaid makes for services they furnish to beneficiaries. Medicaid reimbursements are especially important to those providers that serve high proportions of low-income patients, both those eligible for Medicaid and those who are uninsured. As the Institute of Medicine has observed, for those public and private nonprofit hospitals and clinics that serve as “providers of last resort” in their communities, Medicaid reimbursement often means the difference between fiscal health and insolvency.³⁴

Medicaid plays a special role for certain “safety net” hospitals and clinics through provisions of Medicaid law targeted to these providers. For example, state Medicaid programs must offer coverage for services provided by a Federally-Qualified Health Center (FQHC) and must pay these centers at specified rates. FQHCs include community health centers, migrant health centers, some health care for the homeless programs, and ambulatory care clinics. Medicaid also makes supplemental payments to states for hospitals that serve large numbers of Medicaid and uninsured patients. Medicaid payments to these hospitals, called “disproportionate share” hospitals, are intended to supplement regular Medicaid payments for inpatient hospital services. These supplemental payments represent an important revenue stream for the hospitals that receive them. A 1998 survey of a group of hospitals found that DSH accounted for 34 percent of the total subsidies these hospitals received for uncompensated care.³⁵ Unlike other federal Medicaid matching payments, federal Medicaid DSH payments do not flow to states on an open-ended basis. These payments are allocated among states in amounts that are specified in law, although the same federal-state matching policies that apply to other services also apply to DSH. In FY 2002, federal spending on DSH payments accounted for about 6 percent of all federal Medicaid spending, or about \$8.5 billion. State DSH spending varies significantly.

These are only a few of the objectives that Medicaid helps to fulfill. It helps support a wide range of additional goals, from helping low-income individuals with disabilities enter or remain in the workforce to providing health coverage to uninsured women with breast and cervical cancer. In addition, Medicaid supports goals that the federal government has established for other programs. As discussed earlier in this section, Medicaid helps support national health care goals by supplementing Medicare for low-income elderly and disabled beneficiaries. Medicaid's federal and state spending help extend the reach of many other federal programs as well. The Indian Health Service, Head Start and the Individuals with Disabilities Education Assistance (IDEA) Act programs, as well as the Women, Infants and Children Supplemental Feeding Program (WIC) all rely in some way on Medicaid funding to achieve their program objectives.

How Medicaid Supports Other Programs: The Example of Community Health Centers

The Community Health Centers (CHC) program is one example of the way in which Medicaid supports a separate, but related program.³⁶ Currently, the federal government makes grants directly to health centers that furnish preventive and primary care services to an estimated 12.6 million low-income and uninsured individuals at 3,500 underserved urban and rural areas throughout the country. Because CHCs are a discretionary program in the federal budget, Congress appropriates grant funds for CHCs annually. In FY 2003, the CHC appropriation was \$1.5 billion. This funding is not sufficient to enable the existing health centers to meet the primary care needs of all of the uninsured in their communities.

On average these federal grant funds account for less than half of the operating revenues of health centers. Consequently, the Department of Health and Human Services, which administers the program, assumes that a share of each health center's operating costs will be covered by revenues generated from serving Medicaid patients. Nationally, about one third of all health center patients are Medicaid beneficiaries; these patients account for about the same proportion of all CHC revenues, making Medicaid by far the largest source of third party payments for health centers.³⁷ In the absence of Medicaid reimbursements, many CHC sites would have to reduce staffing or close altogether unless the federal CHC appropriations were increased to offset the lost revenues.

Helping States and the Federal Government Manage the Cost and Unpredictability of Health and Long-Term Care Coverage for Low-Income Americans

Medicaid's financing structure ensures that neither the federal government nor the states must bear the entire expense of covering low-income families, seniors, and people with disabilities. Health insurance, whether it is provided by employers, the federal government, or the states, is an expensive undertaking. Private health care spending, including spending for private insurance and out of pocket spending totaled \$778 billion

in 2001.³⁸ Medicare will spend \$288 billion in FY 2004. Medicaid will cover about 50 million people at a cost of at least \$290 billion this same year. The Medicaid population is generally sicker and has greater health needs than the low-income population that is privately insured.³⁹ The Medicaid population therefore tends to use many costly health care services, including hospital care, nursing home care, and prescription drugs. Medicaid's existing financing structure ensures that states and the federal government share in the costs providing coverage to this population, and that neither entity bears a disproportionate share, or the entire share, of this undertaking.

Because states must make a substantial contribution to the program, they have a strong interest in managing the program and controlling costs. Moreover, health coverage, regardless of who provides it, is an unpredictable expense. Private and public purchasers alike find that the cost of the services they purchase, like hospital care and prescription drugs, can increase significantly, and frequently exceeds their expectations. Between 2002 and 2003, premiums for employer-sponsored health insurance increased 13.9 percent.⁴⁰ This rate of increase is similar to the rate of growth in Medicaid spending, and yet Medicaid spending is subject to additional factors that do not affect most private insurers. When unemployment increases, Medicaid enrollment and spending increase significantly. The demographics of a state, including the number of low-income people in the state, have an effect on Medicaid spending. The degree of this unpredictability also differentiates Medicaid from other entitlement programs that do not finance health care.⁴¹ At the same time Medicaid and other health insurance programs also face some large and predictable pressures from the aging of the population. Medicaid's uncapped matching structure means that neither states nor the federal government bears the entire risk of such changes in spending on health and long-term care.

Financial Benefits to States and Support for Program Discretion

Federal funds are automatically allocated to states based on utilization. From the perspective of states, one of the great benefits of uncapped federal Medicaid matching funds is that, by design, they flow automatically to those states with the greatest need, as it is measured by the state's Medicaid spending. Federal matching funds are disbursed to states based on their total Medicaid spending, which reflects the number of qualified low-income people in the state, how many and what type of services these individuals use, and how much is paid for these services. This means that, within the constraints of state decisions on eligibility levels, benefits, and reimbursement, states with significant low-income populations automatically receive a larger amount of Medicaid matching funds. These payments are made at the state's statutory matching rate.

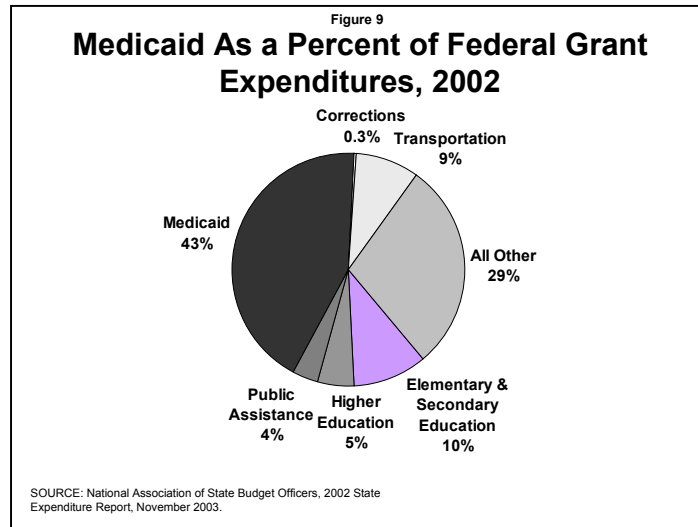
Contrast Medicaid's financing structure with that of SCHIP, in which states are assigned fixed federal allotments that are predetermined by formula. Allocating funds by formula can be an imprecise tool with significant ramifications both for states and beneficiaries, and the SCHIP experience illustrates this. The SCHIP allocation formula, established in 1997 when SCHIP was enacted, did not accurately estimate the need for SCHIP in each state, which means that some states have found themselves called upon to

serve far more people than the federal allotments provide for; other states have found themselves with fewer people to serve than the allotment anticipated. Moreover, the formula failed to take into account that some states had already expanded coverage to children before 1997. This meant that states that had expanded coverage before SCHIP was enacted have received SCHIP matching funds that they have had difficulty using. Although the occasional Congressional redistribution of funds helps to address these issues, it is unpredictable and makes it difficult for states to plan for adequate health coverage for this population.⁴² The SCHIP experience demonstrates that designing a formula that accommodates the needs of every state is difficult. Moving Medicaid, a large health and long term care insurer that states have been operating for 35 years, to a formula-based system would likely be more difficult than creating a formula for SCHIP, which is a new, narrowly targeted program.

