Medicaid Spending and Financing

Medicaid and CHIP Payment and Access Commission

Moira Forbes

Overview

- Introduction to MACPAC
- Federal and non-federal financing
- Themes motivating congressional action

MACPAC Overview

- Non-partisan legislative branch agency
- Provides analysis and advice to Congress and HHS on Medicaid and CHIP policy issues
- 17 commissioners appointed by GAO
- Reports annually on March 15 and June 15
- Technical assistance to Congress
- Information resource to broader health policy community

Current Financing Structure

Medicaid Financing Context

- Medicaid financing is shared by federal and state governments
- Federal share has historically averaged about 57%
  - Increased to about 60% in FY14 as a result of higher match rates for newly eligible adults
- FY15 total spending = $550 billion

Federal Financing

- Federal Medicaid spending is determined by the amount that states spend
- Federal share of service costs determined by each state's federal medical assistance percentage (FMAP)
- Federal share of administrative costs does not vary by state and is generally 50%

Federal Medical Assistance Percentage (FMAP)

- Based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average
  - Statutory minimum of 50% and maximum of 83%
- Exceptions apply in some cases, such as:
  - U.S. territories and D.C. (FMAPs set in statute)
  - Special situations (e.g., temporary state fiscal relief)
  - Certain populations, providers, and services (e.g., Indian Health Service facilities).

Non-federal Financing

- Statute requires that at least 40% of non-federal funds come from the state and up to 60% may come from local governments
  - Recognizes the combination of state and local programs that existed pre-1965
- States raise the non-federal share through many sources
  - General tax revenue
  - Contributions from local governments
  - Health care-related taxes

State Responsibilities, Incentives

- States must make expenditures in order to draw down federal funds
- State decisions about level of Medicaid spending depend upon:
  - Ability to raise the non-federal share
  - Competing funding priorities
  - Policy and political environment
  - State needs for and goals of the program

State Levers to Manage Spending

- Most states subject to balanced budget requirements
- Within federal parameters, states make choices regarding:
  - Eligibility: optional pathways
  - Benefits: optional benefits and amount, duration, and scope
  - Provider payment: methods and rates
  - Delivery system design: use of managed care, valued-based purchasing
  - Program integrity

