Medicaid Financing and Expenditures

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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 (LTSS). 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 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 2018, Medicaid represented 16% of national health expenditures; in that year, private health insurance and Medicare accounted for 34% and 21% of national health expenditures, respectively. Medicaid is a significant payer in the categories of health spending that includes LTSS 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 FY2019, Medicaid expenditures totaled $627 billion, with the federal government paying $405 billion, or about 65% of the total. Spending on managed care comprised almost half of Medicaid expenditures on benefits in FY2019, and LTSS accounted for 20% 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 LTSS 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.

During periods of economic downturn, Medicaid program enrollment usually increases at a faster rate due to job and income losses; at the same time, state revenue growth generally weakens. Since the onset of the recession due to the Coronavirus Disease 2019 (COVID-19) pandemic in February 2020, the growth in Medicaid enrollment has increased and states have experienced reductions in revenues.

These trends are generally expected to continue, and some states are developing budget reduction plans that could affect Medicaid programs. States could reduce Medicaid expenditures by no longer covering optional benefits or populations, reducing provider rates, or imposing Medicaid provider taxes. In addition to reducing Medicaid expenditures, states are requesting additional federal financial assistance for Medicaid. The Family First Coronavirus Response Act (FFCRA; P.L. 116-127) provided federal financial assistance for Medicaid through a 6.2-percentag-point increase during the COVID-19 public health emergency to the regular FMAP rates for all states, the District of Columbia, and the territories, and states are requesting for this percentage to be increased.

The Heroes Act (H.R. 6800), a revised version of the Heroes Act (H.R. 925), and a bill to provide Coronavirus relief (S. 4800) would provide a 14-percentage-point increase to Medicaid FMAP

rates for FY2021, and if the COVID-19 public health emergency continues after September 30, 2021, the FMAP increase would return to 6.2 percentage points through the public health emergency period.

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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 (LTSS).[1] Medicaid is a federal and state partnership with both the federal government and the states financing Medicaid. In FY2019, Medicaid is estimated to have provided health care services to a projected 74 million individuals[2] at a total cost of $627 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 their state's eligibility standards is guaranteed Medicaid coverage, should they apply.

This report's first section, "Medicaid Financing" 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.

[1] For more information about the Medicaid program, see CRS In Focus IF10322, *Medicaid Primer*, and CRS Report R43357, *Medicaid: An Overview*.

[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, Kathryn E. Rennie, Lindsey Wilson, et al., *2018 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), 2020, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/MedicaidReport.)

[3] CMS, Form CMS-64 data as of September 15, 2020, at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

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 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) funding to states cannot exceed a state-specific annual allotment.[6] 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 federal capped funding.[7] Another exception to open-ended federal Medicaid funding is the Qualified Individuals program.[8]

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.[9] 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%. In FY2021, FMAP rates range from 50% (13 states) to 77.76% (Mississippi).[10]

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., individuals covered by the Patient Protection and Affordable Care Act's [ACA, P.L. 111-148 as amended] Medicaid expansion and certain women with breast or cervical cancer), providers (e.g., Indian Health Service facilities), and services (e.g., family planning and home health services). In

[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) payments to hospitals treating a disproportionate share of low-income patients. For more information about Medicaid DSH payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*.

[7] For more information about the federal Medicaid funding for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*.

[8] States 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.

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

[10] Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2020 Through September 30, 2021," 84 *Federal Register* 66204, December 3, 2019.

addition, the federal share for most Medicaid administrative costs does not vary by state and is generally 50%.

During the Coronavirus Disease 2019 (COVID-19) public health emergency period, the Family First Coronavirus Response Act (FFCRA; P.L. 116-127) provides a 6.2-percentage-point increase to the regular FMAP rates for all states, the District of Columbia, and the territories that meet certain conditions.[11] The FFCRA FMAP increase began on January 1, 2020 (the first day of the calendar quarter in which the COVID-19 public health emergency period began), and the FFCRA FMAP increase is set to end on the last day of the calendar quarter in which COVID-19 public health emergency period ends.[12]

Process for Federal Medicaid Funds Getting to States

States incur Medicaid costs by making payments for services (e.g., for beneficiaries' doctor visits or payments to managed care organizations) 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 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

[11] For more information about the Family First Coronavirus Response Act (FFCRA; P.L. 116-127) FMAP increase and the conditions for states to receive this increase, see CRS Report R46346, *Medicaid Recession-Related FMAP Increases*.

[12] The public health emergency period is defined in paragraph (1)(B) of §1135(g) of the Social Security Act as a public health emergency declared by the HHS Secretary pursuant to §319 of the Public Health Service Act. This refers to the public health emergency declared by the HHS Secretary on January 31, 2020, with respect to the Coronavirus Disease 2019 (COVID-19) outbreak. The determination was made retroactive to January 27, 2020.

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

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.[14]

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.[15] For instance, the Further Consolidated Appropriations Act, 2020 (P.L. 116-94), provided Medicaid with $273.2 billion for FY2020 and an advance appropriation of $139.9 billion for the first quarter of FY2021.

