Congressional Research Service
Informing the legislative debate since 1914

Medicaid Financing and Expenditures

Alison Mitchell
Analyst in Health Care Financing

December 14, 2015

Congressional Research Service
7-5700
www.crs.gov
R42640

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term services and supports. Medicaid is a federal and state partnership that is jointly financed by both the federal government and the states.

The federal government's share for most Medicaid expenditures is called the federal medical assistance percentage (FMAP). Generally determined annually, the FMAP formula is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes). Federal Medicaid funding to states is open ended.

The federal government provides states a good deal of flexibility in determining the composition of the state share (also referred to as the nonfederal share) of Medicaid expenditures. As a result, there is significant variation from state to state in how the state share of Medicaid expenditures is financed.

In 2014, Medicaid represented 16% of national health expenditures; in that year, private health insurance and Medicare accounted for 33% and 20% of national health expenditures, respectively. Medicaid is a significant payer in the categories of health spending that include long-term services and supports and hospital expenditures. For the other services (such as durable medical equipment, physician and clinical services, prescription drugs, and dental services), Medicaid accounts for a smaller share of the national expenditures.

In FY2014, Medicaid expenditures totaled $494 billion, with the federal government paying $299 billion, or about 60% of the total. Over the next few years, Medicaid expenditures are expected to increase significantly due to the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) Medicaid expansion. The federal government is paying the vast majority of the costs associated with the ACA Medicaid expansion due to the enhanced federal matching rates available to states that choose to implement the ACA Medicaid expansion.

Spending on managed care and long-term services and supports comprises more than half of Medicaid expenditures on benefits. Per-enrollee Medicaid expenditures for individuals with disabilities and the elderly are significantly higher than per-enrollee expenditures for adults and children, due in part to the higher utilization of long-term services and supports among individuals with disabilities and the elderly.

Medicaid expenditures are influenced by economic, demographic, and programmatic factors. Economic factors include health care prices, unemployment rates, and individuals' wages. In addition, state-specific factors, such as programmatic decisions and demographics, affect Medicaid expenditures and cause Medicaid spending to vary widely from state to state.

Medicaid constitutes a significant portion of the federal budget, and federal Medicaid expenditures are expected to increase significantly over the next ten years due to the ACA Medicaid expansion. As a result, Medicaid could be a focus of any potential deficit reduction or other legislative proposals affecting the federal budget.

This report provides an overview of Medicaid's financing structure, including both federal and state financing issues. The "Medicaid Expenditures" section of the report discusses Medicaid in terms of national health expenditures, trends in Medicaid expenditures, economic factors affecting Medicaid, and state variability in spending.

Contents

Introduction 1
Medicaid Financing 1
Federal Share 1
The Federal Medical Assistance Percentage 2
Medicaid and the Federal Budget Process 3
State Share 4
Medicaid Expenditures 5
Medicaid and National Health Expenditures 5
Trend in Medicaid Expenditures 8
Medicaid Expenditures by Service Type 9
Per-Enrollee Medicaid Expenditures 10
Factors Affecting Medicaid Expenditures 11
State Variability in Medicaid Spending 12
Conclusion 13

Figures

Figure 1. Medicaid as a Percentage of National Health Expenditures 6
Figure 2. Percentage Distribution of National Health Expenditures by Type of Service and Source of Funds 7
Figure 3. Federal and State Actual and Projected Medicaid Expenditures 8
Figure 4. Medicaid Benefit Expenditures by Service Type 10
Figure 5. Expenditures Per Medicaid Enrollee by Major Eligibility Groups 11
Figure 6. States' Share of Total Medicaid Expenditures 12

Appendixes

Appendix. Medicaid Expenditures by State 14

Contacts

Author Contact Information 16

Introduction

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term services and supports.[1] Medicaid is a federal and state partnership. The states are responsible for administering their Medicaid programs, and Medicaid is jointly financed by the federal government and the states. In FY2014, Medicaid is estimated to have provided health care services to 65 million individuals[2] at a total cost of $494 billion (including federal and state expenditures).[3]

Participation in Medicaid is voluntary, though all states, the District of Columbia, and the territories choose to participate. The federal government sets some basic requirements for Medicaid, and states have the flexibility to design their own version of Medicaid within the federal government's basic framework.

States incur Medicaid costs by making payments to service providers (e.g., for beneficiaries' doctor visits) and performing administrative activities (e.g., making eligibility determinations). The federal government reimburses states for a share of each dollar spent in accordance with their federally approved Medicaid state plans.

Medicaid is an entitlement for both states and individuals. The Medicaid entitlement to states ensures that, so long as states operate their programs within the federal requirements, states are entitled to federal Medicaid matching funds. Medicaid is also an individual entitlement, which means that anyone eligible for Medicaid under his or her state's eligibility standards is guaranteed Medicaid coverage.

This report provides an overview of Medicaid's financing structure, including both federal and state financing issues. The "Medicaid Expenditures" section of the report discusses Medicaid in terms of national health expenditures, trends in Medicaid expenditures, economic factors affecting Medicaid, and state variability in spending.

Medicaid Financing

The federal government and the states share the cost of Medicaid. The federal government reimburses states for a portion (i.e., the *federal share* or the *federal financial participation*) of each state's Medicaid program costs. Federal Medicaid funding is an open-ended entitlement to states, which means there is no upper limit or cap on the amount of federal Medicaid funds a state may receive.

Federal Share

A primary goal of the federal Medicaid matching arrangement is to share the cost of providing health care services to low-income residents with the states. The Medicaid financing structure

[1] For more information about the Medicaid program, see CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell.

[2] This enrollment figure is measured according to *person-year equivalents*, which represent the average program enrollment over the course of a year and differ from *ever-enrolled* counts, which measure the number of people covered by Medicaid for any period of time during the year. (Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, *2014 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, Centers for Medicare & Medicaid Services [CMS], U.S. Department of Health & Human Services [HHS], 2015.)

[3] CMS, Form CMS-64 data as of March 30, 2015.

represents a fiscal commitment on the part of the federal government toward paying at least half (but not all) of the cost of Medicaid.[4]

The federal government's open-ended financial commitment to Medicaid provides a fiscal incentive for states to extend Medicaid coverage to more low-income individuals than a state might choose to fund without the federal Medicaid funding. However, this incentive is counterbalanced by the requirement for states to share in the cost of Medicaid.[5]

Although most federal Medicaid funding is provided on an open-ended basis, certain types of federal Medicaid funding are capped. For instance, federal disproportionate share hospital (DSH)[6] funding to states cannot exceed a state-specific annual allotment. In addition, Medicaid programs in the territories (i.e., American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Virgin Islands) are subject to annual spending caps. Another exception to open-ended federal Medicaid funding includes the Qualified Individuals program.[7]

The Federal Medical Assistance Percentage

The federal government's share of most Medicaid expenditures is established by the federal medical assistance percentage (FMAP) rate, which generally is determined annually and varies by state according to each state's per capita income relative to the U.S. per capita income. The formula provides higher FMAP rates, or federal reimbursement rates, to states with lower per capita incomes, and it provides lower FMAP rates to states with higher per capita incomes. FMAP rates have a statutory minimum of 50% and a statutory maximum of 83%.[8] In FY2016, FMAP rates range from 50% (13 states) to 74% (Mississippi).