Context for 115th Congress

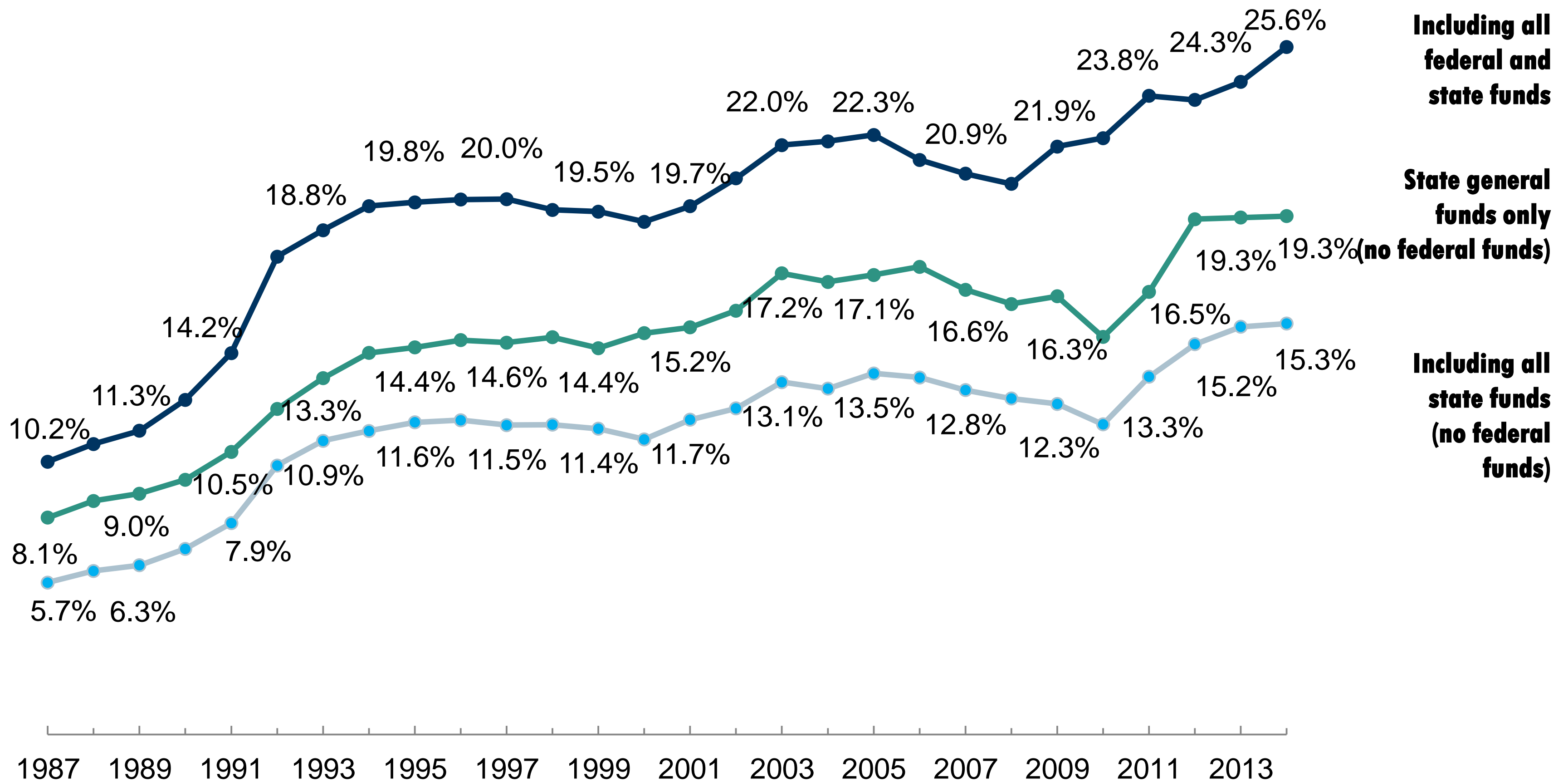
Themes Motivating Action

- Balance between states and federal government
- Size of program
- Rate of growth in spending
- Personal responsibility

Concerns about Medicaid Spending

- Represents a growing share of national health care spending and federal and state budgets
- Spending is projected to grow about 6 percent annually over the next decade
- Medicaid spending seen as crowding out other activities
- Federal spending is open-ended