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,[16] local government funds,[17] 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.[18] Federal regulations also stipulate that the state share not be funded with federal funds (Medicaid or otherwise).[19] In state fiscal year 2018, 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.[20]

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 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, intergovernmental transfers (IGTs), or certified public expenditures (CPEs), and payment policies, such as DSH and non-DSH supplemental payments, to draw down federal Medicaid funds without expending much, if any, state general funds.[21]

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[14] This limitation is commonly referred to as the *Hyde Amendment*. For more information about the Hyde Amendment, see CRS Report RL33467, *Abortion: Judicial History and Legislative Response*.

[15] 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*.

[16] 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*.

[17] 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.

[18] §1902(a)(2) of the Social Security Act.

[19] 42 C.F.R. 433.51(c).

[20] National Association of State Budget Officers, *State Expenditure Report: 2019 State Expenditure Report Fiscal Years 2017-2019*, 2020, at https://www.nasbo.org/reports-data/state-expenditure-report.

[21] *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

Medicaid Expenditures[22]

Medicaid expenditures account for a significant and growing portion of total health expenditures in the United States. Enrollment increases due to expansions of eligibility and economic downturns account for much of Medicaid's expenditure growth over time. 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 2018, Medicaid represented 16% of national health expenditures; in that same year, private health insurance and Medicare accounted for 34% and 21% of national health expenditures, respectively.[23] **Figure 1** shows Medicaid as a percentage of national health expenditures from 1966 (the first year Medicaid was in operation) through 2018.

Over time, Medicaid has become one of the largest payers in the U.S. health care system. Since the start-up years (i.e., 1966 through 1971), Medicaid expenditures have grown as a percentage of national health expenditures, with just a few exceptions.[24] Since 2015, Medicaid has been decreasing slightly each year as a percentage of national health expenditures. In each year from 2015 through 2018, Medicaid spending has increased, but at slower rate than other categories of national health expenditures, mainly due to slower rate of growth for Medicaid enrollment.[25]

a lump sum. For more information about Medicaid supplemental payments, see CRS Report R45432, *Medicaid Supplemental Payments*.

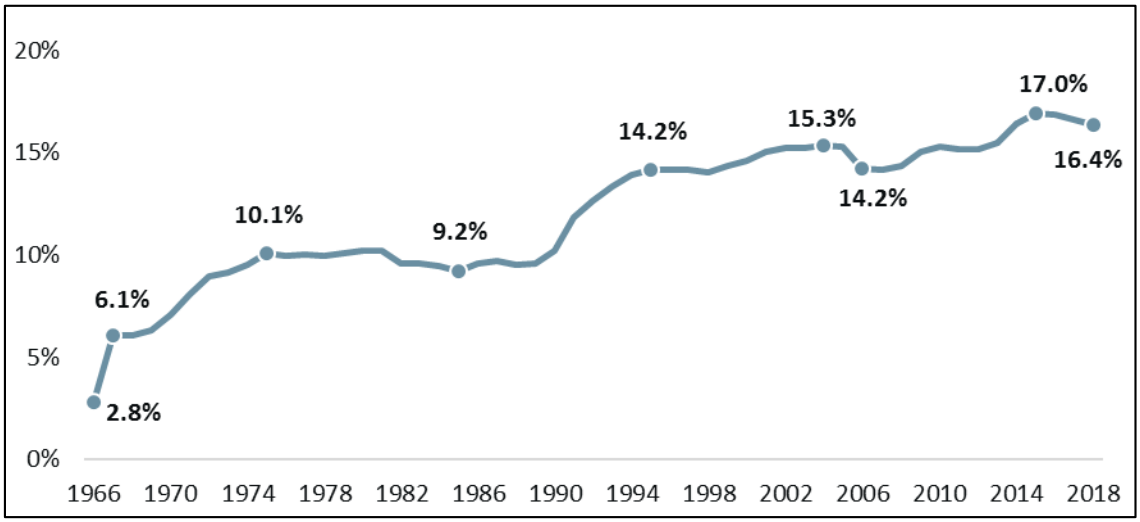
[22] Data in this section are provided for different years (i.e., calendar year 2018, FY2017, or FY2019) because Medicaid data are collected from states at different times for different purposes. For each type of expenditure, the most recent data are provided.

[23] CMS, "National Health Expenditures by Type of Service and Source of Funds, CY 1960-2018," *National Health Expenditure Accounts*, December 17, 2019.

[24] For example, 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.

[25] Micah Hartman, Anne B. Martin, Joseph Benson, et al., "National Health Care Spending In 2018: Growth Driven By Accelerations In Medicare And Private Insurance Spending," *Health Affairs*, December 5, 2019.

Figure 1. Medicaid as a Percentage of National Health Expenditures
(1966-2018)



Source: Centers for Medicare & Medicaid Services (CMS), "National Health Expenditures by type of service and source of funds, CY 1960-2018," *National Health Expenditure Accounts,* December 17, 2019.

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 2018, Medicaid was a major payer in the categories of spending that include LTSS,[26] with Medicaid paying 58% of expenditures in the other health, residential, and personal care category;[27] 35% of home health expenditures; and 30% of nursing care facilities and continuing care retirement communities.[28] Medicaid accounted for 17% of hospital expenditures. For the other services, in 2018, Medicaid accounted for a smaller share of the national expenditures, with Medicaid paying 15% of durable medical equipment, 11% of physician and clinical expenditures, 10% 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 2018.

