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Medicaid Financing: How Does it Work and What are the Implications?

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Medicaid represents \$1 out of every \$6 spent on health care in the US and is the major source of financing for states to provide coverage to meet the health and long-term needs of their low-income residents. The Medicaid program is jointly funded by states and the federal government. There has been renewed interest in how Medicaid is financed in light of the additional federal financing for the Medicaid expansion under the Affordable Care Act (ACA) as well as ongoing budget discussions at the federal level. This brief reviews how the Medicaid program is financed as well as the implications for budgets, responsiveness to state policy choices and need, the links between Medicaid spending and state economies. Key conclusions include:

HOW MEDICAID IS FINANCED

- **Federal Medical Assistance Percentage (FMAP).** The federal government guarantees matching funds to states for qualifying Medicaid expenditures; states are guaranteed at least \$1 in federal funds for every \$1 in state spending on the program. This open-ended financing structure allows federal funds to flow to states based on actual costs and needs as economic circumstances change.
- **Enhanced Matching Rates.** In some instances, Medicaid provides a higher matching rate for select services or populations, the most notable being the ACA Medicaid expansion enhanced match rate. For those states that expand, the federal government will pay 100 percent of Medicaid costs of those newly eligible from 2014 to 2016.¹ The federal share gradually phases down to 90 percent in 2020 and remains at that level. There is no deadline to adopt the expansion; however, the federal match rates are tied to specific years.
- **Disproportionate Share Hospital payments (DSH).** DSH, or “disproportionate share” hospital payments are another source of financing available to hospitals that serve a large number of Medicaid and low-income uninsured patients; in many states, these DSH payments have been crucial to the financial stability of “safety net” hospitals. Based on the assumption of increased coverage and therefore reduced uncompensated care costs under the ACA, the law calls for an aggregate reduction in federal DSH allotments across all states, regardless of whether the state has expanded or not. These cuts have been delayed from FFY 2014 until FFY 2018 and are set to continue through 2025.²
- **State Financing of the Non-Federal Share.** States have flexibility in determining the sources of funding for the non-federal share of Medicaid spending. The primary source of funding for the non-federal share comes from state general fund appropriations. Over the past decade, states’ use of other funds has increased slightly but steadily. This is likely tied at least in part to states’ increased reliance on provider taxes and fees to finance the state share of Medicaid.

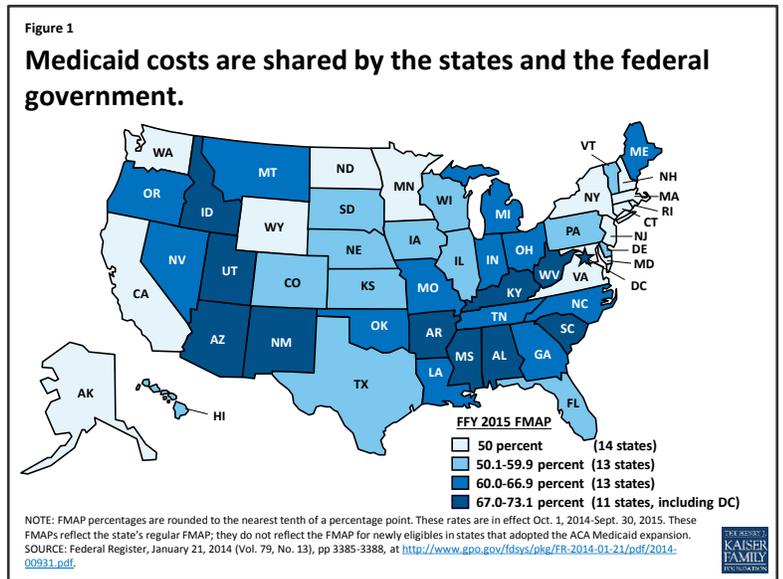
IMPLICATIONS OF THE MEDICAID FINANCING STRUCTURE

- **Role in Budgets.** Medicaid plays a role in both state and federal budgets. While Medicaid is the third largest domestic program in the federal budget following Medicare and Social Security, the program plays a unique role in state budgets. As a result of the joint financing structure, Medicaid acts as both an expenditure and the largest source of federal revenue in state budgets. Unlike at the federal level, states are required to regularly balance their budgets, making decisions about spending across programs as well as how much revenue to collect. Balancing these competing priorities creates an ever present tension. Unlike other programs, state spending on Medicaid brings in federal revenues due to its financing structure. The implementation of the major ACA coverage expansions in 2014 led to higher enrollment and total overall spending growth in Medicaid; however, with full federal financing of the expansion, state Medicaid spending grew at a slower pace. Early evidence from states that have adopted the Medicaid expansion also indicates there are state budget savings both within Medicaid budgets and outside of Medicaid.
- **Responsiveness to State Choices and Changing Needs.** The financing structure guarantees states federal matching dollars for qualifying expenditures, allowing federal funds to flow to states based on actual costs and needs. If medical costs rise, more individuals enroll due to an economic downturn or there is an epidemic (such as HIV/AIDS) or a natural disaster (such as Hurricane Katrina), Medicaid can respond and federal payments automatically adjust to reflect the added costs of the program.
- **Effect of the Economy on Medicaid Spending.** Medicaid is a countercyclical program. During economic downturns, individuals lose jobs, incomes decline and more people qualify and enroll in Medicaid which increases program spending at the same time as state revenues decline, making it difficult for states to match rising expenditures. As economic conditions improve, spending growth in the programs slows. Congress has acted twice to temporarily increase the federal match during acute economic downturns, most recently during the Great Recession.
- **Effect of Medicaid Spending on State Economies.** The influx of federal dollars from the way the Medicaid program is financed has positive effects for state economies. The infusion of federal dollars into the state's economy results in a multiplier effect, directly affecting not only the providers who received Medicaid payments for the services they provide to beneficiaries, but indirectly affecting other businesses and industries as well. The multiplier effect Medicaid spending has on state economies is expected to grow in states that adopt the Medicaid expansion. With the expansion's enhanced 100% match rate phasing down to 90% in 2020 and remaining there thereafter, a new surge of federal funds not otherwise available will flow into states with comparatively modest addition state general fund costs. Early experience in Kentucky showed both net fiscal benefits for the state driven by increases in state and local tax revenues as well as job growth from the expansion.

