Health Advocate

E-Newsletter of the National Health Law Program

Volume 35 March 2015

Medicaid Financing

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Key Resources

[Top 10 Takeaways: CBO Report on Medicaid Spending Caps]

[Health Advocate: Federal Medicaid Reductions]

[Medicaid Block Grants = Devastating Cuts to Health Care]

Coming in April's *Health Advocate*:

Medicaid & Exchange Insurance

Federal budget season has officially begun. The President released his budget blueprint in early February, and Congress is now working on its own budget proposal and other broad fiscal initiatives. As an entitlement program, Medicaid funding is not typically affected by Congress' annual budget resolutions and appropriations process. However, health care spending represents a significant portion of government expenditures, and broad proposals to cap and cut Medicaid spending continue to arise in Congress. These proposals endanger the careful way in which Medicaid is structured to give states flexibility and how the program is financed in a manner that helps states efficiently and cost-effectively care for more than 68 million people.

This issue of the *Health Advocate* describes how Medicaid is funded and how the financial structure supports state Medicaid agencies.

Program Basics

Medicaid is an optional program, although every state has chosen to participate. The program operates as a state-federal partnership. Federal law sets baseline requirements that each state must meet, but states then tailor their Medicaid programs to meet their specific needs by utilizing inherent flexibilities in the program. For example, states have significant discretion in determining whether to cover certain population groups and services, and they can elect to pursue waivers and demonstration projects.

Each state's Medicaid program is financed by a combination of federal and state funds. The Medicaid program effectively leverages state and federal funding to deliver cost-effective care. Medicaid costs significantly less per enrollee than private insurance.[1] Further, Medicaid is an open-ended entitlement program, with no eligibility caps. All individuals who apply and meet the eligibility standards are entitled to receive benefits. In this way, the program is countercyclical. During an economic downturn, individuals are more likely to be unemployed and uninsured and thus eligible for Medicaid. Therefore, in worsening economic times, more individuals gain Medicaid coverage. Conversely, as the economy improves and incomes increase, fewer individuals receive their health coverage through Medicaid. This countercyclical nature helps the program serve as a national safety net. And since funding is not capped, states benefit by receiving additional federal funding as more people enroll.

[1] Edwin Park & Matt Broaddus, Center on Budget and Policy Priorities, Correcting Seven Myths About Medicaid (April 22, 2014) *available at* http://www.cbpp.org/cms/?fa=view&id=4023.

The Federal Medical Assistance Percentage

A formula called the Federal Medical Assistance Percentage (FMAP) is used to calculate the federal government's financial contribution to each state for the services provided through its Medicaid program. The FMAP is calculated using a formula that compares a state's per capita income with the national per capita income. States with lower per capita income receive a greater FMAP than states with higher per capita income. Federal law ensures a minimum FMAP of 50 percent and sets a maximum FMAP of 83 percent (currently no state's FMAP reaches the maximum threshold percentage).[2] The FY 2016 FMAP rates range from 50 percent in 13 states, including New York and California, to 74.17 percent in Mississippi, with an average FMAP of roughly 59 percent.[3]

How Changes in FMAP Affect the Federal Match

FMAP	State Contribution	Federal Match
50%	$1	$1.00
55%	$1	$1.22
60%	$1	$1.50
65%	$1	$1.86
70%	$1	$2.33
75%	$1	$3.00

A state's FMAP affects its ability to leverage and receive federal funds. For example, a state with a 50 percent FMAP will receive $10 in federal funds for every $10 it spends, but a state with a 75 percent FMAP will receive $30 in federal funds for every $10 it spends.

Enhanced FMAP

In addition to the FMAP described above, some covered population groups and services receive an "enhanced" (higher) FMAP. For example, states receive an enhanced FMAP when they cover the Affordable Care Act's Medicaid expansion population (primarily non-pregnant, non-elderly, childless adults up to 138 percent of the Federal Poverty Level (FPL)). The ACA expansion FMAP is 100 percent from 2014-2016, meaning that the federal government will pay for all of the service costs for this population group with no matching state contribution required. This FMAP will gradually decrease from 100 percent in 2016 to 90 percent for 2020 and subsequent years.