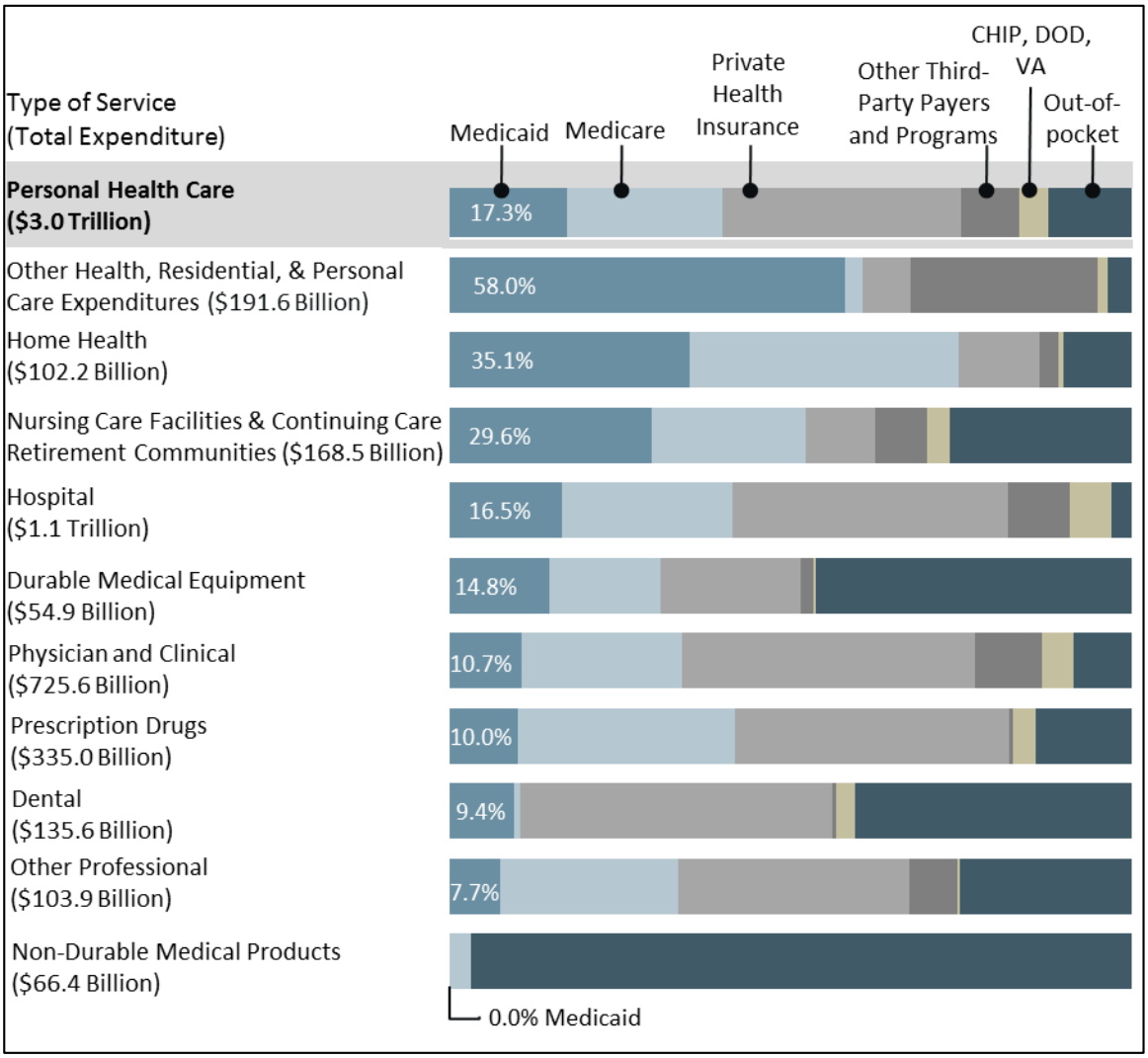
[26] Long-term services and supports (LTSS) refer to a broad range of health and health-related services and supports needed by individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or condition.

[27] 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[27] expenditures, which are both LTSS. The expenditures for each of these two categories make up a little less than a third of the total expenditures for the category.

[28] LTSS expenditures are included in the following national health expenditures categories: nursing care 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-LTSS expenditures, such as school health and worksite health care.

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

(2018)



Source: CMS, "National Health Expenditures by Source of Funds and Type of Expenditure: Calendar Years 2011-2018," *National Health Expenditure Accounts,* December 17, 2019.

Notes: Other third-party payers and programs includes worksite health care, Indian Health Services, workers' compensation, the Maternal and Child Health program, vocational rehabilitation, other federal programs, 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 care 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