HOW IS MEDICAID FINANCED?

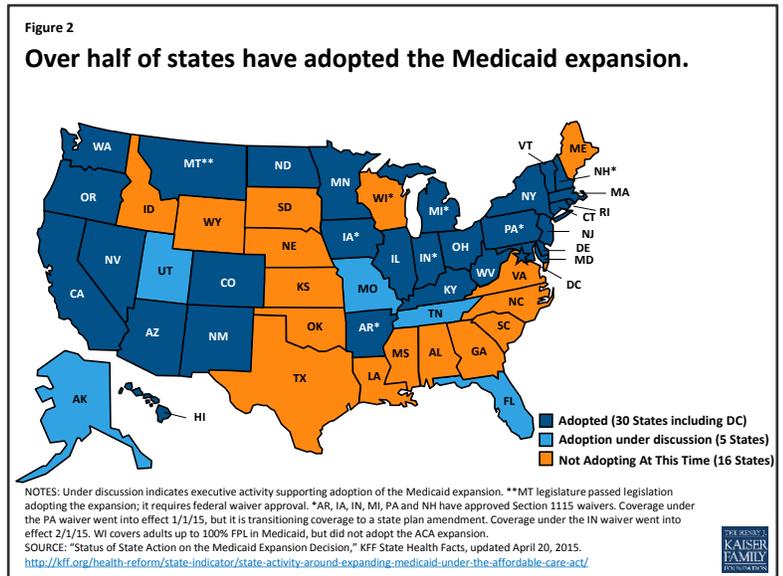
FEDERAL MEDICAL ASSISTANCE MATCH RATES (FMAPS)

Standard match rate. The basis of the state and federal partnership is governed by the federal medical assistance percentage (FMAP.) Under this financing arrangement, the federal government guarantees federal match funds to states for qualifying Medicaid expenditures (payments states make for covered Medicaid services provided by qualified providers to eligible Medicaid enrollees.) The FMAP is calculated annually using a formula set forth in the Social Security Act which is based on a state's average personal income relative to the national average; states with lower average personal incomes have higher FMAPs.



Personal income data are lagged, so data used for Federal Fiscal Year (FFY) 2015 FMAPPs are from 2010, 2011 and 2012. According to the statutory formula, for FFY 2015, the FMAP varies across states from a floor of 50 percent to a high of 73.58 percent. (Figure 1) This means that every \$1 of state spending on the program is matched with at least \$1 of federal funds; Mississippi, with the lowest per capita income level, gets \$2.79 in federal funds for every \$1 it spends on Medicaid.³

Enhanced match rates. While the standard FMAP continues to apply to the vast majority of Medicaid spending, there are a few exceptions that provide higher match rates for specific populations and services (these are summarized in [Appendix Table 1.](#)) Some of these higher match rates are long standing, such as the 90 percent federal match rate for family planning services and supplies that has been in effect since 1973.⁴ Others were enacted in the ACA, the most notable of these being the enhanced match rate for those newly eligible under the ACA Medicaid expansion. As enacted,



the ACA broadened Medicaid's role, making it the base for coverage of nearly all low-income Americans with incomes up to 138 percent of poverty (\$16,242 per year for an individual in 2015). However, the Supreme Court ruling on the ACA effectively made the Medicaid expansion optional for states. For those that expand, the federal government will pay 100 percent of Medicaid costs of those newly eligible from 2014 to 2016.⁵ The federal share gradually phases down to 90 percent in 2020 and remains at that level thereafter. The state's standard FMAP applies to services for those that were previously eligible for Medicaid. As of April 2015, 30 states (including DC) have adopted the Medicaid expansion, though debate continues in other states. (Figure 2) There is no deadline for states to expand; however, the federal match rates are tied to specific calendar years.