Another example of enhanced match is family planning services and supplies, which receive an FMAP of 90 percent. Services provided through Indian Health Services receive an enhanced FMAP of 100 percent. Special short-term FMAPs have also applied. For instance, states affected by Hurricane Katrina received an adjusted FMAP. Sometimes, an enhanced FMAP is used to encourage state Medicaid programs to adopt new policies or extend coverage. For example, a temporary program called the Balancing Incentive Program (BIP) gives participating states an enhanced FMAP of 2 or 5 percentages points if they increase the proportion of long-term care services provided in non-institutionalized settings.

[2] 42 U.S.C. § 1396d(b).

[3] 79 Fed. Reg. 71426 (Dec. 2, 2014).

It is important to note that a different FMAP applies to program administration. Generally, the federal government pays 50 percent of the states' administrative costs, although there are specific instances in which the federal government pays more, such as for technology upgrades. The ACA established an enhanced FMAP through December 31, 2015 of 90 percent for the "design, development or installation" of upgraded eligibility systems and an FMAP of 75 percent for the operation of these systems.[4] The enhanced FMAP for system operation will extend beyond 2015, as long as specific system standards are met before the end of this year.

State Spending Drives Federal Spending

The federal government does not contribute a set amount of money to each state. The federal match is open-ended and depends on the actual amount of money the state spends. Medicaid allows states to make several important decisions that affect state spending on the program. For instance, states decide whether and to what extent they will cover optional population groups and optional services for adults. Additionally, within broad federal guidelines, each state makes its own decisions about the amount, duration and scope of covered services, the delivery systems through which these services will be provided, whether and how much cost sharing will be charged to beneficiaries, and how much participating providers will be paid when they render a covered service. These state-level decisions help determine the amount of money a state will spend on Medicaid and thus affect how much money the federal government will contribute. These decisions also allow states to modify the program so that it meets their specific needs. Thus, in the United States, we have 50 different Medicaid programs, each tailored to the state's population and budget. As the saying goes, if you have seen one Medicaid program you have seen one Medicaid program.

Proposals to Cap and Cut Medicaid Spending

With a new Congress and a new budget season, we are once again seeing proposals to cut and cap Medicaid spending. These proposals often take the form of spending caps such as block grants and per capita caps. While addressing Medicaid spending and health care costs in general are important policy priorities, spending caps fail to address the major driving factors of system-wide increasing health care costs—all of which are largely out of government control. For instance, the release of expensive new treatments (such as Solvaldi to treat Hepatitis C) may cause a state's Medicaid costs to increase. Changing demographics within a state's population can lead to upward fluctuations in Medicaid spending. Notably, the spending cap proposals do not account for these factors; rather, they shift the costs onto the states by limiting the federal contribution. And as these factors occur—and they are inevitable—states will likely be forced to cut services and eligibility or to pass these costs on to enrollees. The solution is to address health care costs across the entire health care system and not put the burden solely on Medicaid to save money.

[4] 76 Fed. Reg. 21949 (April 19, 2011).

Conclusion

States have significant flexibility in designing their Medicaid programs to meet their population, service and budgetary needs. Too often, dangerous proposals to cut and cap Medicaid spending are made without considering how Medicaid operates. Proponents of these proposals often argue about the need to curb costs and give states more flexibility. The very fact that these are the given rationales illustrates the lack of understanding of how Medicaid is structured and financed. Medicaid is cost-effective, and the Medicaid laws already give states significant flexibility in defining the scope and amount of benefits, choosing delivery care models and determining payment rates. Medicaid's financial design helps states provide effective and efficient care to low-income individuals and people with disabilities.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. NHeLP advocates, educates and litigates at the federal and state level.

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