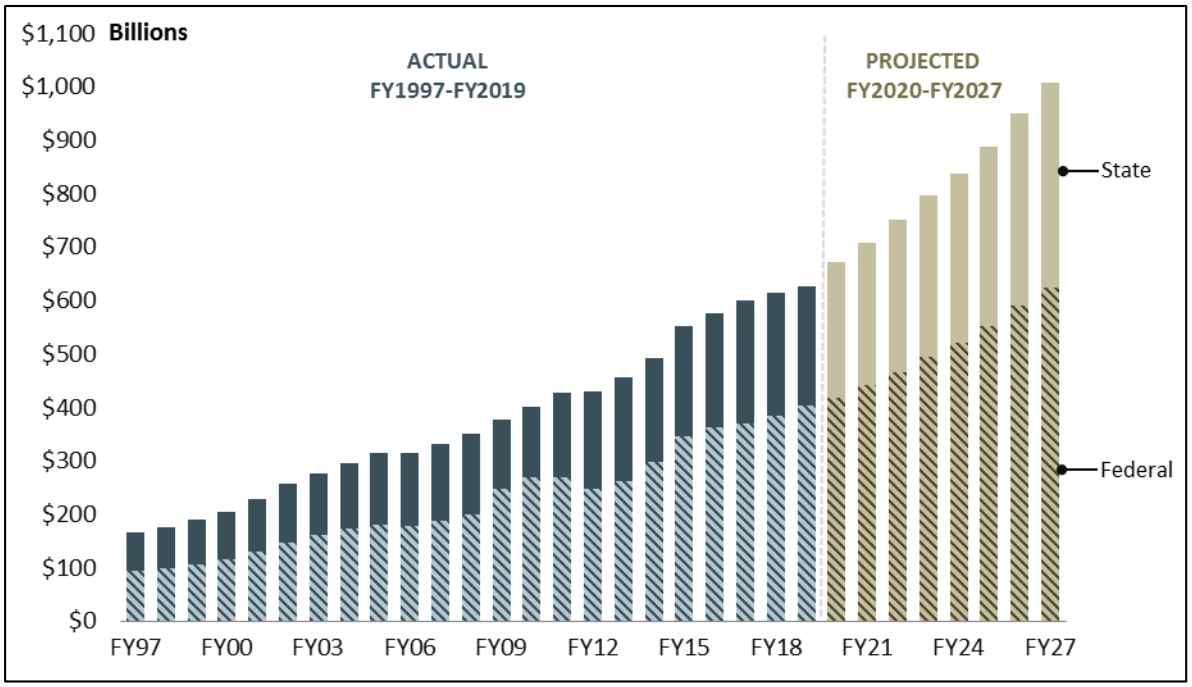
VA: Department of Veterans Affairs

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 has significantly increased Medicaid expenditures since 2014.[29] **Figure 3** shows actual Medicaid expenditures from FY1997 to FY2019 and projected Medicaid expenditures from FY2020 through FY2027 broken down by state and federal expenditures. In FY2019, Medicaid spending on services and administrative activities in the 50 states, the District of Columbia, and the territories totaled $627 billion (see **Table A-1** for FY2019 state-by-state expenditures). Medicaid expenditures are estimated to grow to $1,007.9 billion in FY2027.[30]

Figure 3. Federal and State Actual and Projected Medicaid Expenditures

(FY1997 to FY2027)



Source: Actual expenditures are from Form CMS-64 Data as of September 15, 2020, and the projected expenditures are from the CMS Office of the Actuary's *2018 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.

Historically, the federal share of Medicaid was about 57% of total Medicaid expenditures, but the federal share has increased since FY2014 due to the enhanced federal matching rates for the ACA

[29] 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, Kathryn E. Rennie, Lindsey Wilson, et al., *2018 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, CMS, HHS, 2020, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/MedicaidReport.

[30] HHS, CMS, Form CMS-64 data, September 15, 2020; Christopher J. Truffer, Kathryn E. Rennie, Lindsey Wilson, et al., *2018 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, CMS, HHS, 2020, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/MedicaidReport.

Medicaid expansion.[31] Federal Medicaid expenditures totaled $405 billion, or 65% of total Medicaid spending, in FY2019, and state Medicaid expenditures were $222 billion, which was 35% of total Medicaid spending.[32]

The federal share of Medicaid expenditures is estimated to decrease to 62% for FY2020 through FY2027.[33] However, these estimates were prepared prior to the COVID-19 public health emergency. With the FFCRA 6.2-percentage-point increase to the FMAP rates, the federal share of Medicaid is expected to be higher than previously estimated.

Medicaid Expenditures by Service Type

Most Medicaid expenditures (i.e., 95% in FY2019) are for medical assistance (or nonadministrative) payments. In FY2019, Medicaid spending on medical assistance grew by an estimated 1.7%, which is less than the annual percentage increases for FY2016 (4.6%), FY2017 (3.9%), and FY2018 (2.7%). The slower growth in Medicaid expenditures in recent years is the result of slowing Medicaid enrollment growth and per-enrollee Medicaid expenditure growth.[34]

Figure 4 shows medical assistance payments by service type for FY2019. Managed care, which includes payments to managed care organizations,[35] primary care case management,[36] and non-comprehensive prepaid health plans,[37] accounted for 49% of Medicaid expenditures. LTSS, which include nursing facility and home- and community-based services, made up 20% of all Medicaid expenditures.[38] Hospitals received 7% of total Medicaid expenditures in return for services provided to Medicaid fee-for-service enrollees at the payment rates set by states.[39]

[31] For 2020 and subsequent years, the federal government reimburses states for 90% of the Medicaid expenditures for newly eligible individuals who gained Medicaid eligibility due to the ACA Medicaid expansion. For more information about the ACA Medicaid expansion, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*.

[32] CMS, Form CMS-64 data as of September 15, 2020.

[33] Christopher J. Truffer, Kathryn E. Rennie, Lindsey Wilson, et al., *2018 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, CMS, HHS, 2020, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/MedicaidReport.

[34] Christopher J. Truffer, Kathryn E. Rennie, Lindsey Wilson, et al., *2018 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, CMS, HHS, 2020, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/MedicaidReport.