Administrative match rate. Medicaid administrative costs in general represent a relatively small portion of total Medicaid spending (5 percent or less.)⁶ In general, costs incurred by states in administering the Medicaid program are matched by the federal government at a 50 percent rate. There are, however, some types of administrative functions which are matched at higher rates.⁷ For example, as part of the ACA, states are required to simplify and modernize their enrollment processes, coordinating eligibility and enrollment systems across Medicaid, the Children’s Health Insurance Program (CHIP), and the Marketplace, to facilitate enrollment and promote continuity of coverage. To assist states with these investments and system upgrades, federal regulations provided for an increase in the administrative match rate - 90 percent federal funding for necessary investments in information technology, along with 75 percent federal match for operating expenses. The 90 percent match rate for initial eligibility-related IT investments was initially set to expire at the end of 2015, but CMS recently released a proposal to extend the higher federal match rate permanently.⁸

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

Another source of Medicaid financing focused on select hospitals is DSH payments. DSH, or “disproportionate share” hospitals are hospitals that serve a large number of Medicaid and low-income uninsured patients.⁹ In many states, DSH payments have been crucial to the financial stability of “safety net” hospitals. Federal DSH payments totaled \$16.4 billion in FFY 2013.¹⁰ While states have considerable discretion in determining the amount of DSH payments to each DSH hospital, their discretion is bounded by two caps – one at the state level, and the other at the facility level. At the state level, the total amount of federal funds that each state can spend on DSH is specified in an annual DSH allotment for each state. While there have been some special adjustments, the DSH allotments are generally calculated based on the previous year’s allotment increased by inflation but then subject to a cap of 12 percent of the total amount of Medicaid expenditures under the state plan that fiscal year. When the DSH caps were originally set, they locked in variation across states in DSH spending. At the facility level, Medicaid DSH payments are limited to 100 percent of the costs incurred for serving Medicaid and uninsured patients that have not been compensated by Medicaid (Medicaid shortfall).

Based on the assumption of increased coverage and therefore reduced uncompensated care costs under the ACA, the law calls for a reduction in federal DSH allotments. The statute required annual aggregate reductions in federal DSH funding from FFY 2014 through FFY 2020. However, recent federal legislation delays these reductions so that they would start in FFY 2018 and continuing through 2025.¹¹ The legislation calls for aggregate reductions of \$2 billion for FFY 2018, \$3 billion for FFY 2019, \$4 billion for FFY 2020, \$5 billion for FFY 2021, \$6 billion for FFY 2022, \$7 billion for FFY 2023, and \$8 billion for both FFYs 2024 and 2025. The methodology to distribute these aggregate reductions across states has not been determined; the ACA requires that the Secretary of HHS to take into account the following in developing such a methodology:

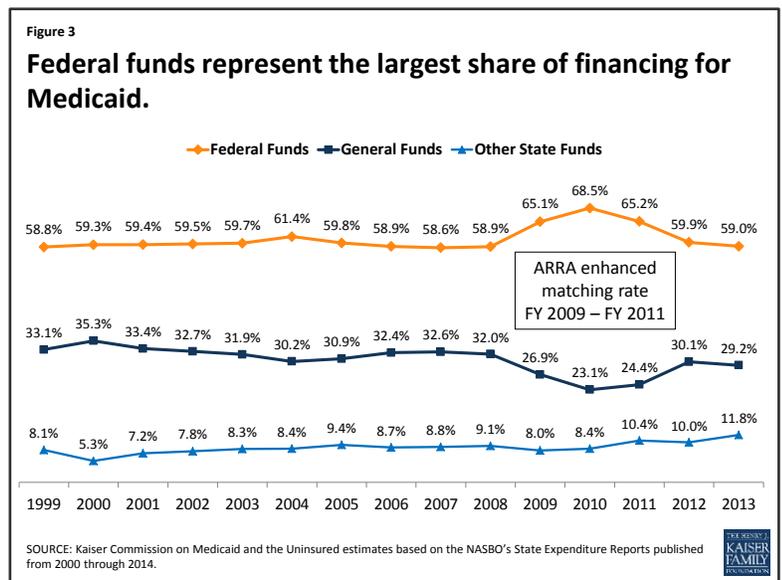
- Impose a smaller percentage reduction on low DSH states;
- Impose larger percentage reductions on states that:
 - have the lowest percentages of uninsured people during the most recent year for which data is available;
 - do not target their DSH payments on hospitals with high volumes of Medicaid inpatients;
 - do not target their DSH payments on hospitals with high levels of uncompensated care;
- Take into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under section 1115 as of July 31, 2009.

While the methodology has not been established to distribute these reductions at this time, it is expected that the reductions are expected to occur across all states, regardless of the state Medicaid expansion decisions.

STATE FINANCING OF THE NON-FEDERAL SHARE

While federal funds have always represented the largest share of Medicaid financing (about \$6 out of every \$10 spent on the program), state and local funds also play an important role in financing the program's spending. States have flexibility in determining the sources of funding for the non-federal share of Medicaid spending – though federal law does require that at least 40 percent of the non-federal share comes from state funds.¹² The

primary source of funding for the non-federal share comes from state general fund appropriations. States also fund the non-federal share of Medicaid with “other state funds” which may include funding from local governments or revenue collected from provider taxes and fees. Over the past decade, states' use of other funds has increased slightly but steadily. (Figure 3) This is likely tied to states' increased reliance on provider taxes and fees to finance the state share of Medicaid. Since state fiscal year (SFY) 2003, the number of states with at least one provider tax has increased from 21 to every state except Alaska in SFY 2014.¹³



While the Medicaid financing structure provides states with flexibility to design programs and meet changing needs, this structure also creates tension between the federal government and states about how financing should be shared. Over the history of the program states have used legal loopholes to maximize the amount of federal funds, sometimes through financing arrangements that may artificially inflate the FMAP. For example, in the 1990s and again a decade later, states were using DSH, provider taxes and then Upper Payment Limits (UPL – regulations on how much institutional providers can be paid) to maximize federal revenues. In response, the federal government passed a series of laws and rules to limit this spending and clamp down on inappropriate use of federal funds. These practices have also led some to advocate for a fixed allotment of federal funds to replace the current open-ended financing structure.