The FMAP rate is used to reimburse states for the federal share of most Medicaid expenditures, but exceptions to the regular FMAP rate have been made for certain states (e.g., the District of Columbia and the territories), situations (e.g., during economic downturns), populations (e.g., certain women with breast or cervical cancer and individuals in the Qualifying Individuals program), providers (e.g., Indian Health Service facilities), and services (e.g., family planning and home health services). In addition, the federal share for most Medicaid administrative costs does not vary by state and is generally 50%.

[4] Andy Schneider and David Rousseau, *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured, Publication Number 2236, January 17, 2003; Teresa A. Coughlin and Stephen Zuckerman, *States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences*, The Urban Institute, June 2002.

[5] Ibid.

[6] The federal Medicaid statute requires that states make disproportionate share hospital (DSH) adjustments to the payment rates of hospitals treating large numbers of low-income and Medicaid patients. For more information about Medicaid DSH payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*, by Alison Mitchell.

[7] States are required to pay Medicare Part B premiums for Medicare beneficiaries with income between 120% and 135% of the federal poverty level (FPL) and limited assets (referred to as *qualifying individuals*), up to a specified dollar allotment.

[8] For more detail about the federal medical assistance percentage (FMAP), see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2016*, by Alison Mitchell.

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) included a couple of FMAP exceptions, such as the *newly eligible* federal matching rates and the *expansion state* federal matching rates. Under the newly eligible federal matching rate, from 2014 through 2016, states receive a 100% federal matching rate for the cost of individuals who are newly eligible for Medicaid due to the ACA expansion,[9] and this newly eligible federal matching rate phases down to 90% for 2020 and thereafter.[10] The expansion state federal matching rate is available for coverage of individuals in expansion states[11] who were eligible for Medicaid on March 23, 2010, and are in the new eligibility group. The expansion state federal matching rate ranged from 72% to 92% in 2014 and varies each year until 2020, when the matching rate will be 90% for 2020 and thereafter.

The federal share of Medicaid expenditures used to be about 57% in a typical year, which meant the state share was about 43%. However, with the exceptions to the FMAP added by the ACA, the federal share of Medicaid expenditures has increased. In FY2014, the federal share of Medicaid expenditures was 60% on average. It is expected to remain around 60% through at least FY2023.[12]

Process for Federal Medicaid Funds Getting to States

States incur Medicaid costs by making payments to service providers (e.g., for beneficiaries' doctor visits) and performing administrative activities (e.g., making eligibility determinations). After a state has made Medicaid expenditures, it can draw down federal matching funds.

The Medicaid financing structure is set up so that states can draw down federal Medicaid matching funds on a real-time basis through commercial banks and the Federal Reserve System against a continuing letter of credit certified by the Secretary of the Treasury in favor of the state payee. Then, the federal government reconciles state Medicaid expenditures on a quarterly basis.

The Centers for Medicare & Medicaid Services (CMS) makes quarterly grant awards to states to cover the federal share of Medicaid expenditures based on the quarterly estimates states submitted to CMS on the Form CMS-37. Each state must submit a Form CMS-64 no later than 30 days after the end of each quarter with the state's accounting of actual recorded expenditures. CMS then reviews the expenditures reported on the CMS-64 to reconcile the states' estimates from the CMS-37 with the actual documented expenditures to ensure that the reported expenditures are allowable under the Medicaid statute and the Medicaid state plan.

If CMS is uncertain as to whether a particular state expenditure is allowable, then CMS must notify the state and provide an opportunity for a hearing. If the state does not comply, CMS may withhold payment or disallow claims for federal Medicaid matching funds until the issue has been resolved.

Medicaid and the Federal Budget Process

As discussed above, Medicaid is a federal entitlement to states, and in federal-budget parlance entitlement spending is categorized as *mandatory spending*, which is also referred to as *direct spending*. Although most mandatory spending programs bypass the annual appropriations process and automatically receive funding each year according to either permanent or multiyear

[9] The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) Medicaid expansion expands Medicaid eligibility to most adults under the age of 65 with income up to 133% of FPL (effectively 138% of FPL with a 5% of FPL income disregard). For more information about the ACA Medicaid expansion, see CRS Report R43564, *The ACA Medicaid Expansion*, by Alison Mitchell.

[10] The newly eligible FMAP rates are available for these specific years, regardless of whether a state implements the ACA Medicaid expansion in 2014 or a later year.

[11] This definition of expansion state was established prior to the Supreme Court decision making the ACA Medicaid expansion optional for states. In this context, *expansion state* refers to states that already had implemented (or partially implemented) the ACA Medicaid expansion at the time the ACA was enacted.

[12] Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, *2014 Actuarial Report on the Financial Outlook for Medicaid*, Centers for Medicare & Medicaid Services' Office of the Actuary, 2015.

appropriations in the substantive law, Medicaid is funded in the annual appropriations acts. For this reason, Medicaid is referred to as an *appropriated entitlement*.[13]

The level of spending for appropriated entitlements, similar to other entitlements, is based on the benefit and eligibility criteria established in law. The amount of budget authority provided in appropriations acts for Medicaid is based on budget projections for meeting the funding needs of the program. Although most changes to the Medicaid program are made through statute, the fact that Medicaid is subject to the annual appropriations process provides an opportunity for Congress to place funding limitations on specified activities in Medicaid, such as the circumstances under which federal funds can be used to pay for abortions.

The appropriations bill usually provides Medicaid with (1) funding for the fiscal year considered in the appropriations bill and (2) an advance appropriation for the first quarter of the following fiscal year.[14] For instance, the Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235), provided Medicaid with $234.6 billion for FY2015 and an advance appropriation of $113.3 billion for the first quarter of FY2016.

State Share

The federal government provides broad guidelines to states regarding allowable funding sources for the state share of Medicaid expenditures. However, to a large extent, states are free to determine how to fund their share of Medicaid expenditures. As a result, there is significant variation from state to state in funding sources.

States can use state general funds (i.e., personal-income, sales, and corporate-income taxes) and "other state funds" (i.e., provider taxes,[15] local government funds,[16] tobacco settlement funds, etc.) to finance the state share of Medicaid. Federal statute allows as much as 60% of the state share to come from local government funding.[17] Federal regulations also stipulate that the state share not be funded with federal funds (Medicaid or otherwise).[18] In state fiscal year 2013, on average, 73% of the state share of Medicaid expenditures was financed by state general funds, and the remaining 27% was financed by other state funds. [19]

A few funding sources have received a great deal of attention over the past couple decades because states have used these funds in financing mechanisms designed to maximize the amount

[13] For more information about appropriated entitlements, see CRS Report RS20129, *Entitlements and Appropriated Entitlements in the Federal Budget Process*, by Bill Heniff Jr.