[35] 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).

[36] 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.

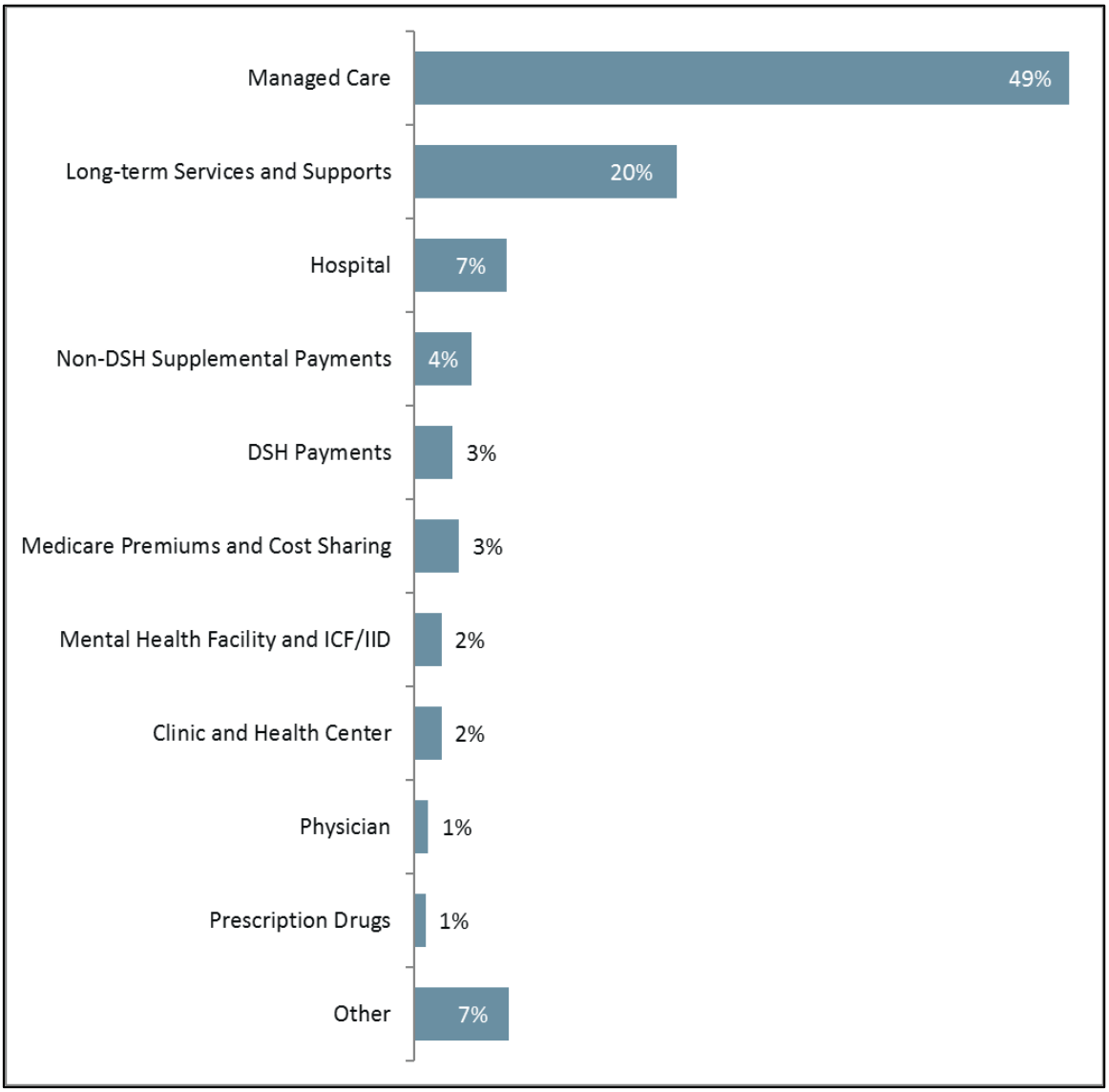
[37] States contract with health plans to provide non-comprehensive benefits (e.g., inpatient behavioral health care or dental care).

[38] For more information about LTSS, see CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*.

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

Figure 4. Medicaid Benefit Expenditures by Service Type

(FY2019)



Source: Congressional Research Service (CRS) analysis of CMS, Form CMS-64 Data as of September 15, 2020.

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.