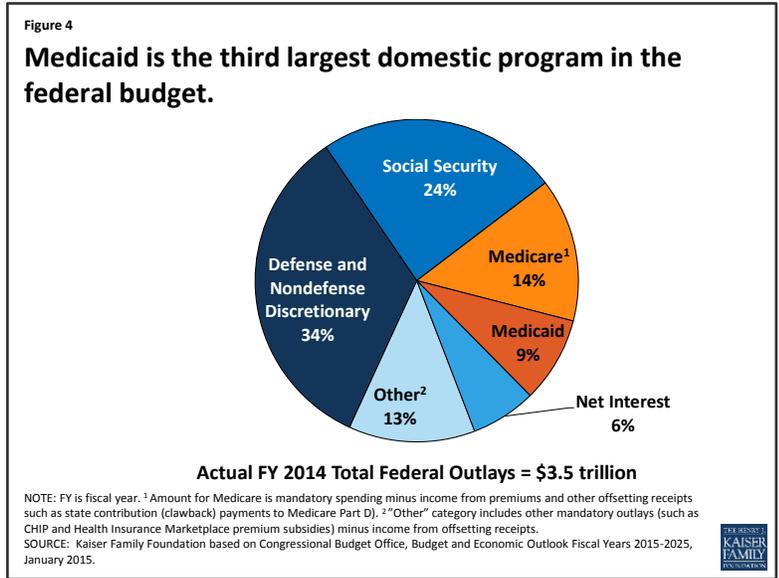
How the non-federal share of Medicaid spending is financed continues to be a focus of federal lawmakers. A recent study conducted by the Government Accountability Office (GAO) found that while the majority of funding for the non-federal share of Medicaid spending does come from state general funds (more than \$6 out of every \$10 dollars- well above the statutory requirements) the use of funds from local governments (commonly through certified public expenditures and intergovernmental transfers) as well as provider taxes and fees has increased in recent years. Given the increase in use of these funding sources, the GAO has called for increased data collection at the provider level to ensure compliance with current federal regulations.¹⁴

IMPLICATIONS OF THE MEDICAID FINANCING STRUCTURE

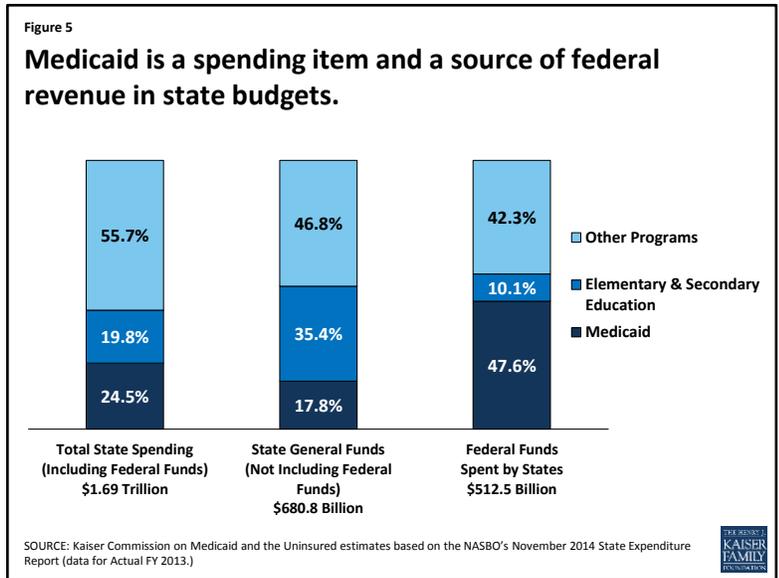
IMPACT ON BUDGETS

Because of Medicaid’s joint financing structure, the program plays a role in both state and federal budgets. Medicaid plays a unique role in state budgets, acting as both an expenditure and the largest source of federal revenues to states.

Medicaid is the third largest domestic program in the federal budget following Medicare and Social Security. In FFY 2014, spending on Medicaid accounted for 9 percent of federal spending. (Figure 4) The Congressional Budget Office projects federal Medicaid spending and program enrollment to continue to grow over the coming decade due largely to the effects of the ACA changes such as the Medicaid expansion. Much of the projected growth in enrollment and spending is driven by increases in the early years of this period as states implement ACA changes, such as the Medicaid expansion.



Medicaid is a spending and revenue item in state budgets. Medicaid’s role in state budgets is unique. Due to the joint financing structure, states are guaranteed to receive at least \$1 of federal funds for every \$1 of state funds spent on the program. As a result, Medicaid acts as both an expenditure and the largest source of federal revenue in state budgets. Medicaid is the largest source of federal funds spent by states; 48 percent of all federal funds spent by states come from the Medicaid program. When looking at what states spend of their own funds combined with these federal funds, Medicaid was the largest category of total spending across states in state fiscal year (SFY) 2013. The share of Medicaid spending from state sources, such as the state general fund, is smaller; in SFY 2013, Medicaid represented less than 18 percent of state general fund spending, a far second to general fund spending for K-12 education (35.4%) (Figure 5) The shares of general fund spending for Medicaid and K-12 education have remained fairly constant over the past decade, though the share of general fund spending on Medicaid did increase slightly as the temporary federal increase in match rates enacted under the American Recovery and Reinvestment Act (ARRA) expired in 2011.