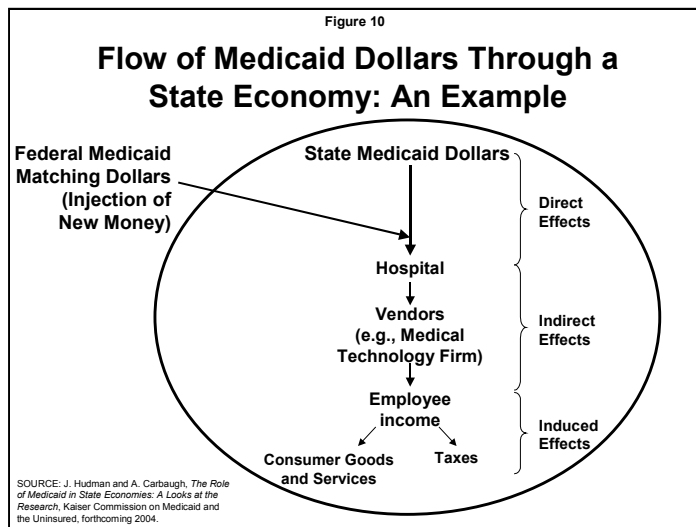
Support for state discretion. Generally, states administer their Medicaid programs within broad federal guidelines. Within these guidelines, a state determines who is eligible for the program, what benefits it will cover, from which health care providers it will purchase services, and how much it will pay for these services.⁴³ This has allowed substantial variation in the program, with some states covering a significant proportion of the low income families, elderly, and disabled individuals who reside in their state and providing a wide range of benefits, and other states covering a relatively small portion of their eligible populations and a narrow range of benefits. Figure 5 illustrates the variation in coverage.

This state discretion is supported by Medicaid's open-ended financing structure, with federal matching funds available to support whatever Medicaid coverage choices each state makes within the limits set in federal law. States are free to take up or not take up eligibility groups and benefits that are designated as "optional" under federal law; Medicaid matching funds are available to support whatever options states decide to offer. Beyond this discretion offered under federal law, states have sought and received substantial additional flexibility through waivers, which have allowed many to offer coverage to groups of low-income people, such as childless adults, who could not otherwise be covered under federal law.⁴⁴ Looked at from the federal perspective, the combination of state discretion and uncapped federal financing means that how much the federal government spends on Medicaid is determined in large part by choices states make on who they cover, how many people they cover, what services they offer, and how much they pay for these services

Medicaid's financing structure helps support state budgets and state economies. Medicaid's matching payments translate into significant support for state budgets. Medicaid is by far the single largest form of federal grant support to states, accounting for 43 percent of all federal grant funds to states (Figure 9). Medicaid has also been by far the fastest growing form of support to states for the past 20 years. Federal aid is the largest single source of state revenue, and most of the growth in federal grant support for states since 1980 has been concentrated in Medicaid spending.⁴⁵ Federal matching payments means that as the program has grown it has brought substantial additional federal support to states.



Given its large size, one would expect Medicaid to play a significant role in states' economies, and it does (Figure 10). Federal matching payments mean that state spending on Medicaid leverages \$1 to \$3.33 in federal funds for every state dollar spent, and, conversely, that states lose that amount of federal funds when they reduce Medicaid spending by one state dollar. As one former state health official has observed, the availability of open-ended federal matching funds "makes Medicaid an attractive vehicle for economic development, with modest state appropriations yielding total in-state spending of a far greater amount."⁴⁶ A number of studies have attempted to quantify the impact of federal Medicaid funds on specific state economies.⁴⁷



The state and federal funds states devote to Medicaid finance payments to a broad range of health care providers: in 2001, Medicaid spent \$29 billion on inpatient hospital care, \$43 billion on nursing home care, and \$20 billion on prescription drugs. Medicaid's payments to health care providers indirectly support their employment and their purchases of supplies and equipment. These providers, as well as their employees and

suppliers, generally pay state or local taxes. In addition to direct payments to providers who care for Medicaid beneficiaries, Medicaid coverage reduces the burden of uncompensated care hospitals and doctors provide by reducing the number of low-income uninsured who seek needed care at hospitals and clinics but are unable to pay for it. Since many of these clinics and hospitals are publicly funded, Medicaid's ability to reduce the burden of uncompensated care relieves pressure on other parts of states' and local governments' budgets. Medicaid also confers clear economic benefits on its enrollees, many of whom who would otherwise face significant medical bills and in some cases personal bankruptcy.

Medicaid's financing structure and state health programs. States have actively sought to extend matching funds to programs paid for with state funds that provide services to populations who are also eligible for their Medicaid programs. Beginning in the 1980s, at the same time that some discretionary health grant programs were subject to federal budgetary constraints, many states started to apply federal Medicaid matching payments to the costs incurred by state and local programs in providing maternal and child health services, home care services and school-based health services to Medicaid beneficiaries. States have also used Medicaid to fund a significant share of their mental health programs, both in institutions and in the community.⁴⁸⁴⁹ Some states have also been able to obtain federal Medicaid matching dollars through section 1115 demonstration waivers to fund health care programs that had previously been entirely state-funded,⁵⁰ or to extend prescription drug coverage to their low-income elderly population.⁵¹ Although states vary in the degree to which their Medicaid programs support services provided through other state agencies, it is clear that many states have significantly expanded Medicaid's role in financing related state health and long-term care programs. Reflecting this and other factors, Medicaid in 2001 accounted for 69 percent of total state spending on health programs.⁵²

IV. The Challenges Facing Medicaid's Federal/State Matching Structure

At the same time as Medicaid's financing structure has brought significant benefits to the low-income population and states and helped advance national health objectives, it also presents some risks and limitations. Medicaid's financing structure distributes the expense of health and long-term care coverage between states and the federal government, but this sharing of costs also brings tensions. Medicaid's financing structure does not respond effectively to economic downturns and has been consistently challenged by issues of accountability for federal funds raised by some state "Medicaid maximization" strategies. This section discusses the challenges embodied in Medicaid's financing structure.

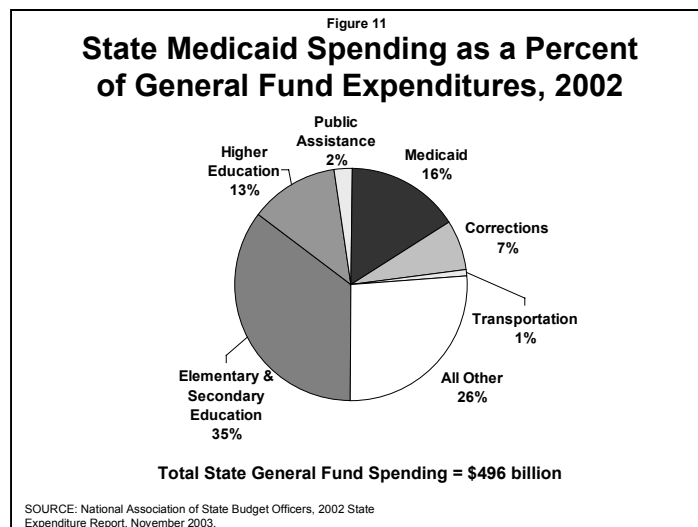
States Bear A Large Share of the Cost and the Risk of Unpredictable Health Care Spending

Medicaid spending plays a significant role in both states' budgets and the federal budget. From the federal perspective, Medicaid represents a major financial commitment. The federal government will spend \$175 billion on Medicaid in fiscal year 2004. This federal spending makes Medicaid the third largest nondefense program in the federal budget after Medicare and Social Security. Moreover, federal spending on Medicaid has grown substantially over time—since 1994, federal spending on Medicaid has more than doubled, from \$82 billion.⁵³ In addition to bearing the majority of the cost related to unpredictable factors like changes in unemployment, the federal government also bears most of the cost of any decisions that the states make, such as changing eligibility, benefits, or the rate at which providers are paid. This means that how much the federal government spends on Medicaid is driven in large part by state decisions. When states expand coverage, the federal government spends significantly more; when states reduce the scope of their programs, the growth in federal spending declines.