[14] Advance appropriations become available for obligation one or more fiscal years after the budget year covered by the appropriations act. For more information about advance appropriations, see CRS Report R43482, *Advance Appropriations, Forward Funding, and Advance Funding: Concepts, Practice, and Budget Process Considerations*, by Jessica Tollestrup.

[15] Federal statute and regulations define a provider tax as a health care-related fee, assessment, or other mandatory payment for which at least 85% of the burden of the tax revenue falls on health care providers. For more information about Medicaid provider taxes, see CRS Report RS22843, *Medicaid Provider Taxes*, by Alison Mitchell.

[16] Local governments and local government providers can contribute to the state share of Medicaid payments through intergovernmental transfers (IGTs) or certified public expenditures (CPEs). For IGTs, a local government transfers funds to the state government to be used to finance Medicaid. When CPEs are used to fund the state share, the local government certifies its Medicaid expenditures to the state, and then the state claims the federal Medicaid matching funds.

[17] §1902(a)(2) of the Social Security Act.

[18] 42 C.F.R. 433.51(c).

[19] National Association of State Budget Officers, *State Expenditure Report: Examining Fiscal 2012-2014 State Spending*, 2014.

of federal Medicaid funds coming to the state. For example, some states have used financing mechanisms that involve the coordination of fund sources, such as provider taxes and intergovernmental transfers, and payment policies, such as DSH and supplemental payments,[20] to draw down federal Medicaid funds without expending much, if any, state general funds.

Medicaid Expenditures[21]

Medicaid expenditures account for a significant and growing portion of total health expenditures in the United States. Expansions of eligibility account for much of Medicaid's expenditure growth over time, and the ACA Medicaid expansion is expected to significantly increase Medicaid expenditures over the next few years. However, Medicaid expenditures also are influenced by economic, demographic, and programmatic factors. In addition, there is considerable variation in Medicaid spending from state to state due to demographic differences, state policy choices, utilization of services, and provider payment rates.

Medicaid and National Health Expenditures

In 2014, Medicaid represented 16% of national health expenditures; in that same year, private health insurance and Medicare accounted for 33% and 20% of national health expenditures, respectively.[22] **Figure 1** shows Medicaid as a percentage of national health expenditures from 1966 (the first year Medicaid was in operation) through 2014. Since the start-up years (i.e., 1966 through 1971), Medicaid expenditures have grown as a percentage of national health expenditures with just a couple of exceptions.[23] In the past, much of Medicaid's expenditure growth has been due to federal or state expansions of Medicaid eligibility criteria.[24] Over time, Medicaid has become one of the largest payers in the U.S. health care system.

[20] *Supplemental payments* are Medicaid payments made to providers that are separate from and in addition to the standard payment rates for services rendered to Medicaid enrollees. Often, providers receive supplemental payments in a lump sum.

[21] Data in this section are provided for different years (i.e., calendar year 2013, FY2013, or FY2014) because Medicaid data are collected from states at different times for different purposes. For each type of expenditure, the most recent data are provided.

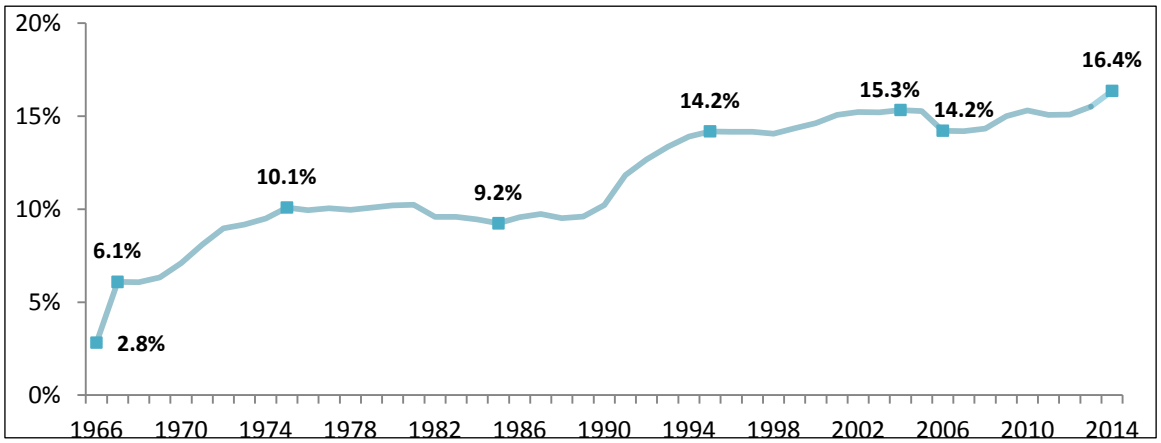
[22] CMS, "National Health Expenditures by type of service and source of funds, CY 1960-2014," *National Health Expenditure Accounts,* December 2, 2015.

[23] For the years 1982 through 1984, Medicaid expenditure growth decreased due to a three-year reduction to the federal Medicaid matching rate. In addition, Medicaid expenditures as a percentage of national health expenditures dropped from 15% in 2005 to 14% in 2006 due to prescription drug coverage for dual-eligible beneficiaries moving from Medicaid to Medicare Part D beginning on January 1, 2006, which resulted in a substantial reduction in Medicaid prescription drug spending.

[24] Rachel Garfield et al., *Enrollment-Driven Expenditure Growth: Medicaid Spending during the Economic Downturn, FFY2007-2010*, Kaiser Commission on Medicaid and the Uninsured, Publication #8309, May 2012.

Figure 1. Medicaid as a Percentage of National Health Expenditures

(1966-2014)



Source: Centers for Medicare & Medicaid Services (CMS), "National Health Expenditures by type of service and source of funds, CY 1960-2014," *National Health Expenditure Accounts,* December 2, 2015.

Medicaid is a major payer in some categories of national health expenditures and accounts for a smaller share of other categories of expenditures. **Figure 2** shows that in 2014, Medicaid was a major payer in the categories of spending that include long-term services and supports,[25] with Medicaid paying 56% of expenditures in the other residential, and personal care category;[26] 36% of home health expenditures; and 32% of nursing facilities and continuing care retirement communities.[27] Medicaid accounted for 17% of hospital expenditures. For the other services, in 2014, Medicaid accounted for a smaller share of the national expenditures, with Medicaid paying 13% of durable medical equipment, almost 11% of physician and clinical expenditures, 9% of prescription drugs, 9% of dental expenditures, and 7% of other professional expenditures. Medicaid did not have any expenditures for non-durable medical products in 2014.