States generally are required to balance budgets, creating tension across programs. Unlike at the federal level, states are required to balance their budgets. State lawmakers must therefore balance competing spending priorities (K-12 education, Medicaid, transportation, etc.) as well as make decisions about the amount of revenue to collect. Balancing these competing priorities creates an ever present tension. Increases in Medicaid spending are driven largely by enrollment growth but also reflect states need to respond to rising health care costs. While ever present, the ever present tension of balancing spending across programs is particularly acute during economic downturns, when state revenues decline and Medicaid enrollment increases as people lose jobs and income at the same time as demand for other programs increases. Although the guaranteed federal match reduces the need for increased Medicaid spending from state sources, states still must increase the amount of non-federal dollars spent on the program in order to access those federal funds. States sometimes turn to provider tax revenues, inter-governmental transfers and other non-federal revenue sources to help fund the state share of Medicaid spending during such periods.

The implementation of the major ACA coverage expansions in 2014 led to higher enrollment and total overall spending growth in Medicaid; however, with full federal financing of the expansion, state Medicaid spending grew at a slower pace. The implementation of the major ACA coverage expansions in 2014 led to increased Medicaid enrollment among those previously eligible who are covered at the state's regular matching rate and among those newly eligible covered at the enhanced match rate in states that adopted the Medicaid expansion. While total spending on the program increased on average across all states at rates similar to enrollment increases, state spending on the program grew more slowly. This was due to the increased federal funds from the expansion leading expansion states to see much a slower growth rate for state spending on average compared to the rate of growth for total spending (state and federal combined) or enrollment. This was in contrast to historical patterns and to the experience in non-expansion states during this period where growth rates for state spending, total spending and enrollment are similar.¹⁵

Early evidence from states that have adopted the Medicaid expansion indicates there are state budget savings both within Medicaid budgets and outside of Medicaid. Savings from within Medicaid programs include the transition of populations served through optional eligibility pathways, such as limited benefit waivers, medically needy spend-down populations, Breast and Cervical Cancer Treatment program enrollees among other groups, previously matched at the standard match rate. After adopting the expansion, these Medicaid enrollees could qualify for coverage under the newly eligible adult group, where their Medicaid expenditures are matched at the higher ACA expansion match rate. Early evidence from some expansion states also indicates budget savings from either the reduced need for or the replacement of state spending on programs for behavioral health, corrections, public health and uncompensated care because of the federal funds for increased coverage in the expansion; some of these savings were captured as reductions in state general fund spending while others were reinvested, often to compensate for prior cuts in funding.¹⁶

RESPONSIVENESS TO STATE CHOICES AND CHANGING NEEDS

Medicaid spending responds to changing needs. The Medicaid financing model, which has remained largely unchanged since Medicaid was enacted,¹⁷ is unique across state and federal programs. Medicaid's financing structure guarantees states federal matching dollars for qualifying expenditures, allowing federal funds to flow to states based on actual costs and needs. If medical costs rise, more individuals enroll due to an economic downturn or there is an epidemic (such as HIV/AIDS) or a natural disaster (such as Hurricane

Katrina), Medicaid can respond and federal payments automatically adjust to reflect the added costs of the program. During acute economic downturns, the structure allows increased federal funds to flow quickly to states by increasing the federal match to stimulate economic recovery and help states struggling with declining revenue and increased enrollment and demand for assistance due to the economic downturn.

Medicaid financing supports state choice. This structure also underpins state policy choices about how to structure their Medicaid programs. Federal law specifies core requirements, such as mandatory benefits and mandatory groups that must be covered as a condition of receiving federal Medicaid funding. However, beyond the core requirements, states have broad flexibility regarding optional eligibility groups, optional benefits, provider payment, delivery systems, and other aspects of their programs. This enables states to provide services and coverage suited to their state, but also means Medicaid coverage varies across the country.

This open-ended financing structure provides spending flexibility but makes federal outlays less predictable and driven by state spending decisions. To control federal spending, over the years some policymakers have called for restructuring the financing arrangement to cap federal spending by block granting federal spending or imposing other limits. Block grants generally provide fixed federal allotments to states that are based on current expenditures trended forward using a pre-determined growth rate. The implications of any block grant or cap would depend on funding levels, inflation adjustments and many other details. However, analysis of past proposals has showed that these changes could result in substantial shifts in costs to states, beneficiaries or providers or reductions in coverage or benefits if, to reduce federal spending, Medicaid funding is set below expected levels.¹⁸ Pre-determined levels of funding would make the program less responsive to changing program needs, such as when demand increases during economic downturns, epidemics or natural emergencies. Experiences from other federal programs like Temporary Assistance for Needy Families (TANF) and the AIDS Drug Assistance Program (ADAP) that operate under a block grant structure have shown challenges in setting and maintaining funding levels to meet program needs across states and across time.¹⁹