Some have argued that the size of the program and its rate of growth are unsustainable. For example, the Congressional Budget Office recently developed three scenarios for the future rate of Medicare and Medicaid spending as part of a broader long-term analysis of the federal budget. CBO characterizes its "high-cost" scenario, under which the future rate of growth in Medicare and Medicaid spending per enrollee is 2.5 percent faster than the rate of growth in per capita GDP, as "seemingly unsustainable."⁵⁴ With the annual federal deficit approaching \$400 billion, the largest in the nation's history, it has been argued that the federal government can no longer afford to continue to share in Medicaid's costs. Others argue that the financing structure and large revenue base of the federal government enables it to assume this role, especially relative to those of state governments.⁵⁵ In 2002, the federal government took in \$1.85 trillion in revenues; during that same year, state and local governments combined raised a little more than half that amount: \$993 billion.⁵⁶ In 2001, the federal government collected as much from its personal income tax alone as states did from all their different revenue sources combined.⁵⁷ More broadly, the federal government possesses broad borrowing authority that the states do not. This authority is in part designed to enable the

federal government to undertake stimulative measures when the economy is weak, despite reduced revenue.⁵⁸

From the state perspective, even though the federal government finances most Medicaid spending, state Medicaid spending is still a large part of state budgets. Looking only at state funding for Medicaid and other programs, Medicaid is the second largest expenditure in state budgets, after K-12 education, and accounts for 16 percent of state own-source spending (Figure 11). Medicaid's large place in state budgets has significant implications both for the program and for the rest of states' budgets. Medicaid's size means that spending increases in the program, even at rates that are fairly modest, translate into significant increases in the state funds that are required to maintain the program. At the same time, when state revenues are stagnant or declining, Medicaid's size as a share of state budgets means that states have difficulty financing their share of the program's costs and turn to Medicaid to reduce spending growth. This is true despite the fact that the federal government bears most of the cost of the program. When states try to reduce their Medicaid spending growth, they find that Medicaid is, by definition, different from most other programs in their budgets. Most programs in states' budgets are discretionary, which means that the state can generally set a funding level and reduce the number of people served or the scope of the program to fit within that funding level. As an entitlement program, Medicaid is harder for states to control financially. States cannot set a definite level of funding for Medicaid in advance; when they do, they frequently find that that level they appropriate in advance either falls short of or exceeds what is required to pay for services that the eligible population needs, and that they consequently need to reallocate funding in mid-year. Although states have many levers available to them to control their Medicaid spending, ranging from setting provider payments to changing eligibility levels, they cannot constrain program spending based solely on a predetermined dollar limit.



Medicaid's Financing Structure Does Not Adjust Rapidly to Changing Economic Conditions

Medicaid's shared state/federal matching structure generally works well when states' economies – and state tax revenues – are growing. This structure becomes strained, however, during recessions, when state economies are not growing, state tax revenues fall, and the need for Medicaid coverage increases. At these times, generating enough state funding to maintain state Medicaid programs can present a major policy and political challenge for states. And for this reason, Medicaid and the economic cycle seem to be inextricably linked. During economic expansions, states expand Medicaid coverage and make program improvements. During recessions, states trim back the scope of their programs in an effort to contain program costs. This tendency to cut back on Medicaid spending growth seems to have been especially pronounced during the recent economic downturn.⁵⁹ (How Medicaid relates to states' overall fiscal choices is discussed in additional detail in Appendix B, *States' Fiscal Choices and Their Impact on Medicaid*.)

Although federal Medicaid matching funds help cushion states from some of the impact of Medicaid cost increases during downturns, they do not hold states harmless from them. Federal matching rates are fixed for one year at a time, based on data that may reflect a dramatically different economic climate.⁶⁰ States still must generate their state share at the same time that state tax revenue collections are stagnant or falling. Federal matching payments are generally thought of as providing an incentive for states to expand coverage when times are good and to retain coverage when times are bad. But the recent changes states have been making to their Medicaid programs seem to indicate that existing federal matching payments are not sufficient to enable states, within the scope of their existing revenue levels and structures, to maintain the scope of their Medicaid coverage when their economies falter. States could, alternatively, raise taxes at times when their fiscal conditions render them unable to maintain Medicaid coverage but many seem unwilling to do so in the present environment.⁶¹ State reductions in their own Medicaid outlays result in the loss of federal matching payments, which in turn compounds the difficulties facing their economies.

This is a shortcoming that could be addressed within the program's existing financing structure by increasing the federal share of Medicaid spending during economic downturns. This approach was recently implemented, although on a temporary basis. In May 2003, Congress provided a temporary increase in each state's Medicaid matching rate as part of a larger state fiscal relief package. Although states have continued to put new Medicaid cost containment mechanisms in place, initial evidence indicates that the temporary increase in their matching rates has helped states avoid making additional and larger reductions in their Medicaid programs as part of their budget balancing efforts. Another potential change that would address this shortcoming would be to base the calculation of states' matching rates on more current data, so that federal matching payments better reflect states' current economic conditions.⁶²

Issues of Accountability for Federal Funds

At several points in the program's history, issues have been raised with regard to whether federal matching funds are being spent appropriately. There have been two periods in which this problem has been especially visible and problematic. In the late 1980s and early 1990s, some states collected taxes and donations from health care providers and used them to claim federal matching funds without putting up a direct state payment to match the federal funds. After federal matching funds were claimed, the funds from these taxes and donations were returned to the providers who had paid them. States then kept the matching funds, at times distributing some of them to the providers who had paid the taxes or donations. Often these transactions involved "disproportionate share" payments to (DSH) hospitals that serve large numbers of Medicaid and uninsured patients. These strategies were a driving factor behind the historically high growth rates the Medicaid program experienced in the early 1990s.

In the late 1990's, many states began to take advantage of a regulatory loophole known as the "upper payment limit" (UPL). The essence of this technique was to transfer funds from local public hospitals and nursing homes to state treasuries, and use those intergovernmental transfers as the state share of Medicaid payments to those hospitals and nursing homes. At the end of the transaction, the providers recouped their transferred funds, and most or all of the federal share of the Medicaid payments to the providers ended up in the state treasury at no cost to the state. In January 2003 these types of strategies prompted the General Accounting Office to add Medicaid to its list of "high risk" federal programs requiring improved fiscal and management oversight. (For a more detailed discussion of DSH and UPL arrangements, see Appendix C).

From the federal perspective, these issues raise fundamental questions about state accountability for the use of federal funds. In some cases, the federal funds generated by these strategies are devoted to the Medicaid program; in other cases, they are not. Federal officials and Members of Congress have understandably questioned the use of federal Medicaid funds for purposes unrelated to the goals of the program, which are specified in federal law. Others have questioned the legitimacy of states effectively "recycling" federal funds by substituting the excess federal funds these arrangements generate as the state share of Medicaid funding. And these arrangements have had the unquestionable effect of increasing the relative federal contribution to Medicaid and decreasing the state contribution in those states that have employed them. Finally, even though state funds are not involved, these strategies have caused total Medicaid spending to grow, at times significantly.

From the state perspective, these strategies have helped the states that have used them balance their budgets or finance Medicaid program improvements, sometimes under conditions where available resources are quite constrained. As states have applied federal matching funds to other areas of their budgets, the burden of state financing for these services has shrunk, freeing up state funds. Recently, as states have faced difficult fiscal conditions, some are turning to Medicaid maximization to finance improvements in the program, like provider rate increases, that they would otherwise not be able to afford.

And advocates for states have pointed out that most of these strategies have been legal when they were carried out.