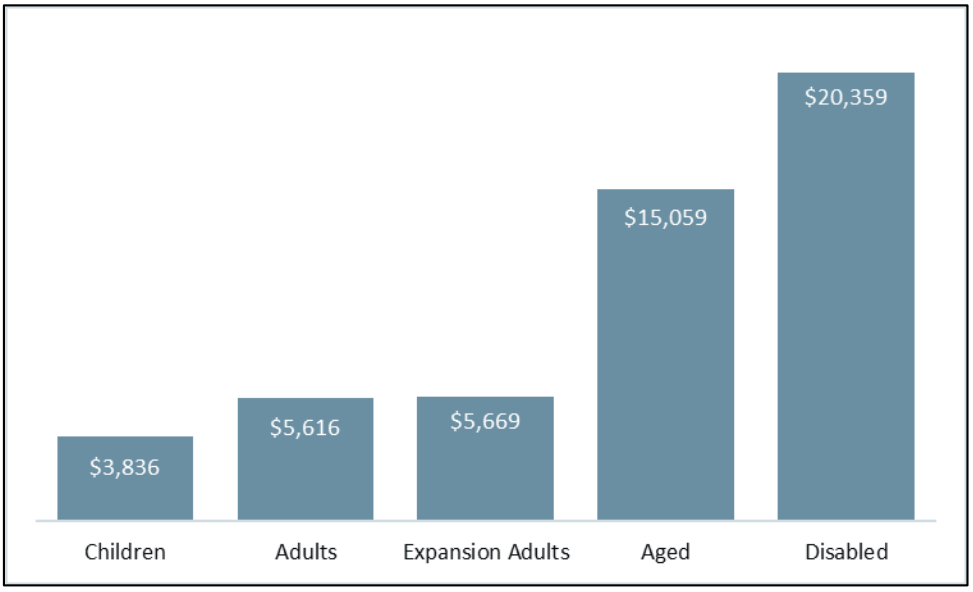
DSH: Disproportionate Share Hospital

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

Per-Enrollee Medicaid Expenditures

In Medicaid, there are five main eligibility groups: children, adults, expansion adults,[40] the aged, and individuals with disabilities. Per-enrollee Medicaid expenditures across these groups averaged an estimated $7,871 in FY2017.[41] However, as shown in **Figure 5**, per-enrollee expenditures varied significantly by eligibility group, with the estimated per-enrollee expenditures by eligibility group ranging from $3,836 for children to $20,359 for individuals with disabilities.[42]

Figure 5. Estimated Expenditures Per Medicaid Enrollee by Major Eligibility Groups
(FY2017)



Source: Christopher J. Truffer, Kathryn E. Rennie, Lindsey Wilson, et al., *2018 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, CMS, U.S. Department of Health & Human Services, 2020, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/MedicaidReport.

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). These estimates of per enrollee spending by eligibility group are based on data from 2013 or 2014 for most States, which is the most recent data available. As a result, these estimates of expenditures per enrollee by eligibility category are less reliable than in the past and the actual expenditures per enrollee by eligibility group could vary significantly from the estimates.

[40] Expansion adults are adults made newly eligible for Medicaid under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) beginning in 2014 pursuant to SSA §1902(a)(10)(A)(i)(VIII). For more information about the ACA Medicaid expansion, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*.

[41] The estimates of per enrollee expenditures 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, Kathryn E. Rennie, Lindsey Wilson, et al., *2018 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, CMS, HHS, 2020, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/MedicaidReport.

[42] These estimates of per enrollee spending by eligibility group are based on data from 2013 or 2014 for most states, which are the most recent data available. As a result, these estimates of expenditures per enrollee by eligibility category are less reliable than in the past and the actual expenditures per enrollee by eligibility group could vary significantly from the estimates.

One reason the aged and disabled populations have higher per-enrollee expenditures is because these populations consume most of the LTSS, which comprise 20% 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, who have higher costs on average than other nondisabled adults.

In FY2017, the aged and disabled populations together accounted for about 23% of Medicaid enrollment and 53% of Medicaid expenditures. In comparison, the other populations (i.e., children, adults, and expansion adults) accounted for about 78% of Medicaid enrollment and 46% of Medicaid expenditures.[43]

Even though these differences are substantial, the estimates understate the total health expenditures for the aged and disabled populations because many aged and disabled individual also are enrolled in Medicare (referred to as dual-eligible individuals). For dual-eligible individuals, Medicare is the primary payer before Medicaid.[44] The per-enrollee expenditures shown in **Figure 5** reflect only the Medicaid expenditures, and Medicare expenditures for the dual-eligible individuals are not included.

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 tends to accelerate when the economy weakens and tends to slow when the economy gains strength. People become eligible for Medicaid during economic downturns because they lose their jobs, experience reductions in income, or lose access to health benefits.[45] For instance, since the onset of the recession due to the COVID-19 pandemic in February 2020 through July 2020, Medicaid enrollment has increased by 6.7%, nationally.[46]

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 FY2019 (see **Table A-1** for FY2019 state-

[43] Totals do not add to 100% due to rounding. Christopher J. Truffer, Kathryn E. Rennie, Lindsey Wilson, et al., *2018 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, CMS, HHS, 2020, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/MedicaidReport.