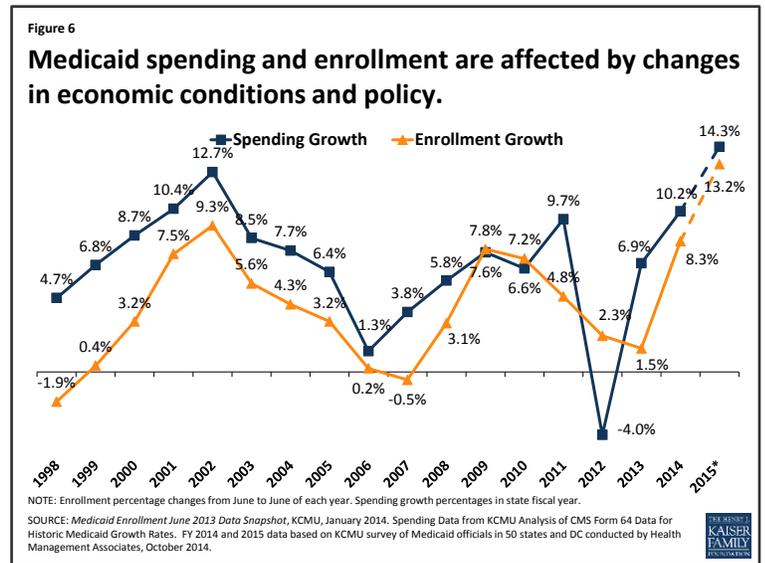
EFFECT OF THE ECONOMY ON MEDICAID SPENDING

The economy has a strong effect on Medicaid enrollment and therefore spending. Medicaid spending and enrollment are affected by a number of factors – health care inflation, policy changes, etc. However, one of the largest drivers of Medicaid spending and enrollment trends is changes in economic conditions. Medicaid is a countercyclical program. During economic downturns, individuals lose jobs, incomes decline and more people qualify and enroll in Medicaid which increases program spending. As economic conditions improve, Medicaid enrollment and spending growth tend to slow.

Over the past 15 years, Medicaid enrollment increased substantially during two major recessions, with annual growth peaking in SFY 2001 at over 9 percent, and again at nearly 8 percent in SFY 2009. (Figure 6) While economic downturns increase demand for these program, they also negatively affect state tax revenues. This places additional pressure on state budgets as demand for other forms of assistance (i.e. food stamps and unemployment benefits) also increases. During economic downturns, states face difficulty balancing these pressures and affording their share of Medicaid spending increases. In response, Congress has twice passed temporary increases to the FMAP rates to help support states during particularly acute economic downturns, most recently in 2009 as part of the American Recovery and Reinvestment Act (ARRA.) The most significant

source of fiscal relief to states in ARRA was the temporary increase in the federal share of Medicaid costs. The ARRA-enhanced match rates provided states with over \$100 billion in additional federal funds over 11 quarters, ending in June 2011.²⁰

With the economy continuing to improve, Medicaid enrollment growth across the country slowed considerably in SFY 2012 and SFY 2013. Over those two years, average spending also slowed, but the end of the ARRA enhanced match rates at the end of SFY 2011 shifted state spending patterns as states tried to mitigate the loss of federal dollars in SFY 2012 resulting in a dip in spending in SFY 2012. With economic conditions improving, the largest driver of Medicaid enrollment and spending growth during SFYs 2014 and 2015 has been related to the implementation of the ACA.²¹ (Figure 6)



MEDICAID SPENDING’S EFFECT ON STATE ECONOMIES

The influx of federal dollars from Medicaid spending has positive effects for state economies.²²

Medicaid spending flows through a state’s economy and can generate impacts greater than the original spending alone. The infusion of federal dollars into the state’s economy results in a multiplier effect, directly affecting not only the providers who received Medicaid payments for the services they provide to beneficiaries, but indirectly affecting other businesses and industries as well. For example, a medical supply firm may be affected through its business dealings with Medicaid providers — increases in Medicaid funding may affect a Medicaid provider’s supply order, which then may affect the medical supplier’s purchases from its vendors and so on. Both the direct and indirect effects induce changes in household consumption and tax collection primarily due to household income fluctuations. Employees of Medicaid health care providers that are directly affected or the employees of businesses that are indirectly affected may change their spending patterns according to increases or decreases in income — the change in income triggers the household to increase or decrease spending on consumer goods. Due to changes in personal income and, subsequent spending, sources of state government revenue — including income and sales taxes — would be affected as well.

Similar to previous findings, a review of economic analyses of the Medicaid expansion show that new funds as a result of the Medicaid expansion are anticipated to have a noticeable and sustained increase in state economic activity. Since the federal government fully pays for the cost of coverage for newly eligible beneficiaries for the first three years, a new surge of federal funds not otherwise available will flow into states with relatively little additional state costs. A December 2013 study found that the amount of federal funds estimated to come into states by 2022 if they decided to expand will be substantially higher (1.35 times higher on average) than the amount of federal funds estimated to flow into states through the federal highway program.²³ A review of studies estimating the impact of the Medicaid expansion on state economies found that, regardless of the economic impact model used, all of the studies anticipated positive increases to state output and Gross State Product (GSP). The magnitude of the impact depends on the level of current and anticipated new Medicaid funding and the economic conditions within the state.²⁴ Early experience

in Kentucky has shown both net fiscal benefit for the state driven by increases in state and local tax revenues and job growth from the expansion.²⁵

CONCLUSION

The Medicaid program is jointly financed by the federal and state governments with contributions governed by the FMAP formula that has remained largely unchanged over the program's 50 year history. The federal/state matching arrangement provides a financing structure that is responsive to changes in enrollment and program needs, enabling states to adjust program expenditures in response to economic and policy changes. A program as large as Medicaid will always be a focus of budget scrutiny at the state and federal levels. Changes to Medicaid's financing structure would have implications for states, the federal government and beneficiaries which would warrant careful analysis.