States and the federal government will always struggle over their relative contributions to financing Medicaid. It is one significant challenge posed by a system where both parties share in all the program's costs, but where a share of the program's spending is determined largely by one of those parties, the states. In each of the periods described above, the federal government has reacted to limit the strategies being used to draw down excessive federal funds. In reaction to the provider tax and donation and DSH strategies of the late 1980's and early 1990s, Congress enacted laws that significantly restricted states' use of these strategies. Similarly, CMS responded to the UPL strategies of the late 1990's by issuing a regulation curtailing and phasing out these arrangements. Most recently, in the 2003 Medicare drug benefit legislation Congress directed states to submit annual, independent certified audits of the DSH expenditures and the uncompensated care costs of DSH hospitals.⁶³

A significant amount of federal funds is at stake. For example, the Congressional Budget Office estimated that the federal government spent \$7.4 billion on UPL strategies in fiscal year 2002.⁶⁴ While the cost of these strategies is significant, it represents a very small proportion of Medicaid spending – five percent of federal Medicaid spending in 2002 and less than three percent of total Medicaid spending that year. The federal government can and should be proactive in limiting the use of these arrangements and ensuring that federal taxpayer money is spent appropriately. Undertaking additional financial management activities would also put the financial management of the Medicaid program more on a par with that of other federal programs, like Medicare, and the private sector.⁶⁵

V. Conclusion

Medicaid's federal matching payments, which finance the majority of total Medicaid spending, play a number of roles in financing health and long-term care coverage for the nation's low-income population. These matching payments help states purchase needed health and long-term care services for 50 million low-income families, elderly and disabled Americans. They are a necessary condition of providing an entitlement to basic coverage for individual Americans who meet the financial and other requirements for eligibility. And they help states manage both the cost and the unpredictability of adequately funding health and long-term care coverage for their low-income populations.

Medicaid's financing structure has yielded many benefits. It has funded progress toward several important national health objectives: covering the low-income uninsured; financing maternity and neonatal care; filling in gaps in Medicare coverage; financing long-term care; responding to epidemics and public health emergencies; and supporting the health care infrastructure in the United States. Medicaid's financing structure has also facilitated state discretion in the administration of the program and played a significant role in supporting state budgets, economies, and health care programs.

Against this fairly broad array of benefits, the financing structure has also posed a number of challenges. Because health and long term care services are expensive, Medicaid remains an expensive proposition for both states and the federal government and does not completely cushion states from the effects of unpredictable spending changes. Its federal matching payments do not adjust quickly during economic downturns to absorb a higher share of program costs when states' ability to do so is constrained. And Medicaid's state/federal financing structure means that states and the federal government will always struggle with the issue of who is responsible for what, as several generations of state creative financing strategies have shown.

On balance, Medicaid's financing structure has been remarkably resilient for nearly 40 years, providing powerful incentives for states to furnish health and long-term care coverage to their low-income populations. It has made the entitlement of basic health coverage to individuals possible, and its benefits, both in terms of coverage and fiscal support for states, have been impressive. Its drawbacks, while significant, could likely be addressed within the existing structure of the program. As the debate over Medicaid's future continues, any reform efforts should balance the need to address the financing structure's limitations with the enormous benefits it continues to bring to low-income Americans, states, and our nation's health care system.

The authors are grateful to Molly O'Malley for her wonderful assistance in writing this paper.

APPENDIX A

How the Federal Medical Assistance Percentage Works

Medicaid's open-ended federal matching is governed by formula written in the Social Security Act, the federal law that governs the Medicaid program, among others. The rate at which the federal government matches a state's Medicaid spending for services is the Federal Medical Assistance Percentage, or FMAP. Each state's FMAP is determined by the following statutory formula:

$$1 - \left[\left(\frac{(\text{State Per Capita Income})^2}{(\text{National Per Capita Income})^2} \right) * 0.45 \right]$$

Under this formula, a state's federal Medicaid matching rate is based on the ratio of its per capita income, squared, to the average per capita income of all states, squared. States with per capita incomes above the national average receive a lower federal matching percentage; states with per capita incomes below the national average receive higher percentages. A state with average per capita income will have an FMAP of 55 percent. The effect of the square is to increase the range of the matching percentages. The operation of the formula is bounded by two other statutory provisions: a minimum of 50 percent and a maximum of 83 percent.⁶⁶

Twelve states have federal matching rates of 53 percent in FY 2004: California, Colorado, Connecticut, Delaware, Illinois, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, and Washington. Most of these states would have FMAPs lower than 53 percent if it were not for the statutory floor constraining the operation of the formula. At the other end of the range, 10 states have matching rates of 74 percent or more. Alabama, Arkansas, Idaho, Louisiana, Mississippi, Montana, New Mexico, Oklahoma, Utah, and West Virginia. The District of Columbia also normally has an FMAP of 70 percent, a result produced not by the statutory formula but by a 1997 Congressional decision to set the District's FMAP permanently at that level. (If the formula applied, the District's FMAP would be 50 percent). Like other state FMAPs, the District's FMAP was temporarily increased by almost three percent in 2003.

The FMAP produced by this formula applies to a state's spending for almost all covered services on behalf of almost all Medicaid beneficiaries. However, Congress has established higher FMAPs for selected services and populations. For example, in the case of family planning services and supplies, each state's costs are matched at 90 percent, regardless of its normal FMAP, to reflect a national public health priority. Similarly, when a state buys any covered service – hospital care, physician services, prescription drugs, etc. – on behalf of a Native American or Alaska Native beneficiary from a facility run by the Indian Health Service (IHS) or a tribal contractor to the IHS,

the federal matching rate is 100 percent. This ensures that state funds are not used to pay for services at federal facilities. Finally, to encourage states to take up the option of covering uninsured women who need treatment for breast or cervical cancer, the costs of treatment for these women are matched at the same enhanced FMAP that the state receives under the State Children's Health Insurance Program (SCHIP).⁶⁷

The FMAP formula does not apply to administrative costs. While federal matching payments for these costs, like those for the costs of covered services, are open-ended, the matching rates vary by function, not by state.⁶⁸ The basic federal matching rate for Medicaid administrative costs is 50 percent in all states. The costs of some administrative activities, such as survey and certification of nursing facilities and fraud investigations and prosecutions, are matched at higher rates.

Many concerns have been raised with regard to the adequacy of the FMAP formula. The formula has been criticized because it does not take sufficient account of the proportion of states' populations that live in poverty or of the variation in taxable resources from state to state.⁶⁹ Some have expressed concerns that the matching formula essentially redistributes wealth from wealthier states to poorer ones; others think it should be more redistributive, not less. The formula has also been criticized because it does not provide additional incentives to states that provide more coverage. These issues, which relate to the design of the formula for determining federal matching rates rather than the broader federal/state financing structure, are not addressed in this paper.⁷⁰

APPENDIX B

States' Fiscal Choices and Their Impact on Medicaid

Although the federal government shares substantially in Medicaid spending, states bear responsibility for ensuring that they have adequate funds to maintain the state share of funding for the program, even during recessions. States' spending on Medicaid, and states' ability to meet the federal standards that govern the program, are driven in large part by the decisions states make about taxes and spending on other programs. This Appendix provides an overview of some of the recent history in fiscal choices states have made.

Rainy Day Funds. During the boom years of the mid to late 1990s, states significantly increased their "rainy day" funds, the funds set aside for states to draw down in case of emergencies or recession. By 2000, the peak of the economic growth cycle, states had built up reserve funds of more than 10 percent of their expenditures – up from 6.8 percent four years earlier. States did this at least in part to respond to criticism leveled by analysts and others during the recession of the early 1990s that states had not generated sufficient reserve funds to help them endure even a short recession without cutting spending or raising taxes. States responded to this criticism by building up significant reserve funds. At the same time, a number of states also set aside funds from a Medicaid-related settlement with the tobacco industry, holding these funds in reserve to help the state withstand economic and budgetary fluctuations. Although states built up reserve funds to historically high levels, and had significant tobacco settlement trust funds at their disposal, these funds have not been sufficient to last through the present state fiscal crisis. In FY 2003, state year-end balances fell to 3.1 percent of state spending, and are estimated to be 3.2 percent in FY 2004, below what is considered adequate by many fiscal analysts.⁷¹

Tax cuts. At the same time that states built up their rainy day funds to improve their ability to withstand a recession, they also cut taxes, compromising their ability to weather a recession. During the recent economic expansion, when state tax revenues reached historically high levels and the rate of spending growth in Medicaid and other programs was low, states reduced taxes significantly. States cut taxes by an estimated \$36 billion between 1995 and 2001, according to data collected by the National Conference of State Legislatures.⁷² These tax cuts followed several years of tax increases in the early 1990s, when the economy was in recession. The tax reductions of the mid-to-late 1990s hurt states' chances of withstanding a recession without significant spending reductions.