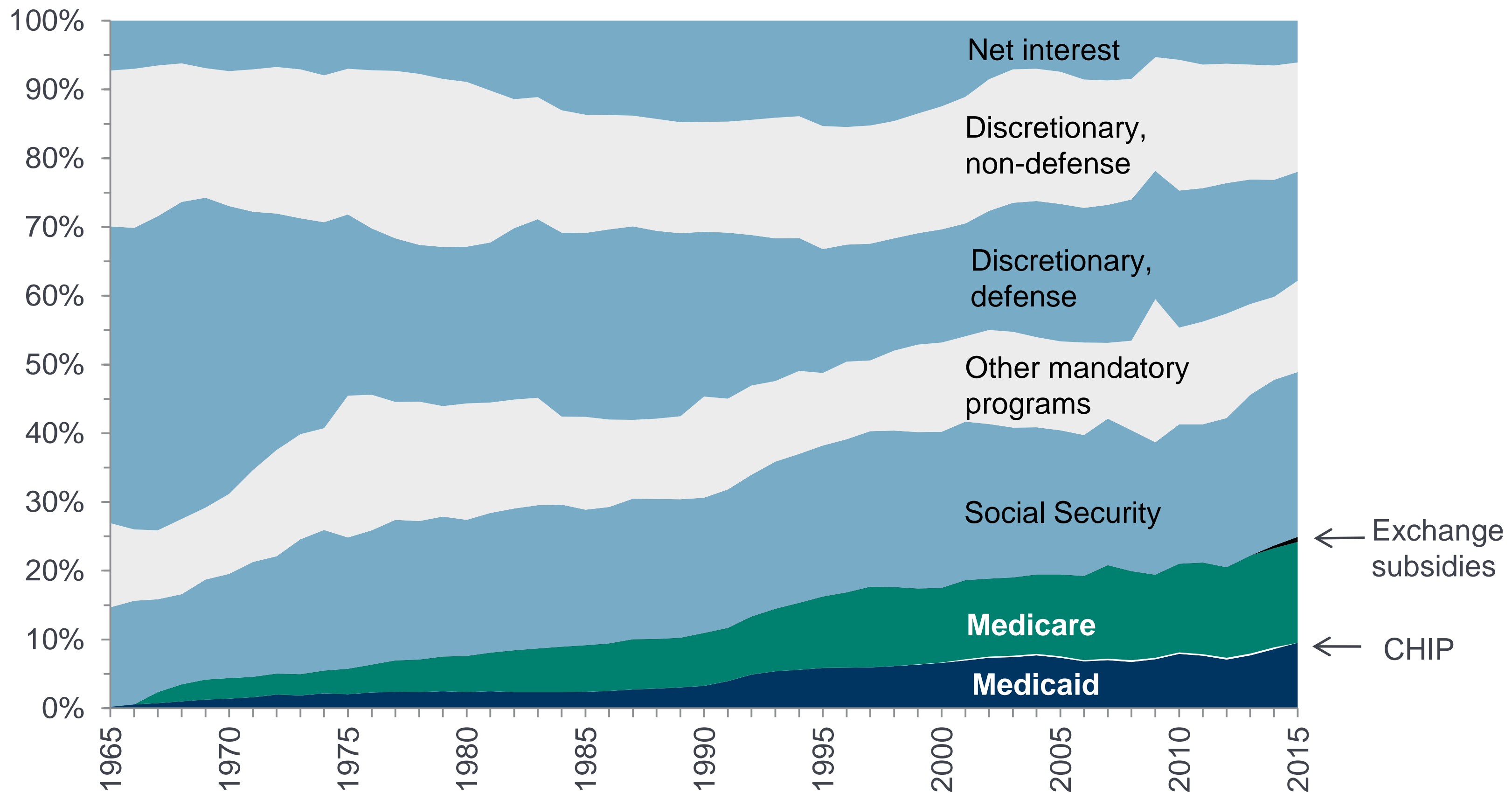
Medicaid's Share of State Budgets Including and Excluding Federal Funds, SFYs 1987–2014



Note: Total state budgets include all state and federal funds; state-funded state budgets include all nonfederal funds.

Source: MACPAC analysis of information from National Association of State Budget Officers.

Major Components of Federal Budget as a Share of Total Federal Outlays, FY 1965–2015