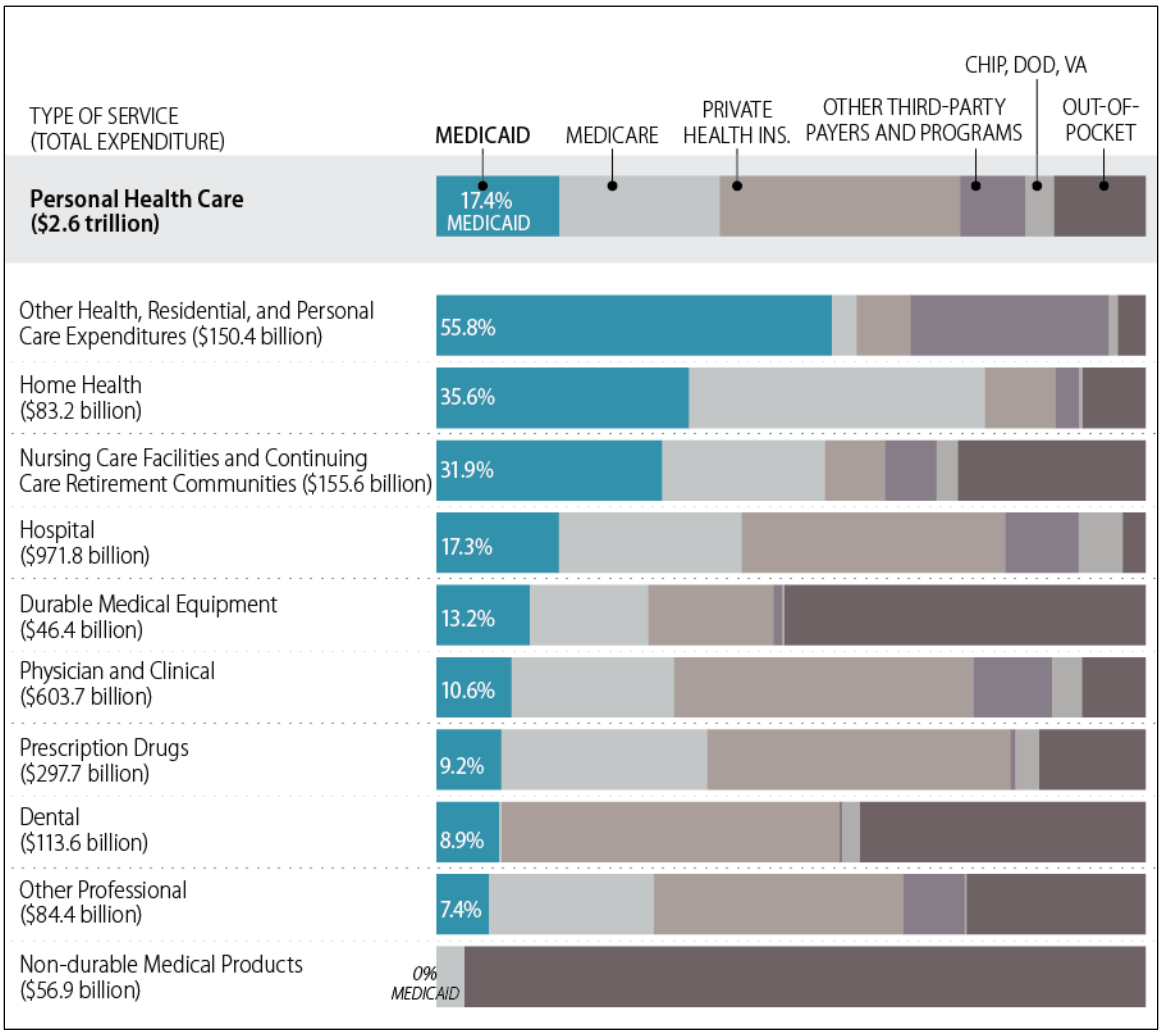
[25] Long-term services and supports refer to a broad range of health and health-related services and supports needed by individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or condition.

[26] The two largest components of the other residential and personal care category are (1) residential intellectual and developmental disability, mental health, and substance abuse facilities and (2) Medicaid home- and community-based services waiver[26] expenditures, which are both long-term services and supports. The expenditures for each of these two categories make up a little less than a third of the total expenditures for the category. (Communication with the CMS Office of the Actuary on September 2, 2015.)

[27] Long-term services and supports expenditures are included in the following national health expenditures categories: nursing facilities and continuing care retirement communities; home health; and other health, residential, and personal care. However, the other health, residential, and personal care category includes non-long-term services and supports expenditures, such as school health and worksite healthcare.

Figure 2. Percentage Distribution of National Health Expenditures by Type of Service and Source of Funds

(2014)



Source: CMS, "National Health Expenditures by type of service and source of funds, CY 1960-2014," *National Health Expenditure Accounts,* December 2, 2015.

Notes: Other third-party payers and programs includes worksite health care, Indian Health Services, workers' compensation, the Maternal and Child Health program, vocational rehabilitation, Substance Abuse and Mental Health Services Administration grants, other state and local programs, and school health.

The categories of spending that include long-term services and supports expenditures are other health, residential, and personal care expenditures; home health expenditures; and nursing facilities and continuing care retirement communities.

Medicaid estimates are based primarily on financial information reports filed by the state Medicaid agencies on Form CMS-64. These data have a category for capitated payments (including managed care), but the information does not break down managed care spending by service. For the National Health Expenditure Accounts (NHEA), Medicaid managed care payments are reduced by administrative costs and then allocated to NHEA service categories based on the distribution of Medicaid fee-for-service spending for selected services in the state.