This tax-cutting trend has largely ended over the past two years, and some states are starting to increase taxes. According to the National Governors' Association, 36 states have increased taxes and fees for fiscal year 2004, while two states reduced taxes.⁷³ However, the tax increases that have been enacted during the current economic downturn

are smaller than the tax cuts that states put in place during the 1990s. Moreover, states are relying primarily on increasing consumption taxes, such as cigarette taxes, rather than personal or corporate income taxes, which have stronger revenue-raising potential.⁷⁴ And even as some states increase taxes, opposition to tax increases is strong, and in some states tax increases have been considered out of the question as states balanced their Fiscal Year 2003 budgets.⁷⁵

Structural issues in states' revenue bases. States have in recent years cut taxes and increased spending despite a growing recognition that structural issues in states' revenue bases would significantly erode state fiscal conditions in the long-term. As the nation has transitioned from a manufacturing economy to one that is highly dependent on the provision of services, tax structures that are based heavily on sales taxes have not been able to keep up with the obligations of state governments. The growth of remote sales over the Internet has also undermined the revenue-raising potential of the sales tax. Some fiscal analysts have expressed concern that these trends put some states at risk of structural deficits; that is, of not having sufficient revenue to meet state spending obligations in the long term. Although these challenges to states' tax structures are not new -- many fiscal analysts described them in the 1990s-- the economic boom of the late 1990s masked many of the underlying structural problems states were experiencing, and most states left these challenges unaddressed.⁷⁶

The overall fiscal decisions states make affect their ability to maintain Medicaid coverage during recessions. The evidence with regard to states' efforts to ensure that they had sufficient resources to preserve state funding for Medicaid during recessions is mixed. Although states built up substantial rainy day funds and set aside tobacco settlement revenue to help them offset the effects of revenue shortfalls, they also cut taxes significantly, increased spending for a variety of programs, and largely left structural issues in their state budgets that impede revenue growth in the long term unaddressed.

APPENDIX C

A Brief Summary of DSH and UPL Financing Arrangements

The General Accounting Office (GAO) and the Inspector General of HHS (OIG) have been sharply critical of what they view as “abusive financing schemes” on the part of some states to draw down federal Medicaid matching funds without a corresponding expenditure of state-only funds. This Appendix briefly summarizes two of these financing arrangements: payment adjustments to Disproportionate Share (DSH) hospitals and payments to local public hospitals and nursing facilities under “upper payment limits” (UPLs). While the details of these mechanisms differ, their common characteristic is federal Medicaid matching funds are paid to a state even though some or all of the required state matching payment is not actually made. As a result, the effective federal matching rate to the state is higher than the nominal matching rate specified in the statutory FMAP formula discussed in Appendix A. For a more extensive discussion these and other “creative” financing mechanisms, see *The Medicaid Resource Book* (July 2002), Kaiser Commission on Medicaid and the Uninsured, pp. 105-115, www.kff.org.

Disproportionate Share Hospital (DSH) Payments

Under federal Medicaid law, states are required to supplement the regular payments made for inpatient hospital services furnished to Medicaid patients in the case of hospitals “which serve a disproportionate number of low-income patients with special needs” – i.e., hospitals serving disproportionately high numbers of Medicaid and uninsured patients. The additional payments made by states to these DSH hospitals are eligible for federal matching payments at the state’s regular matching rate (FMAP). However, unlike other federal Medicaid matching payments, these federal funds are allocated among the states in amounts specified in a table set forth in the federal Medicaid statute. States may claim federal Medicaid matching funds for supplemental DSH payments only up to their allotment. In addition, states are subject to a separate limit on how much of their federal DSH matching fund allotment may be paid to mental hospitals.

These statutory caps on federal Medicaid payments were imposed by the Congress in 1991 and 1993 in reaction to the rapid growth in federal spending on DSH hospitals. This federal spending growth occurred without a corresponding increase in state spending on DSH payments; instead, through a number of mechanisms, including provider donations, provider taxes, and intergovernmental transfers, federal DSH payments were in effect substituted for state matching payments. Moreover, not all federal DSH funds were actually retained by DSH hospitals; significant portions were redirected into state treasuries to be used for other purposes. A recent Urban Institute survey of 34 states found that, in 2001, states on average directed 74 percent of federal

DSH payments to hospitals while retaining 26 percent of federal DSH funds for other state uses.

The state-specific DSH caps have proven to be an expedient budget control tool for the federal government. In the 1997 Balanced Budget Act, the caps were lowered in all states but those with very low DSH payments over the period FY 1998 through FY 2002 in order to generate federal budget savings of \$10.4 billion over this 5-year period and an additional \$30 billion over the subsequent 5 years.⁷⁷

Upper Payment Limit (UPL) Arrangements

Federal Medicaid law allows states to use local funds as the state share of Medicaid expenditures for purposes of claiming federal matching funds. To qualify, these funds must be transferred by a local public agency to the state Medicaid program. Among the public agencies qualified to make these intergovernmental transfers, or IGTs, are county or municipal hospitals and nursing facilities. At the same time, federal Medicaid law does not specify how States must pay hospitals or nursing facilities for covered services. There is no facility-specific floor or ceiling for these payments. Instead, there is an aggregate ceiling, or upper payment limit (UPL), that applies to all hospitals or nursing facilities in a class. (DSH payments are subject to a separate set of limits noted above). This UPL is set at the estimated amount that would have been paid to all the facilities in the class had Medicare payment principles been used to determine rates.

Prior to 2001, UPLs were imposed on aggregate payments to all hospitals (state, county, and private) as a class and to all nursing facilities (state, county, and private) as a class. In addition, UPLs were imposed on aggregate payments to state-operated hospitals for inpatient services and state-operated nursing facilities. No UPL applied to aggregate payments to county-operated hospitals or to county-operated nursing facilities. As a result, States could pay county-operated hospitals or nursing homes amounts far in excess of their costs, so long as total Medicaid payments did not exceed the amount under the aggregate UPL. Because state Medicaid payments to non-county hospitals or nursing homes were often well below Medicare rates, there was substantial “room” under the aggregate UPL for additional payments to county hospitals or nursing homes. These additional payments could then be transferred back to the state treasury as an IGT, to be set by the state to draw down additional federal Medicaid funds or for other purposes. As of October 2000, 28 states were using UPL arrangements in order to realize an estimated \$5.8 billion in federal revenue annually.

Regulations issued by CMS in January 2001, and modified in January 2002, restructured the UPLs to limit these arrangements. Separate UPLs now apply to payments for inpatient hospital services to state-owned facilities, to county- or locally-owned hospitals, and to privately owned hospitals. The same approach was taken to UPLs for nursing facility services. These regulatory changes were estimated to save the federal government more than \$64 billion over 10 years. However, to ease the fiscal impact on states, the new regulations were phased in using transition periods extending as

long as FY 2008. Over the period FY 2003 – FY 2008, CBO estimates that federal UPL payments will total \$28 billion; in comparison, federal DSH payments over the same period are estimated at \$54 billion.⁷⁸

Medicaid Glossary

Centers for Medicare and Medicaid Services (CMS) – The agency in the Department of Health and Human Services with responsibility for administering the Medicaid, Medicare, and State Children’s Health Insurance programs at the federal level. Formerly known as the Health Care Financing Administration (HCFA).

Copayment – A fixed dollar amount paid by a Medicaid beneficiary at the time of receiving a covered service from a participating provider. Copayments, like other forms of beneficiary cost-sharing (e.g., deductibles, coinsurance), may be imposed by state Medicaid programs only upon certain groups of beneficiaries, only with respect to certain services, and only in nominal amounts as specified in federal regulation.

DSH (Disproportionate Share Hospital) Payments – Payments made by a state’s Medicaid program to hospitals that the state designates as serving a “disproportionate share” of low income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid beneficiaries. States have some discretion in determining which hospitals qualify for DSH payments and how much they receive. The amount of federal matching funds that a state can use to make payments to DSH hospitals in any given year is capped at an amount specified in the federal Medicaid statute.

Dual Eligibles – A term used to describe an individual who is eligible both for Medicare and for full Medicaid coverage, including nursing home services and prescription drugs, as well as for payment of Medicare premiums, deductibles, and co-insurance. Some Medicare beneficiaries are eligible for Medicaid payments for some or all of their Medicare premiums, deductibles, and co-insurance requirements, but not for Medicaid nursing home or, until 2006, prescription drug benefits.