APPENDIX

Table 1: Special Federal Matching Percentages (FMAPs)

Service/Population	FMAP	
Special FMAPs Enacted under the ACA		
Newly eligible, non-disabled adults under age 65 up to 138% FPL ²⁶	100%	(1/14 - 12/16)
	95%	(1/17 - 12/17)
	94%	(1/18 - 12/18)
	93%	(1/19 - 12/19)
	90%	(1/20 & beyond)
Health Home Services*	90%	
State Balancing Incentive Program (BIP)**	State's FMAP + 5 or 2 percentage points	(10/11 - 9/15)
Community First Choice (CFC)***	State's FMAP + 6 percentage points	(10/11 & beyond)
Clinical Preventive Services for Adults	State's FMAP + 1 percentage point	(1/13 & beyond)
Special FMAPs Predating the ACA		
Breast and Cervical Cancer Treatment	State's CHIP eFMAP rate ²⁷	
Family Planning Services	90%	
Indian Health Service and Tribal Facility Services ²⁸	100%	
Money Follows the Person Rebalancing Demo	MFP-enhanced FMAP***	

* These services are matched at the enhanced rate for eight calendar quarters. After that, spending is matched at the state's standard FMAP. States can adopt multiple Health Home SPAs targeting different populations at different times.

** The BIP makes enhanced Medicaid matching funds available to certain states that meet requirements for expanding the share of LTSS spending for HCBS (and reducing the share of LTSS spending for institutional services).

*** States electing the CFC state plan option to provide Medicaid-funded home and community-based attendant services and supports will receive an FMAP increase of six percentage points for CFC services.

ENDNOTES

¹ Beginning in 2014, the higher FMAP for newly-eligible Medicaid beneficiaries is available for non-elderly, non-disabled adults with incomes up to 138% FPL who would not be eligible for Medicaid under the rules that a state had in place on December 1, 2009.

A few states had already expanded coverage to parents and childless adults up to 100% FPL or to higher income levels across the state at the time the ACA was passed. Costs related to these populations qualify for the “expansion” or “transition” FMAP instead. In recognition of these states already provided coverage at these higher Medicaid eligibility levels, these states can receive a phased-in increase in their federal matching rate for adults without dependent children under age 65 beginning on January 1, 2014 so that by 2019 it will equal the enhanced matching rate available for newly-eligible adults. In addition, expansion states that do not have any newly-eligible Medicaid beneficiaries because they already covered people up to 138% FPL or higher (e.g. Massachusetts) also receive a temporary (January 1, 2014 through December 31, 2015) 2.2 percentage point increase in their federal matching rate for all populations.

For more information on how claiming works for the Medicaid expansion, please see the following brief:

Robin Rudowitz, Understanding How States Access the ACA Enhanced Medicaid Match Rates. (Washington, DC: Kaiser Family Foundation,) September 2014. <http://kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/>.

² H.R. 2 – Medicare Access and CHIP Reauthorization Act of 2015. Signed into law April 17, 2015. <https://www.congress.gov/bill/114th-congress/house-bill/2/text?q=%7B%22search%22%3A%5B%22SGR+repeal%22%5D%7D>.

³ State Health Facts, Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier, (Washington, DC: Kaiser Family Foundation,) downloaded March 2015. <http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/>.

⁴ Section 299E(a) of the Social Security Amendments of 1972. P.L. 92-603.

⁵ Beginning in 2014, the higher FMAP for newly-eligible Medicaid beneficiaries is available for non-elderly, non-disabled adults with incomes up to 138% FPL who would not be eligible for Medicaid under the rules that a state had in place on December 1, 2009.

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⁶ Urban Institute estimates based on data from CMS (Form 64) (as of 9/16/13).

⁷ 8 Section 1903(a)(2) –(7) of the Social Security Act.

⁸ Centers for Medicare & Medicaid Services (CMS). *Notice of Proposed Rulemaking: Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10.)* (Washington, DC: Federal Register,) April 16, 2015. <https://www.federalregister.gov/articles/2015/04/16/2015-08754/medicaid-program-mechanized-claims-processing-and-information-retrieval-systems-9010#h-9>.

⁹ To qualify as a DSH hospital a hospital must meet two minimum qualifying criteria. The first criterion is that the hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid patients (except when the hospital predominantly serves children under 18 years or the hospital does not offer obstetric services to the general public). The second criterion is that the hospital has a Medicaid inpatient utilization rate (MIUR) of at least 1 percent. A hospital is deemed as a DSH if the hospital’s MIUR is at least one standard deviation above the mean MIUR in the state, or if the hospital’s low-income utilization rate exceeds 25 percent.

¹⁰ Kaiser Family Foundation, State Health Facts. Distribution of Medicaid Spending by Service, FY 2013. <http://kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/>.