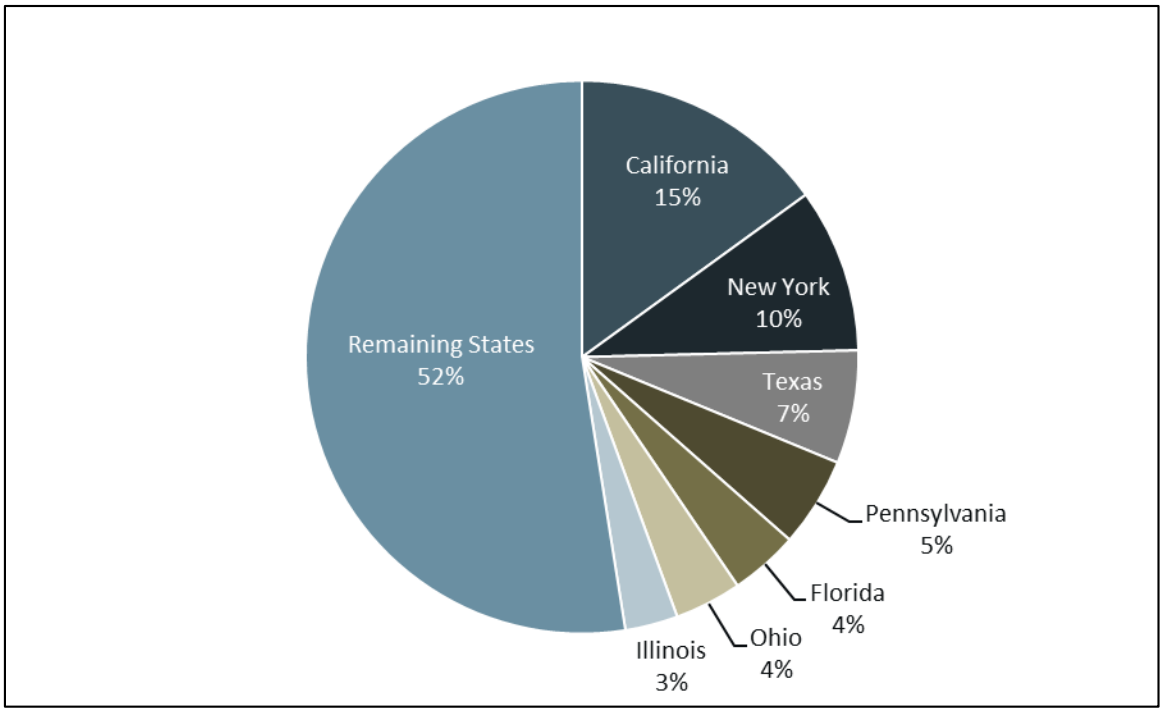
[44] Christopher J. Truffer, Kathryn E. Rennie, Lindsey Wilson, et al., *2018 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, CMS, HHS, 2020, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/MedicaidReport.

[45] For more information about the impact of recessions on the Medicaid programs, see CRS Report R46346, *Medicaid Recession-Related FMAP Increases*.

[46] CMS, Medicaid and CHIP Eligibility and Enrolment Performance Indicators data, as of October 30, 2020.

by-state expenditures).[47] State variation in Medicaid per-enrollee expenditures is significant, with per-enrollee Medicaid expenditures ranging from $4,717 in Alabama to $12,061 in Alaska for FY2013.[48]

Figure 6. States' Share of Total Medicaid Expenditures
(FY2019)



Source: CRS analysis of CMS, Form CMS-64 Data as of September 15, 2020.

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.

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. 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.

[47] U.S. Census Bureau, "Table 1. Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2019 (NST-EST2019-01)," December 2019.

[48] Medicaid and CHIP Payment and Access Commission, *December 2019 MACStats: Medicaid and CHIP Data Book*, "EXHIBIT 22. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group," December 2019, at https://www.macpac.gov/publication/medicaid-benefit-spending-per-full-year-equivalent-fye-enrollee-by-state-and-eligibility-group/.

Conclusion

Medicaid is jointly financed by the federal government and the states. In FY2019, Medicaid expenditures totaled $627 billion, with the federal government paying $405 billion, or about 65% of the total. States paid the remaining $222 billion, or 35%, of Medicaid expenditures.

In recent years, the growth in Medicaid expenditures has slowed due to the slowing of growth in Medicaid enrollment and per-enrollee Medicaid expenditures. The recession that began in February 2020 might reverse this trend. Medicaid enrollment growth has increased during the first few months of the recession, which also is expected to result in increased Medicaid expenditures.[49]

These increased Medicaid expenditures might put additional pressure on state budgets. States already have experienced a reduction in revenues since the beginning of the recession.[50] Since Medicaid expenditures are expected to increase and state revenues are expected to continue to be lower than estimated, some states are establishing budget reduction plans that likely will impact Medicaid programs. States received some financial assistance in the FFCRA in the form of a FMAP increase of 6.2 percentage points, and states also are requesting additional federal financial assistance for Medicaid.

The Heroes Act (H.R. 6800) and a revised version of the Heroes Act (H.R. 925) include a provision that would provide a 14-percentage-point increase to Medicaid FMAP rates for FY2021, and if the COVID-19 public health emergency continues after September 30, 2021, the FMAP increase would return to 6.2 percentage points through the public health emergency period. The House of Representatives passed H.R. 6800 on May 15, 2020, and H.R. 925 on October 1, 2020. A bill to provide Coronavirus relief (S. 4800) that includes the same FMAP provision as H.R. 6800 and H.R. 925 was introduced in the Senate on October 29, 2020.

[49] Centers for Medicare & Medicaid Services, *Medicaid and CHIP Enrollment Trends Snapshot*, October 30, 2020, at https://www.medicaid.gov/sites/default/files/2020-10/july-medicaid-chip-enrollment-trend-snapshot.pdf.

[50] Shelby Kerns, *State Revenues Decline for First Time Since the Great Recession, With the Worst Still to Come*, National Association of State Budget Officers, September 9, 2020, at https://www.nasbo.org/blogs/shelby-kerns1/2020/09/08/state-revenues-decline-for-first-time-since-the-gr.