Entitlement – A program that creates a legal obligation on the federal government to any person, business, or unit of government that meets the criteria set in law. Federal spending in an entitlement program is controlled through the program’s eligibility criteria and benefit and payment rules, not by the appropriation of a specific level of funding in advance. Entitlement programs such as Medicare and Medicaid are also referred to (for federal budget purposes) as “direct” or “mandatory” spending. Medicaid is both an individual entitlement and an entitlement to the states that elect to participate.

Federal Poverty Level (FPL) – The federal government’s working definition of poverty that is used as the reference point for the income standard for Medicaid eligibility for certain categories of beneficiaries. Adjusted annually for inflation and published by the Department of Health and Human Services in the form of Poverty Guidelines, the FPL in calendar year 2003 is \$15,260 for a family of 3 in 48 contiguous States and the District of Columbia, \$19,070 in Alaska, and \$17,550 in Hawaii.

FFP (Federal Financial Participation) – The technical term for federal Medicaid matching funds paid to states for allowable expenditures for Medicaid services or administrative costs. States receive FFP for expenditures for services at different rates, or FMAPs, depending on their per capita incomes. FFP for administrative costs vary not by state, but by function. The general matching rate for administrative costs is 50 percent; some functions (e.g., survey and certification, fraud control units) qualify for enhanced matching rates of 75 percent or more. See FMAP.

FMAP (Federal Medicaid Assistance Percentage) – The statutory term for the federal Medicaid matching rate – i.e., the share of the costs of Medicaid services or administration that the federal government bears. In the case of covered services, FMAP varies from 50 to 83 percent depending upon a state’s per capita income; on average, across all states, the federal government pays at least 57 percent of the costs of Medicaid.

FQHC (Federally Qualified Health Center) – States are required to include services provided by FQHCs in their basic Medicaid benefits package. FQHC services are primary care and other ambulatory care services provided by community health centers and migrant health centers funded under section 330 of the Public Health Service Act, as well as by “look alike” clinics that meet the requirements for federal funding but do not actually receive federal grant funds. FQHC status also applies to health programs operated by Indian tribes and tribal organizations or by urban Indian organizations.

HIFA (Health Insurance Flexibility and Accountability) Waivers – The term used by the Bush Administration to describe its demonstration initiative, using the section 1115 waiver authority, to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources. See Section 1115 Waivers.

Home and Community-Based Services (HCBS) Waiver – Also known as the “1915(c) waiver” after the enabling section in the Social Security Act, this waiver authorizes the Secretary of HHS to allow a state Medicaid program to offer special services to beneficiaries at risk of institutionalization in a nursing facility or facility for the mentally retarded. These home and community-based services, which otherwise would not be covered with federal matching funds, include case management, homemaker/home health aide services, personal care services, adult day health services, habilitation services, and respite care. They also include, in the case of individuals with chronic mental illness, day treatment and partial hospitalization, psychosocial rehabilitation services, and clinic services.

ICF/MR (Intermediate Care Facility for the Mentally Retarded) – A public or private facility, the primary purpose of which is to provide health or rehabilitative services to individuals with mental retardation or related conditions (e.g., cerebral palsy). State Medicaid programs may at their option cover services provided by ICFs/MR.

Intergovernmental Transfer (IGT) – The transfer of non-Federal public funds from a local government (or locally owned hospital or nursing facility) to the state Medicaid agency, or from another state agency (or state-owned hospital) to the State Medicaid agency, usually for the purpose of providing the state share of a Medicaid expenditure for purposes of drawing down federal matching funds. Often used in connection with payments to DSH hospitals and UPL transactions. See DSH, UPL.

Mandatory – State participation in the Medicaid program is voluntary. However, if a state elects to participate, as all do, the state must at a minimum offer coverage for certain services to certain populations. These eligibility groups and services are referred to as “mandatory” in order to distinguish them from the eligibility groups and services that a state may, at its option, cover with federal Medicaid matching funds. See Optional.

Optional – The term used to describe Medicaid eligibility groups or service categories that states may cover if they so choose and for which they may receive federal Medicaid matching payments at their regular matching rate, or FMAP. About two thirds of all federal Medicaid funds are used to match the cost of optional services for mandatory or optional groups and all services for optional populations.

Pharmacy Plus Waivers – The term used by the Bush Administration to describe its demonstration initiative, using the section 1115 waiver authority, to enable states to use federal Medicaid funds to extend pharmacy coverage to elderly and disabled individuals who are not eligible for Medicaid and whose incomes are below 200 percent of the Federal Poverty Level (FPL). See Section 1115 Waivers.

Provider Tax – A tax, fee, assessment, or other mandatory payment required of health care providers by a state. States may use revenues from provider taxes to pay the state share of Medicaid spending only under limited circumstances specified in federal Medicaid law.

Section 1115 Waiver – Under section 1115 of the Social Security Act, the Secretary of Health and Human Services is authorized to waive compliance with many of the requirements of the Medicaid statute to enable states to demonstrate different approaches to “promoting the objectives of” the Medicaid program while continuing to receive federal Medicaid matching funds. In FY 2002, 23 states and 1 county were operating

a total of 28 Medicaid section 1115 waivers affecting some or all of their eligible populations and involving \$19.9 billion in federal matching funds, or one sixth of all federal Medicaid spending that year on benefits. The waivers, which are granted (or renewed) for 5-year periods, are administered by CMS. See also HIFA Waivers, Pharmacy Plus Waivers.

State Children’s Health Insurance Program (SCHIP) – Enacted in the 1997 Balanced Budget Act as Title XXI of the Social Security Act, SCHIP is a federal-state matching program of health care coverage for uninsured low-income children. In contrast to Medicaid, SCHIP is a block grant to the States; eligible low-income children have no individual entitlement to a minimum package of health care benefits. Children who are eligible for Medicaid are not eligible for SCHIP. States have the option of administering SCHIP through their Medicaid programs or through a separate program (or a combination of both). The statutory federal matching rate for SCHIP services (on average, 70 percent) is higher than that for Medicaid (on average, at least 57 percent), but the federal allotment to each state for SCHIP services is capped at a specified amount each year.

Title XIX – Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., is the federal statute that authorizes the Medicaid program. Related titles of the Social Security Act are Title IV-A (TANF), Title IV-E (Foster Care and Adoption Assistance), Title XVI (SSI), Title XVIII (Medicare), and Title XXI (SCHIP).

Upper Payment Limit (UPL) – Limits set forth in CMS regulations on the amount of Medicaid payments a state may make to hospitals, nursing facilities, and other classes of providers. Payments in excess of the UPLs do not qualify for federal Medicaid matching funds. The UPLs are generally are keyed to the amounts that can reasonably be estimated would be paid, in the aggregate, to the class of providers in question using Medicare payment rules.

Waivers – Various statutory authorities under which the Secretary of HHS may, upon the request of a state, allow the state to receive federal Medicaid matching funds for its expenditures even though it is no longer in compliance with certain requirements or limitations of the federal Medicaid statute. In the case of program waivers such as the 1915(c) waiver for home and community-based (HCBS) services, states may receive federal matching funds for services for which federal matching funds are not otherwise available. In the case of demonstration waivers such as the section 1115 waivers, states may receive federal matching funds for the costs of covering certain categories of individuals for whom federal matching funds are not otherwise available. See Section 1115, HIFA, Pharmacy Plus, and Home and Community-Based Services (HCBS) Waivers.

ENDNOTES

¹ Congressional Budget Office, Fact Sheet for CBO's March 2003 Baseline, Medicaid and the State Children's Health Insurance Program, www.cbo.gov.

² Congressional Budget Office, *The Budget and Economic Outlook: An Update*, (August 26, 2003), www.cbo.gov.

³ Guyer, Jocelyn, *Bush Administration Medicaid/SCHIP Proposal*, Kaiser Commission on Medicaid and the Uninsured (February 2003) www.kff.org.

⁴ Some states also require local governments to provide funding for Medicaid.

⁵ Section 1905(b) of the Social Security Act, 42 U.S.C. 1396d(b).

⁶ For the purposes of this paper, matching rates for FY 2003 will be cited, rather than the FY 2004 matching rates, which are temporarily higher pursuant to the Congressional fiscal relief law.