CHIP: State Children's Health Insurance Program

DOD: Department of Defense

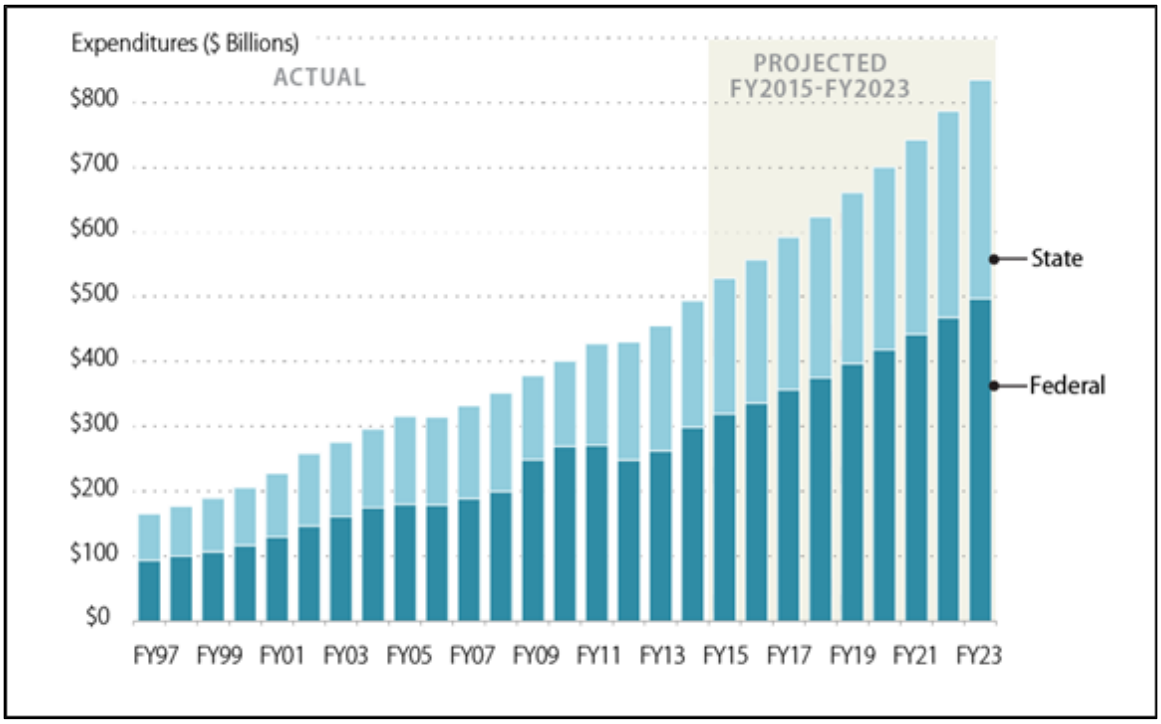
VA: Veterans Affairs

Trend in Medicaid Expenditures

Over time, much of Medicaid's expenditure growth has been due to federal or state expansions of Medicaid eligibility criteria, and the ACA Medicaid expansion is expected to significantly increase Medicaid expenditures over the next few years.[28] **Figure 3** shows actual Medicaid expenditures from FY1997 to FY2014 and projected Medicaid expenditures from FY2015 through FY2023 broken down by state and federal expenditures. In FY2014, Medicaid spending on services and administrative activities in the 50 states, the District of Columbia, and the territories totaled $494 billion (see **Table A-1** for state-by-state expenditures for FY2014). Medicaid expenditures are estimated to grow to $835 billion in FY2023.[29]

Figure 3. Federal and State Actual and Projected Medicaid Expenditures

(FY1997 to FY2023)



Source: Actual expenditures are from Form CMS-64 Data as of March 30, 2015, and the projected expenditures are from the CMS Office of the Actuary's *2014 Actuarial Report on the Financial Outlook for Medicaid*.

Notes: The expenditures shown in this figure include all Medicaid expenditures, which include both administrative and benefit spending. These expenditures exclude state Medicaid Fraud Control Units, Medicaid survey and certification of nursing and intermediate care facilities, and the Vaccines for Children program.

Federal Medicaid expenditures totaled $299 billion, or 60% of total Medicaid expenditures, in FY2014, and state Medicaid expenditures were $195 billion, which was 40% of total Medicaid

[28] Rachel Garfield et al., *Enrollment-Driven Expenditure Growth: Medicaid Spending during the Economic Downturn, FFY2007-2010*, Kaiser Commission on Medicaid and the Uninsured, Publication #8309, May 2012; Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, *2014 Actuarial Report on the Financial Outlook for Medicaid*, CMS Office of the Actuary, 2015.

[29] HHS, CMS, Form CMS-64 data, December 9, 2014; Christopher J. Truffer et al., *2013 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, CMS, HHS, 2014.

spending.[30] From FY2013 to FY2014, federal Medicaid expenditures grew by almost 14% whereas state Medicaid expenditures grew by only 1% due to the enhanced federal matching rates for the ACA Medicaid expansion (discussed in the "The Federal Medical Assistance Percentage" section).[31] Medicaid expenditures resulting from the ACA Medicaid expansion are projected to be $457 billion from FY2014 to FY2023, with the federal government paying about 93% of this amount.

Medicaid Expenditures by Service Type

Most Medicaid expenditures (i.e., 95% in FY2014) are for medical assistance (or nonadministrative) payments. In FY2014, Medicaid spending on medical assistance grew by an estimated 9.5%, which is significant relative to the annual percentage increases for FY2012 and FY2013—0.2% and 6.0%, respectively. The ACA Medicaid expansion was the main reason for the large increase in Medicaid spending, but the woodwork effect[32] also contributed to the increase.[33]

Figure 4 shows medical assistance payments by service type for FY2014. Managed care, which includes payments to managed care organizations,[34] primary care case management,[35] and non-comprehensive prepaid health plans,[36] accounted for 37% of Medicaid expenditures. Long-term services and supports, which include nursing facility care and home- and community-based services, made up 23% of all Medicaid expenditures.[37] Hospitals received 11% of total Medicaid expenditures in return for services provided to Medicaid fee-for-service enrollees at the payment rates set by states.[38]

[30] CMS, Form CMS-64 data as of March 30, 2015.

[31] CRS analysis of CMS, Form CMS-64 Data from FY2013 and FY2014 as of March 30, 2015; Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, *2014 Actuarial Report on the Financial Outlook for Medicaid*, CMS Office of the Actuary, 2015.

[32] The *woodwork effect* is the term for uninsured individuals who are eligible for Medicaid without the expansion but who decide to enroll in Medicaid due to increased media attention and outreach efforts associated with the ACA.

[33] Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, *2014 Actuarial Report on the Financial Outlook for Medicaid*, CMS Office of the Actuary, 2015.

[34] States contract with managed care organizations to provide a comprehensive package of benefits to enrolled Medicaid beneficiaries, primarily on a capitated basis (i.e., a set amount per enrollee regardless of the services utilized).

[35] Under primary care case management, states contract with primary care physicians to provide case management services to Medicaid enrollees. For these enrollees, other services generally are provided on a fee-for-service basis.