¹¹ H.R. 2 – Medicare Access and CHIP Reauthorization Act of 2015. Passed by the House and Received in the Senate March 26, 2015. <https://www.congress.gov/bill/114th-congress/house-bill/2/text?q=%7B%22search%22%3A%5B%22SGR+repeal%22%5D%7D>.

¹² *Medicaid Financing; States’ Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection.* (Washington, DC: US Government Accountability Office,) July 2014. <http://www.gao.gov/products/GAO-14-627>.

¹³ Smith, Vernon et al. *Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Budget Survey.* (Washington, DC: Kaiser Family Foundation,) October 2014. <http://kff.org/medicaid/report/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2014-and-2015/>.

¹⁴ The data reported here reflect information gathered from states for state fiscal year 2012; three states – Alaska, Delaware and Hawaii reported not using funds from provider taxes and fees or local governments to fund the non-federal share of Medicaid. Delaware and Hawaii adopted provider taxes the following year.

Medicaid Financing; States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection. (Washington, DC: US Government Accountability Office,) July 2014. <http://www.gao.gov/products/GAO-14-627>.

¹⁵ Rudowitz, Robin et al. *Implementing the ACA: Medicaid Spending & Enrollment Growth for FY 2014 and FY 2015.* (Washington, DC: Kaiser Family Foundation,) October 2014. <http://kff.org/medicaid/issue-brief/implementing-the-aca-medicaid-spending-enrollment-growth-for-fy-2014-and-fy-2015/>.

¹⁶ *The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States.* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) March 2015. <http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/>.

¹⁷ On one occasion in the early 1980s, legislation was passed to temporarily reduce federal Medicaid matching payments to states over a 3- year period, but this legislation did not alter the FMAP formula. Section 2161(a) of the Omnibus Budget Reconciliation Act of 1981, P. L. 97-35, temporarily reduced federal Medicaid matching payments to states over a 3-year period but it did so without altering the FMAP formula. Instead, it reduced the amount of federal Medicaid matching funds a state would otherwise receive after applying its regular FMAP to its spending on services. The amount of the reduction was determined by a percentage: 3 percent in FY 1982, 4 percent in FY 1983, and 4.5 percent in FY 1984. This percentage was adjusted downward in the case of states with high unemployment, states that adopted specified policies to control hospital costs, states that had high fraud and abuse recoveries, and states that met low spending growth targets.

¹⁸ *National and State-By-State Impact of the 2012 House Republican Budget Plan for Medicaid.* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) October 2012. <http://kff.org/health-reform/report/national-and-state-by-state-impact-of/>.

¹⁹ *Implications of a Federal Block Grant Program for Medicaid.* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) April 2011. <http://kff.org/health-reform/issue-brief/implications-of-a-federal-block-grant-program/>.

²⁰ To be eligible for ARRA funds, states could not restrict eligibility or tighten enrollment procedures in Medicaid or CHIP.

Vic Miller et al. *Impact of the Medicaid Fiscal Relief Provisions in the American Recovery and Reinvestment Act (ARRA).* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) October 2011. <http://kff.org/medicaid/issue-brief/impact-of-the-medicaid-fiscal-relief-provisions/>.

²¹ Rudowitz, Robin et al. *Implementing the ACA: Medicaid Spending & Enrollment Growth for FY 2014 and FY 2015.* (Washington, DC: Kaiser Family Foundation,) October 2014. <http://kff.org/medicaid/issue-brief/implementing-the-aca-medicaid-spending-enrollment-growth-for-fy-2014-and-fy-2015/>.

²² *The Role of Medicaid in State Economies: A Look at the Research.* (Kaiser Commission on Medicaid and the Uninsured, January 2009), <http://kff.org/medicaid/issue-brief/the-role-of-medicaid-in-state-economies/>.

²³ Sherry Glied and Stephanie Ma, *How States Stand to Gain or Lose Federal Funds by Opting In or Out of the Medicaid Expansion.* (New York City, NY: The Commonwealth Fund,) December 2013. <http://www.commonwealthfund.org/Publications/Issue-Briefs/2013/Dec/Federal-Funds-Medicaid-Expansion.aspx>.

²⁴ *The Role of Medicaid in State Economies: A Look at the Research.* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) November 2013. <http://kff.org/medicaid/issue-brief/the-role-of-medicaid-in-state-economies-and-the-aca/>.

²⁵ *Report on Medicaid Expansion in 2014.* (Kentucky: Deloitte commissioned by the Commonwealth of Kentucky,) February 2015. http://governor.ky.gov/healthierky/Documents/medicaid/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.

²⁶ See Endnote 8.

²⁷ Enhanced Federal Medical Assistance Percentages (eFMAPs) are for the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. Section 2105(b) of the Act specifies the formula for calculating Enhanced Federal Medical Assistance Percentages. For FFY 2015, the eFMAPs range from a floor of 65 percent to 81.51%. These rates do not take into account the increase included under Section 2101(a) of the Affordable Care Act amended which would increase eFMAPs by 23 percentage points (not to exceed 100 percent;) this increase is scheduled to begin in FFY 2016.

State Health Facts, Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP, (Washington, DC: Kaiser Family Foundation,) downloaded March 2015. <http://kff.org/other/state-indicator/enhanced-federal-matching-rate-chip/>.

²⁸ Section 402(e) of the Indian Health Care Improvement Act of 1976, P.L. 94-437.