⁷ For definitions of mandatory and optional eligibility categories and services, see *Medicaid "Mandatory" and "Optional" Eligibility and Benefits*, Kaiser Commission on Medicaid and the Uninsured (July 2001) www.kff.org. As examples, two of the "mandatory" groups states are required to cover are pregnant women and children under age six with family incomes under 133 percent of poverty. However, states have the option of exceeding the 133 percent income cutoff to cover children under age six at higher income levels. Similarly, while some services, like physician and hospital services, are designated as "mandatory," others are termed "optional," such as prescription drugs and physical therapy.

⁸ *Ibid.*

⁹ Participation in Medicaid is optional for states; all states have chosen to participate.

¹⁰ Mann, C., "The Flexibility Factor: Finding the Right Balance," *Health Affairs* (January/February 2003), pp.62 – 76; Jost, T., "The Tenuous Nature of the Medicaid Entitlement," *Health Affairs* (January/February 2003), pp. 145-153.

¹¹ For the purposes of the federal budget, entitlement programs such as Medicare and Medicaid are referred to as "direct" or "mandatory" spending. This differentiates it from "discretionary" spending, which refers to programs for which Congress appropriates set levels of funding, usually each year. Kaiser Commission on Medicaid and the Uninsured, *The President's Fiscal Year 2003 Budget: An Overview of Health Programs* (March 2002), www.kff.org. Congress can base its appropriations for discretionary programs on forecasts of the need for the program, but if these forecasts are incorrect, the appropriation does not change and the program spending does not meet the program's needs.

¹² As of December 2002, 3.7 million children were enrolled in SCHIP programs in all 50 states and the District of Columbia. Smith, V., and Rousseau, D., *SCHIP Program Enrollment: December 2002 Update* Kaiser Commission on Medicaid and the Uninsured (July 2003), www.kff.org.

¹³ A State's SCHIP matching is the state's Medicaid matching rate with the state share reduced by 30 percent. For example, a state with a 50 percent Medicaid FMAP has an SCHIP matching rate of 65 percent. The SCHIP enhanced matching rate cannot exceed 85 percent. Section 2105(b) of the Social Security Act, 42 U.S.C. 1397ee(b).

¹⁴ Section 2104 (a) of the Social Security Act, 42 U.S.C. 1397dd(a).

¹⁵ Silberman, P. et al., *The North Carolina Health Choice Enrollment Freeze of 2001* (January 2003), www.kff.org. One option states have at their disposal for avoiding SCHIP cost control mechanisms like an enrollment cap when they face SCHIP funding constraints is to expand eligibility to cover these children in Medicaid.

¹⁶ U.S. Office of Management and Budget, "Budget of the United States Government for Fiscal Year 2003, Analytical Perspectives," (February 2002).

¹⁷ Guyer, Jocelyn, *The Financing of Pharmacy Plus Waivers: Implications for Seniors on Medicaid of Global Funding Caps*, Kaiser Commission on Medicaid and the Uninsured (May 2003), www.kff.org.

¹⁸ The State Children's Health Insurance Program offers a significantly higher matching rate to states than Medicaid does. The average SCHIP matching rate across all states is 70 percent, which is approximately 30 percent higher than the average Medicaid matching rate. This higher matching rate is one of the primary reasons that SCHIP was subject to fewer cuts than Medicaid was as states developed their Fiscal Year 2003 budgets.

¹⁹ Stevens and Stevens, *Welfare Medicine in America: A Case Study of Medicaid*, 1974, pp. 57-61.

²⁰ Holahan, J., et al., *Health Policy for the Low-Income Population: Major Findings from the Assessing the New Federalism Case Studies*, The Urban Institute (November 1998), p. 53, www.urban.org.

²¹ Two primary factors prevent Medicaid from covering a greater share of the nation's uninsured. First, Medicaid generally does not cover childless adults who are not elderly or disabled. Second, states vary significantly in the extent to which they cover populations for which federal matching funds are available. This variation is the result of a number of factors, including the availability of employer-based insurance in the state and the state's own policy preferences.

²² Bruen, B. and Holahan, J., *Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government*, Kaiser Commission on Medicaid and the Uninsured, forthcoming.

²³ Kaiser Family Foundation, *Fact Sheet: Medicare at a Glance* (February 2003), www.kff.org.

²⁴ The exception to this policy is Medicaid's Qualifying Individuals program.

²⁵ Section 1935(d)(1) of the Social Security Act.

²⁶ CBO, Table 3, "Estimated Change in State Medicaid Outlays under Title I of the Conference Agreement for H.R. 1," in Letter to Honorable Don Nickles, Chairman, Senate Budget Committee (November 20, 2003), www.cbo.gov.

²⁷ American Association of Retired Persons, *The Policy Book: AARP Public Policies 2001* (June 2001), Chapter 7, page 7-55.

²⁸ However, 11 states exceeded this national average: Florida, Iowa, Kansas, Maine, Rhode Island, West Virginia, Connecticut, Indiana, New Jersey, North Dakota, and South Dakota - State Health Facts Online, www.statehealthfacts.org.

²⁹ Kaiser Family Foundation, HIV/AIDS Policy Fact Sheets: *The Global HIV/AIDS Epidemic* (July 2002); *The HIV/AIDS Epidemic in the United States* (July 2002), www.kff.org.

³⁰ Alagiri, P., Summers, T., Kates, J., *Trends in U.S. Spending on HIV/AIDS* (July 2002), www.kff.org.

³¹ www.statehealthfacts.org.

³² As of February 2002, 8 state ADAP programs had enrollment caps in effect. Aldridge, Davis, Doyle, Kates, and Chou, *National ADAP Monitoring Project Annual Report* (April 2002), pp. 9-10, <http://www.kff.org/content/2002/6032/ADAP02fin.pdf>.

³³ Perry, M., *New York's Disaster Relief Medicaid: Insights and Implications for Covering Low-income People* (August 2002), www.kff.org.

³⁴ Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered* (2000), pp. 87-102, www.nap.edu.

³⁵ National Association of Public Hospitals and Health Systems; *America's Safety Net Hospitals and Health Systems, 1998*, (October 2000).

³⁶ This program operates as the Consolidated Health Centers program under section 330 of the Public Health Service Act.

³⁷ Medicare and private insurance each account for only about 7 percent of all CHC revenues. Markus, Roby, and Rosenbaum, *A Profile of Federally Funded Health Centers Serving a Higher Proportion of Uninsured Patients* (June 2002), Table 6, pp. 14-15, www.kff.org.

³⁸ Fronstein, P., "National Health Spending Up 8.7 Percent Between 2000-2001; Spending for Health Care Will Continue to Grow," Employee Benefits Research Institute Notes (June 2002).

³⁹ Holahan and Hadley, *Medicaid: A High Cost Population, A Low-Cost Program*, Kaiser Commission on Medicaid and the Uninsured, forthcoming.

⁴⁰ Kaiser Family Foundation and Health Research and Educational Trusts, *Employer Health Benefits: 2003 Annual Survey*, (September 2003), www.kff.org.

⁴¹ Consider a federal entitlement program like Supplemental Security Income (SSI), which provides cash payments to disabled individuals. Because the level of cash payment is set at a fixed amount, unanticipated spending changes for SSI are driven primarily by the number of people who qualify. This stands in contrast to Medicaid, where unpredictability can be driven by not only by changes in the number of people who qualify, but also in the cost of health care services, the relative age and sickness of the population, and the types of health services this population requires. Sharing this financing burden between the federal government and the states means that no one entity of government must bear the cost or unpredictability of health and long-term care coverage.

⁴² Guyer, Jocelyn, *Issues Related to Unspent SCHIP Money*, Kaiser Commission on Medicaid and the Uninsured (November 2001), www.kff.org.