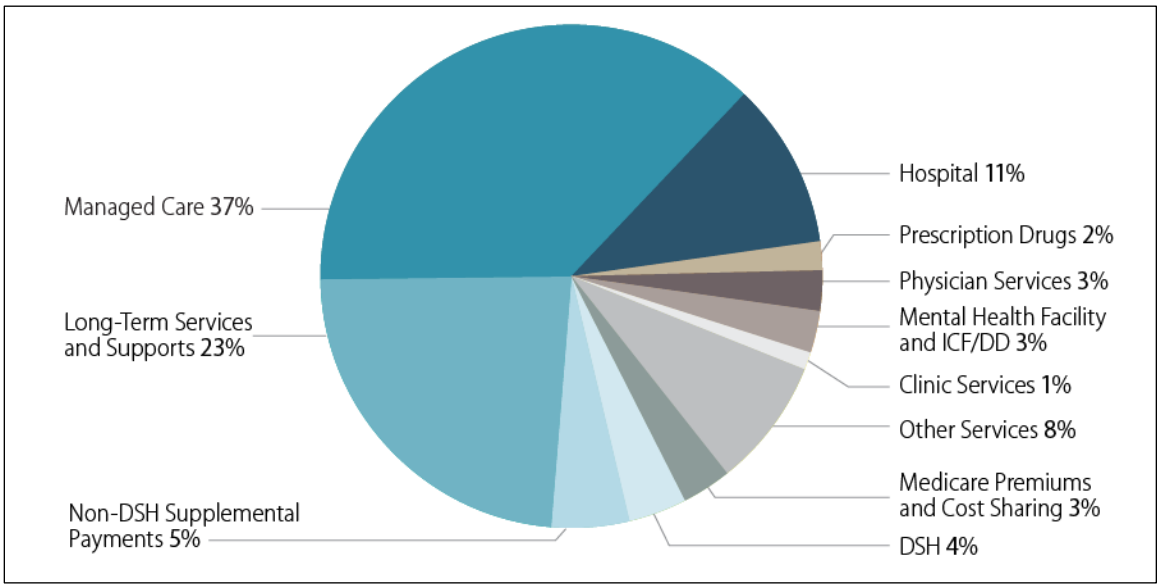
[36] States contract with health plans to provide non-comprehensive benefits (e.g., inpatient behavioral health care or dental care).

[37] For more information about long-term services and supports, see CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*, by Kirsten J. Colello.

[38] Hospitals also receive a significant portion of both the Medicaid DSH funding and the supplemental payments.

Figure 4. Medicaid Benefit Expenditures by Service Type

(FY2014)



Source: Congressional Research Service (CRS) analysis of CMS, Form CMS-64 Data as of March 30, 2015.

Notes: Prescription drug expenditures are net of rebates. The other service category includes any expenditure type that amounts to less than 1% of total Medicaid expenditures, such as laboratory services, rural health, targeted case management, physical therapy, etc. Long-term services and supports comprise spending for nursing facility services, home health services, home- and community-based services, personal care services, etc. Managed care is a system for delivering care in which Medicaid enrollees get most or all of their services through an organization under contract with the state. ICF/DD is an optional Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence. DSH and non-DSH supplemental payments are Medicaid payments made to providers that are separate from and in addition to the standard payment rates for services rendered to Medicaid enrollees.

DSH: Disproportionate Share Hospital

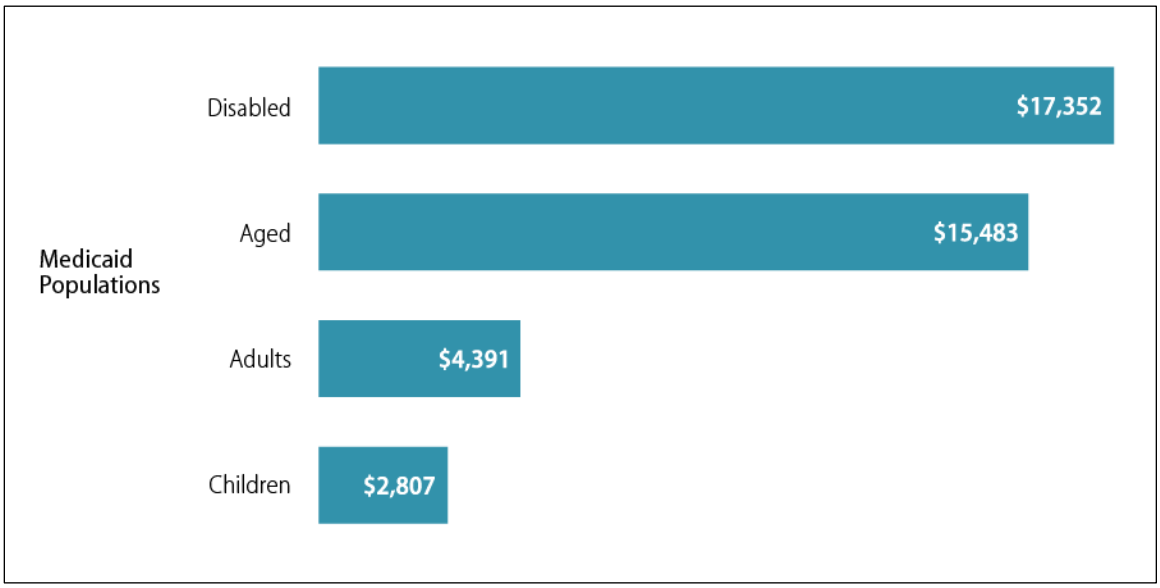
ICF/DD: Intermediate care facility for individuals with developmental disabilities

Per-Enrollee Medicaid Expenditures

In Medicaid, there are four main eligibility groups: children, adults, the aged, and individuals with disabilities. Per-enrollee Medicaid expenditures across these groups averaged $6,897 in FY2013.[39] However, as shown in **Figure 5**, per-enrollee expenditures varied significantly by eligibility group, with the per-enrollee expenditures by eligibility group ranging from $2,807 for children to $17,352 for individuals with disabilities.

[39] This figure excludes Medicaid expenditures for DSH, the territories, and administrative costs. In addition, this figure is based on Medicaid enrollment measured by person-year equivalents, which is the average enrollment over the course of a year. Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, *2014 Actuarial Report on the Financial Outlook for Medicaid*, CMS Office of the Actuary, 2015.

Figure 5. Expenditures Per Medicaid Enrollee by Major Eligibility Groups
(FY2013)



Source: Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, *2014 Actuarial Report on the Financial Outlook for Medicaid*, CMS Office of the Actuary, 2015.

Notes: Enrollment is measured in person-year equivalents, which is the average enrollment over the course of the year. This chart does not include expenditures for DSH, the territories, or adjustments (i.e., net adjustments of benefits from prior periods and the difference between expenditures and outlays).

One reason the aged and disabled populations have higher per-enrollee expenditures is because these populations consume most of the long-term services and supports, which comprise almost a quarter of all Medicaid expenditures (see **Figure 4**). Another reason for the difference in per-enrollee expenditures by eligibility group is that children and adults tend to be healthier and therefore tend to have lower health care costs than the aged and disabled populations, even though a significant number of nondisabled adults are pregnant women.

In FY2013, the aged and disabled populations together accounted for about 26% of Medicaid enrollment and 64% of Medicaid expenditures. In comparison, the children and adult populations accounted for about 74% of Medicaid enrollment and 36% of Medicaid expenditures.[40]

Factors Affecting Medicaid Expenditures

Medicaid expenditures are influenced by economic, demographic, and programmatic factors. Economic factors include health care prices, unemployment rates, and individuals' wages. Demographic factors include population growth and the age distribution of the population. Programmatic factors include state decisions regarding which optional eligibility groups and services to cover and how much to pay providers. Other factors include the number of eligible individuals who enroll and their utilization of covered services.