Appendix. Medicaid Expenditures by State

Table A-1 provides the most recent Medicaid expenditures for each state, the District of Columbia, and the territories, including both the federal and state shares of spending on benefits, administrative services, and total Medicaid expenditures. These Medicaid expenditures exclude 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. FY2019 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	$4,243	$1,637	$5,880	$132	$85	$216	$4,375	$1,722	$6,096
Alaska	1,528	568	2,096	100	48	147	1,628	616	2,244
American Samoa	46	7	53	3	0	3	48	7	55
Arizona	10,109	3,059	13,168	210	104	314	10,319	3,163	13,482
Arkansas	5,230	1,613	6,843	273	128	401	5,503	1,741	7,244
California	52,919	34,937	87,856	3,798	2,446	6,243	56,717	37,382	94,099
Colorado	5,311	3,891	9,202	207	109	316	5,517	4,000	9,518
Connecticut	4,820	3,348	8,168	238	124	362	5,058	3,472	8,531
Delaware	1,461	784	2,246	66	35	101	1,528	819	2,347
District Of Columbia	2,125	767	2,892	149	82	231	2,274	849	3,123
Florida	14,858	9,526	24,384	436	309	745	15,294	9,835	25,129
Georgia	7,359	3,493	10,852	367	211	579	7,726	3,704	11,430
Guam	106	7	113	3	0	3	108	8	116
Hawaii	1,396	782	2,178	70	32	102	1,467	814	2,281
Idaho	1,525	618	2,143	79	45	123	1,604	662	2,266
Illinois	10,932	7,538	18,470	564	321	885	11,496	7,859	19,356
Indiana	8,885	3,554	12,439	355	200	555	9,240	3,754	12,994
Iowa	3,439	1,761	5,200	102	50	153	3,542	1,811	5,352
Kansas	2,061	1,541	3,602	128	69	197	2,189	1,610	3,799
Kentucky	7,964	2,243	10,208	212	91	303	8,176	2,334	10,510
Louisiana	8,433	3,209	11,642	264	141	405	8,698	3,350	12,047
Maine	1,885	982	2,867	104	48	152	1,989	1,030	3,019
Maryland	7,067	4,663	11,730	341	184	524	7,408	4,847	12,254
Massachusetts	9,647	7,766	17,413	740	487	1,227	10,386	8,253	18,640
Michigan	12,974	5,284	18,258	502	229	731	13,476	5,513	18,989

	Benefits			State Program Administration			Total Medicaid		
Minnesota	7,227	5,494	12,721	475	323	798	7,702	5,817	13,519
Mississippi	4,210	1,296	5,507	121	54	175	4,331	1,350	5,681
Missouri	6,950	3,585	10,535	239	137	376	7,189	3,722	10,910
Montana	1,442	416	1,858	64	29	94	1,506	446	1,952
CNMI	49	10	59	1	0	1	50	10	60
Nebraska	1,135	1,007	2,142	82	41	124	1,217	1,048	2,266
Nevada	2,948	1,030	3,979	135	66	201	3,084	1,096	4,179
New Hampshire	1,098	887	1,985	100	42	142	1,199	928	2,127
New Jersey	9,386	6,523	15,909	568	374	941	9,953	6,897	16,850
New Mexico	4,153	1,109	5,263	150	79	229	4,303	1,188	5,492
New York	41,098	16,997	58,094	1,276	839	2,115	42,373	17,836	60,209
North Carolina	9,151	4,445	13,596	548	242	790	9,699	4,687	14,386
North Dakota	693	471	1,164	86	25	111	779	495	1,275
Ohio	16,017	7,449	23,466	614	430	1,043	16,630	7,879	24,509
Oklahoma	3,072	1,688	4,760	124	80	204	3,196	1,769	4,965
Oregon	6,927	2,500	9,427	317	193	510	7,244	2,693	9,936
Pennsylvania	18,706	13,374	32,080	561	320	881	19,267	13,694	32,961
Puerto Rico	2,489	-36	2,453	156	0	156	2,646	(36)	2,609
Rhode Island	1,562	1,024	2,586	117	62	179	1,679	1,087	2,765
South Carolina	4,495	1,811	6,306	252	122	374	4,747	1,932	6,680
South Dakota	552	347	899	30	21	50	582	368	949
Tennessee	6,680	3,412	10,092	488	204	692	7,168	3,616	10,784
Texas	23,361	16,664	40,026	893	567	1,460	24,254	17,232	41,486
Utah	1,902	822	2,724	118	56	174	2,020	878	2,899
Vermont	971	667	1,638	108	56	164	1,079	723	1,802
Virgin Islands	112	26	138	12	2	14	124	28	151
Virginia	6,337	4,970	11,307	329	184	513	6,666	5,154	11,820
Washington	8,259	4,869	13,128	743	619	1,362	9,001	5,489	14,490
West Virginia	3,093	834	3,926	132	51	183	3,225	884	4,109
Wisconsin	5,452	3,681	9,133	250	143	393	5,701	3,824	9,525
Wyoming	307	277	584	58	20	77	365	297	662
Total	**386,159**	**211,226**	**597,385**	**18,587**	**10,958**	**29,545**	**404,746**	**222,184**	**626,930**

Source: Centers for Medicare & Medicaid Services, CMS-64 data, as of September 15, 2020.

Notes: May not sum to totals due to rounding.

CNMI: Commonwealth of the Northern Mariana Islands.

a. Figures presented in this table may change if states revise their expenditure data after this date.

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