-
- ⁴³ Schneider, A., et al., *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured (July 2002) p. 130, www.kff.org.
- ⁴⁴ Gill, S. and C. Mann, *Section 1115 Waivers at a Glance: Summary of Recent Medicaid and SCHIP Waiver Activity*, Kaiser Commission on Medicaid and the Uninsured (April 2003), www.kff.org.
- ⁴⁵ Tannenwald, R., "Are State and Local Revenue Systems Becoming Obsolete?," *New England Economic Review*, Issue Number 4 (2001).
- ⁴⁶ Weil, A., "There's Something About Medicaid," *Health Affairs* (January/February 2003), p. 25
- ⁴⁷ Hudman, J. and A. Carbaugh, *The Role of Medicaid in State Economies: A Look at the Research*, The Kaiser Commission on Medicaid and the Uninsured (Forthcoming 2004), www.kff.org.
- ⁴⁸ Spending on mental health services other than prescription drugs accounts for 10 percent of total Medicaid spending. Federal Medicaid matching funds are not available for the costs of treating beneficiaries between the ages of 21 and 65 residing in Institutions for Mental Diseases (IMDs), but they are available for the costs of mental health services and prescription drugs furnished through emergency rooms, hospital outpatient clinics, community mental health programs, and licensed mental health practitioners. See Rowland, D., Garfield, R., and Elias, R., "Accomplishments and Challenges in Medicaid Mental Health," *Health Affairs* (September/October 2003), p. 74.
- ⁴⁹ Coughlin, T., and Zuckerman, S., "States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences," The Urban Institute, (June 2002).
- ⁵⁰ Lambrew, J., *Section 1115 Waivers in Medicaid and the State Children's Health Insurance Program: An Overview*, The Kaiser Commission on Medicaid and the Uninsured (July 2001), www.kff.org, and Mann, C., S. Artiga, J. Guyer, *Assessing the Role of Recent Waivers in Providing New Coverage*, The Kaiser Commission on Medicaid and the Uninsured (December 2003), www.kff.org.
- ⁵¹ Guyer, J., *The Financing of Pharmacy Plus Waivers: Implications for Seniors on Medicaid of Global Funding Caps* (May 2003), www.kff.org.
- ⁵² Milbank Memorial Fund and the National Association of State Budget Officers, "2000-2001 State Health Care Expenditure Report," (April 2003).
- ⁵³ Congressional Budget Office, *The Budget and Economic Outlook, FY 2004-2013*, www.cbo.gov.
- ⁵⁴ Congressional Budget Office, *The Long-Term Budget Outlook* (December 2003), pp. 31-32, www.cbo.gov <<http://www.cbo.gov>>.
- ⁵⁵ Miller, Vic. "Fiscal Federalism and Medicaid," in *Spectrum: The Journal of State Government* (Spring 2003).
- ⁵⁶ U.S. Office of Management and Budget, "Budget of the United States Government for Fiscal Year 2004: Historical Tables," (February 2003).
- ⁵⁷ Miller, Vic. "Fiscal Federalism and Medicaid."
- ⁵⁸ Miller, Vic, personal conversation, June 8, 2003.
- ⁵⁹ See Vernon Smith, et al., *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004*, Kaiser Commission on Medicaid and the Uninsured, (September 2003), www.kff.org.
- ⁶⁰ Although the federal matching rate is designed to account for variations in personal income, the data it relies on is not up to date. The matching rates for fiscal year 2003, which began October 1, 2002, are based on state personal income data for calendar year 1998, 1999, and 2000. States are therefore presently using matching rates that are based on data that is more than two years out of date. This means that in most cases, states' existing matching rates are based on information from when their economies were still experiencing the longest economic expansion in the history of the country, not from the past two years, when states have faced what some have called the most difficult fiscal situation since World War II. Although Congress recently temporarily increased Medicaid matching rates to provide more support for states in the current weak economy, this increase does not address the underlying data issues.
- ⁶¹ Holahan J. et al. "State Responses to Budget Crises in Fiscal Year 2004." Kaiser Commission on Medicaid and the Uninsured, January 2004.
- ⁶² Vernon Smith, et al.
- ⁶³ Section 1923(j)(2) of the Social Security Act, as added by section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173.
- ⁶⁴ Congressional Budget Office, "Fact Sheet for CBO's March 2003 Baseline, Medicaid and the State Children's Health Insurance Program," (March 2003), www.cbo.gov.

⁶⁵ Thompson, P., *Medicaid's Federal-State Partnership: Alternatives for Improving Financial Integrity*, Kaiser Commission on Medicaid and the Uninsured, forthcoming.

⁶⁶ Section 1905(b)(1) of the Social Security Act, 42 U.S.C. 1396d(b)(1).

⁶⁷ Section 1905(b)(4) of the Social Security Act, 42 U.S.C. 1396d(b)(4). The enhanced rate under SCHIP is calculated by reducing the state's share under its Medicaid FMAP by 30 percent; the highest possible enhanced matching rate is 85 percent. Section 2105(b) of the Social Security Act, 42 U.S.C. 1397ee(b). Thus, the enhanced FMAP in a state with a 50 percent Medicaid FMAP is 65 percent; in a state with a 70 percent FMAP, 79 percent.

⁶⁸ Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Resource Book* (July 2002), Chapter IV: Medicaid Administration, pp. 129–164, www.kff.org.

⁶⁹ United States General Accounting Office, *Medicaid Formula: Differences in Funding Ability Among States Often Are Widened*, GAO-03-620 (July 2003), www.gao.gov.

⁷⁰ For a discussion of these issues, see Miller, V., and Schneider, A., *The Medicaid Matching Formula: Policy Considerations and Options for Modification*, AARP Public Policy Institute (forthcoming 2004).

⁷¹ National Governors Association/National Association of Budget Officers, "The Fiscal Survey of States," (December 2003), <http://www.nasbo.org/Publications/fiscsurv/fsfall2003.pdf>.

⁷² National Conference of State Legislatures, "State Budget and Tax Actions Preliminary Report, 2002."

⁷³ National Governors Association/National Association of Budget Officers, *The Fiscal Survey of States*, (December 2003).

⁷⁴ Johnson, Nick, et al., "State Revenues Have Fallen Dramatically: Tax Increases So Far Have Failed to Fill the Gap," Center on Budget and Policy Priorities, (October 22, 2003), <http://www.cbpp.org/10-22-03sfp.htm>.

⁷⁵ Holahan, et al., "The State Fiscal Crisis and Medicaid: Will Health Programs Be Major Budget Targets?" Kaiser Commission on Medicaid and the Uninsured, (January 2003), p. 3. The case studies also found that states, which have placed a very high priority on elementary and secondary education, put education in a favorable position during state budget debates. Elementary and secondary education is protected in some states by constitutional amendments, ballot initiatives, or dedicated revenue streams. In Colorado, for example, a constitutional amendment guaranteed increases in per pupil spending on education, which essentially exempts 40 percent of the state's overall budget from spending cuts. Other states had recently made other commitments to education, like reducing class size, that require significant funding increases. In some states, binding funding commitments were made to other programs as well. In Florida, revenues dedicated to specific programs, like transportation, as well as other earmarked revenues, mean that only \$20 billion of the state's \$50 billion budget is classified as general revenue. These types of choices can make it more difficult for a state to fund its share of Medicaid costs.

⁷⁶ See Don Boyd, *The State Fiscal Crisis and Its Aftermath*, Kaiser Commission on Medicaid and the Uninsured, (September 2003), <http://www.kff.org/medicaid/kcmu4138report.cfm>. See also Hal Hovey, "The Outlook for State and Local Finances: The Dangers of Structural Deficits for the Future of Public Education," National Education Association, 1998.

⁷⁷ The caps also allow Congress to relieve budgetary pressure on "high-DSH" states -- those in which federal and state spending on DSH payments equals 3 percent or more of a state's total Medicaid spending -- on a temporary basis. For example, Congress recently increased each state's DSH allotment by 16 percent for FY 2004. Section 1001 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173. (In the case of "low-DSH" states, the 16 percent annual increases continue for an additional four years, through FY 2008.) The cost to the federal treasury is estimated at \$2.5 billion over 5 years. Congressional Budget Office, *CBO Estimate of Effect on Direct Spending and Revenues of Conference Agreement on H.R. 1: Detail* (November 20, 2003), www.cbo.gov.

⁷⁸ Congressional Budget Office, *Fact Sheet for CBO's March 2003 Baseline Medicaid and the State Children's Health Insurance Program* (March 2003).

1330 G STREET NW, WASHINGTON, DC 20005
PHONE: (202) 347-5270, FAX: (202) 347-5274
WEBSITE: WWW.KFF.ORG/KCMU

Additional copies of this report (#7000) are available
on the Kaiser Family Foundation's website at www.kff.org.



The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.