Medicaid enrollment is affected by economic factors, which in turn impact Medicaid expenditures. Medicaid is a countercyclical program, which means Medicaid enrollment growth

[40] Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, *2014 Actuarial Report on the Financial Outlook for Medicaid*, CMS Office of the Actuary, 2015.

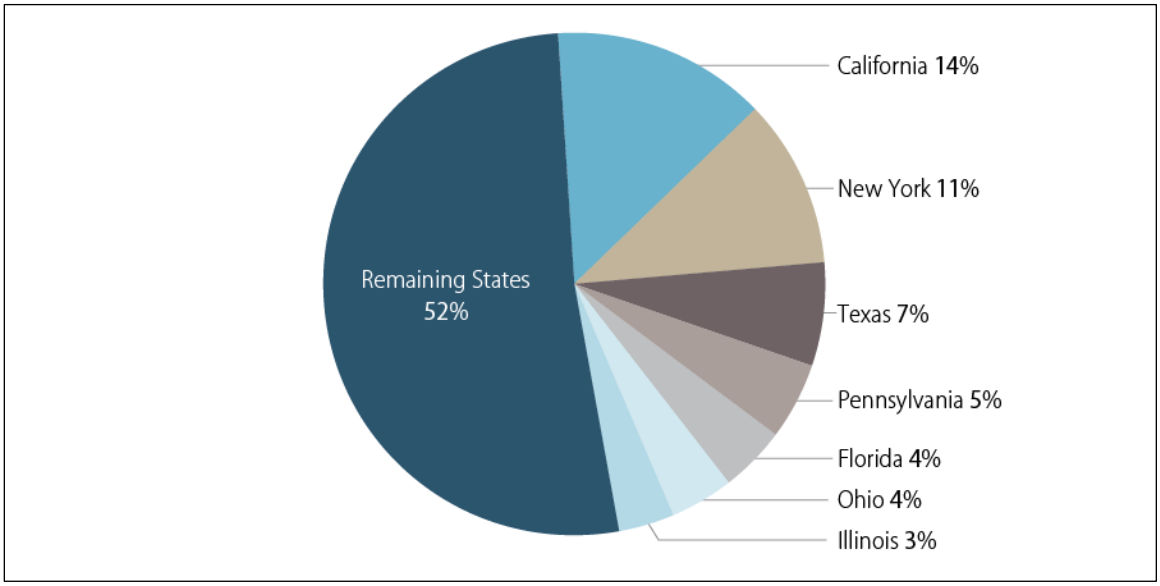
tends to accelerate when the economy weakens and tends to slow when the economy gains strength. During the most recent recession, researchers estimated that for every 1% increase in the national unemployment rate, Medicaid enrollment increased by 1 million individuals.[41] People become eligible for Medicaid during economic downturns because they lose their jobs, experience reductions in income, or lose access to health benefits.[42]

State Variability in Medicaid Spending

Figure 6 shows that total Medicaid spending is highly concentrated, with the seven most populous states (California, New York, Texas, Pennsylvania, Florida, Ohio, and Illinois) accounting for almost half of Medicaid expenditures in FY2014 (see **Table A-1** for state-by-state expenditures for FY2014).[43] State variation in Medicaid per-enrollee expenditures is significant, with per-enrollee Medicaid expenditures ranging from $4,803 in California to $13,039 in the District of Columbia for FY2012.[44]

Figure 6. States' Share of Total Medicaid Expenditures

(FY2014)



Source: CRS analysis of CMS, Form CMS-64 Data as of March 30, 2015.

Notes: The expenditures shown in this figure include all Medicaid expenditures, which include both administrative and benefit spending. These expenditures exclude state Medicaid Fraud Control Units, Medicaid survey and certification of nursing and intermediate care facilities, and the Vaccines for Children program.

[41] John Holahan and A. Bowen Garrett, *Rising Unemployment, Medicaid and the Uninsured*, Kaiser Commission on Medicaid and the Uninsured, Publication #7850, January 2009.

[42] Rachel Garfield et al., *Enrollment-Driven Expenditure Growth: Medicaid Spending during the Economic Downturn, FFY2007-2010*, Kaiser Commission on Medicaid and the Uninsured, Publication #8309, May 2012.

[43] U.S. Census Bureau, "Table 1. Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2013 (NST-EST2013-01)," December 2013.

[44] Medicaid and CHIP Payment and Access Commission, *MACStats*, "Exhibit 22. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2012," December 2015.

Some of the state variation in Medicaid per-enrollee expenditures is due to demographic differences across states. For instance, states with lower-than-average proportions of elderly and disabled Medicaid enrollees and higher-than-average proportions of Medicaid enrollees who are children and adults would be expected to have lower-than-average per-enrollee Medicaid expenditures.[45] However, state policy choices regarding optional populations and services cause variation in Medicaid spending. Other reasons for state variation in Medicaid per-enrollee expenditures include variation in utilization and provider payment rates.[46]

Conclusion

Medicaid is the largest source of general revenue-based spending on health services (even when compared to Medicare) because a sizable portion of Medicare spending is funded by a dedicated revenue source. Medicaid constitutes a significant portion of the federal budget, and federal Medicaid expenditures are expected to increase significantly over the next ten years due to the ACA Medicaid expansion. As a result, Medicaid could be a focus of potential deficit reduction or other legislative proposals affecting the federal budget.

Both the House and Senate FY2016 budget resolutions included proposals to reform Medicaid financing. The House Budget Resolution for FY2016 (H.Con.Res. 27) and its resolutions for the previous four years have included converting Medicaid to a block grant[47] as an illustrative example for achieving budget savings. The FY2016 Senate Budget Resolution (S.Con.Res. 11) proposes to convert Medicaid for the "low-income, working-age, able-bodied adults" and children to a capped allotment[48] like CHIP.[49] Also, in February 2015, Senators Richard Burr and Orrin Hatch along with Representative Fred Upton released the Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act, which is a policy proposal that would convert Medicaid to a capped allotment.[50]

[45] Todd P. Gilmer and Richard G. Kronick, "Differences in the Volume of Services and in Prices Drive Big Variation in Medicaid Spending Among U.S. States and Regions," *Health Affairs*, vol. 30, no. 7 (July 2011).

[46] Ibid.

[47] Block grants are a form of grant-in-aid that the federal government uses to provide state and local governments a specified amount of funding to assist them in addressing broad purposes, such as community development, social services, public health, or law enforcement. For additional information on block grants, see CRS Report R40486, *Block Grants: Perspectives and Controversies*, by Robert Jay Dilger and Eugene Boyd, or Congressional Budget Office, *Options for Reducing the Deficit: 2014 to 2023*, November 13, 2013, Mandatory Spending Function 550 – Health Option 1: Impose Caps on Federal Spending for Medicaid.

[48] There is no agreed-upon definition for *capped allotment*, but it seems as though the terms *block grant* and *capped allotment* are being used somewhat interchangeably.

[49] Senator Mike Enzi, "A Balanced Budget That Supports Economic Growth And Expands Opportunity for Hardworking Families," March 17, 2015, at http://www.budget.senate.gov/republican/public/index.cfm?a=Files.Serve&File_id=81b01032-186d-4166-b21b-8035b89853d9.

[50] Energy & Commerce Committee, "Burr, Hatch, Upton Unveil Obamacare Replacement Plan," February 5, 2015, at http://energycommerce.house.gov/press-release/burr-hatch-upton-unveil-obamacare-replacement-plan.

Appendix. Medicaid Expenditures by State

Table A-1 provides the most recent Medicaid expenditures for each state, including both the federal and state shares of spending on benefits, administrative services, and total Medicaid expenditures. These Medicaid expenditures exclude expenditures in the territories and spending for State Medicaid Fraud Control Units, Medicaid survey and certification of nursing and intermediate care facilities, and the Vaccines for Children program.

Table A-1. FY2014 Medicaid Expenditures for Benefits and Administration for the States, the District of Columbia, and the Territories

($ in millions)

	Benefits			State Program Administration			Total Medicaid		
	Federal	State	Total	Federal	State	Total	Federal	State	Total
Alabama	$3,599	$1,614	$5,213	$136	$76	$212	$3,735	$1,690	$5,425
Alaska	832	580	1,412	85	50	134	917	630	1,547
Arizona	6,565	2,620	9,185	195	73	268	6,760	2,693	9,453
Arkansas	3,615	1,225	4,840	211	104	314	3,826	1,328	5,154
American Samoa	14	11	25	0	0	1	15	11	26
California[a]	35,756	27,628	63,384	2,724	2,140	4,864	38,480	29,769	68,248
Colorado[a]	3,335	2,584	5,919	224	122	346	3,559	2,706	6,265
Connecticut	3,879	2,942	6,821	215	132	347	4,094	3,074	7,168
Delaware	1,004	688	1,692	80	33	113	1,084	721	1,805
District of Columbia	1,721	647	2,368	100	57	157	1,821	704	2,524
Florida	12,151	8,152	20,303	471	276	747	12,623	8,428	21,050
Georgia	6,347	3,050	9,397	312	150	461	6,659	3,199	9,858
Guam	42	32	74	3	1	5	45	33	78
Hawaii	1,125	824	1,950	76	24	100	1,201	848	2,050
Idaho	1,137	448	1,586	77	30	107	1,214	478	1,692
Illinois	8,940	7,676	16,616	669	438	1,106	9,609	8,114	17,723
Indiana	6,145	2,949	9,094	324	182	506	6,469	3,131	9,600
Iowa	2,460	1,462	3,922	137	51	189	2,597	1,513	4,110
Kansas	1,562	1,165	2,728	136	69	205	1,699	1,234	2,933
Kentucky	5,935	1,858	7,793	157	66	223	6,092	1,924	8,016
Louisiana	4,408	2,647	7,056	177	105	282	4,586	2,752	7,338
Maine	1,471	895	2,365	117	47	163	1,587	941	2,529
Maryland	5,255	3,955	9,210	268	147	415	5,523	4,102	9,626
Massachusetts	7,321	6,929	14,251	422	280	702	7,743	7,209	14,952
Michigan	9,270	4,233	13,503	439	206	645	9,709	4,439	14,148

	Benefits			State Program Administration			Total Medicaid		
Minnesota	5,481	4,437	9,918	370	225	595	5,851	4,663	10,513
Mississippi	3,585	1,280	4,865	102	49	151	3,687	1,330	5,016
Missouri	5,545	3,284	8,829	271	139	410	5,816	3,423	9,239
Montana	729	343	1,072	52	21	72	781	363	1,145
Nebraska	979	793	1,772	91	45	136	1,070	838	1,907
Nevada	1,589	692	2,281	109	42	151	1,698	734	2,432
New Hampshire	678	645	1,323	66	32	98	744	677	1,421
New Jersey	7,099	5,371	12,470	408	316	724	7,507	5,687	13,194
New Mexico	3,140	1,029	4,169	121	59	180	3,261	1,088	4,349
New York	27,622	24,184	51,806	1,074	719	1,792	28,696	24,903	53,599
North Carolina	7,945	4,047	11,993	440	222	663	8,386	4,269	12,655
North Dakota[a]	206	195	402	32	17	49	239	212	451
Commonwealth of the Northern Mariana Islands	19	14	34	0	0	1	20	14	34
Ohio	13,068	6,371	19,439	502	282	784	13,570	6,653	20,223
Oklahoma	3,038	1,629	4,666	178	81	259	3,215	1,710	4,925
Oregon	4,952	1,832	6,784	281	226	507	5,233	2,058	7,291
Pennsylvania	12,705	10,757	23,462	602	351	953	13,306	11,109	24,415
Puerto Rico	1,139	703	1,842	62	26	87	1,201	728	1,929
Rhode Island[a]	1,410	1,027	2,437	88	42	129	1,498	1,069	2,566
South Carolina[a]	3,771	1,550	5,321	185	90	276	3,956	1,640	5,597
South Dakota	455	323	778	42	21	63	497	344	841
Tennessee	6,064	3,141	9,205	282	167	449	6,346	3,308	9,654
Texas	18,790	12,595	31,385	884	562	1,446	19,674	13,157	32,831
Utah	1,459	606	2,064	124	46	170	1,583	652	2,235
Vermont	901	625	1,526	39	5	44	940	630	1,570
Virgin Islands	40	31	71	8	1	9	47	32	80
Virginia	3,843	3,704	7,547	299	134	433	4,142	3,838	7,980
Washington	6,434	3,816	10,250	361	235	596	6,794	4,051	10,846
West Virginia	2,454	877	3,331	105	52	157	2,559	929	3,488
Wisconsin	4,448	2,949	7,396	241	146	387	4,689	3,094	7,783
Wyoming	276	263	539	37	18	55	313	281	595
Total	283,754	185,929	469,683	15,209	9,230	24,440	298,964	195,159	494,123

Source: Medicaid and CHIP Payment and Access Commission, *MACStats*, Updated March 25, 2015; Centers for Medicare & Medicaid Services, CMS-64 data, as of March 30, 2015.

Notes: May not sum to totals due to rounding.

a. Not all states had certified their CMS-64 Financial Management Report submissions as of February 25, 2015. California's and Colorado's 2nd, 3rd, and 4th quarter submissions are not certified; North Dakota's 3rd and 4th quarter submissions are not certified; South Carolina's 2nd quarter submission is not certified; Rhode Island's 4th quarter submission is not certified. Figures presented in this table may change if states revise their expenditure data after this date.

Author Contact Information

Alison Mitchell
Analyst in Health Care Financing
amitchell@crs.loc.gov, 7-0152