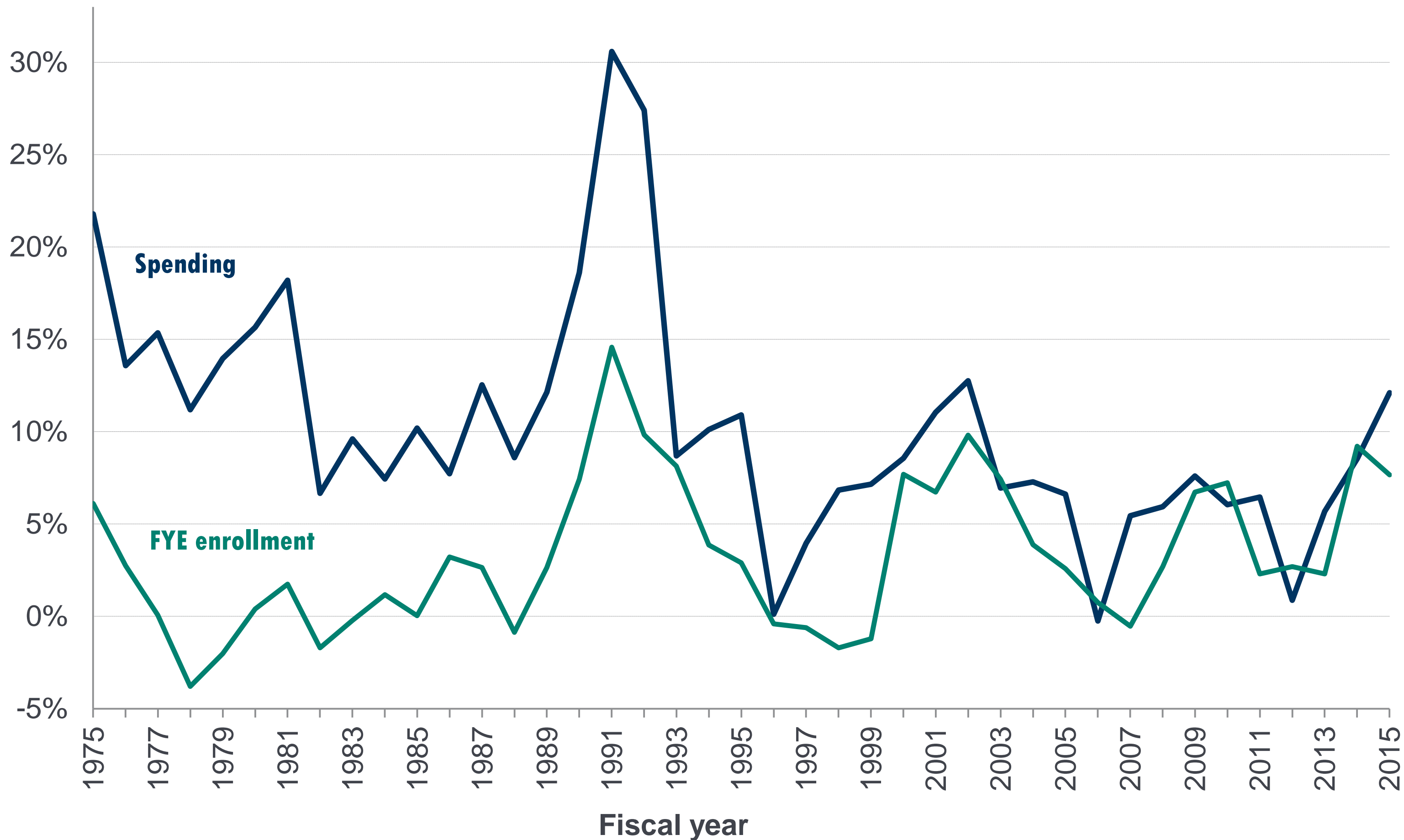


Note: FY is fiscal year.
Source: MACPAC, 2016, *MACStats*, Exhibit 4, December 2016.

Keep in Mind

- Growth in spending per enrollee has been lower than or comparable to Medicare and private insurance
- Growth reflects a number of factors
  - Federal and state policy decisions
  - External factors such as changes in demography, economic conditions

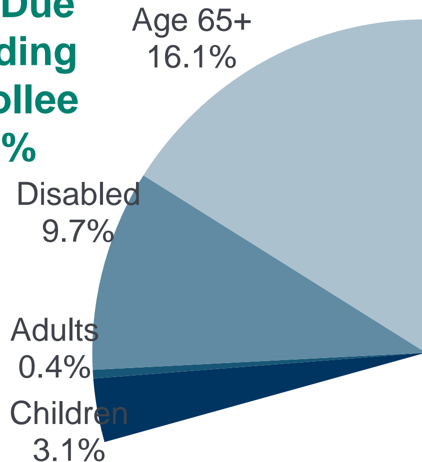
Annual Growth in Medicaid Enrollment and Spending, FY 1975-FY 2015

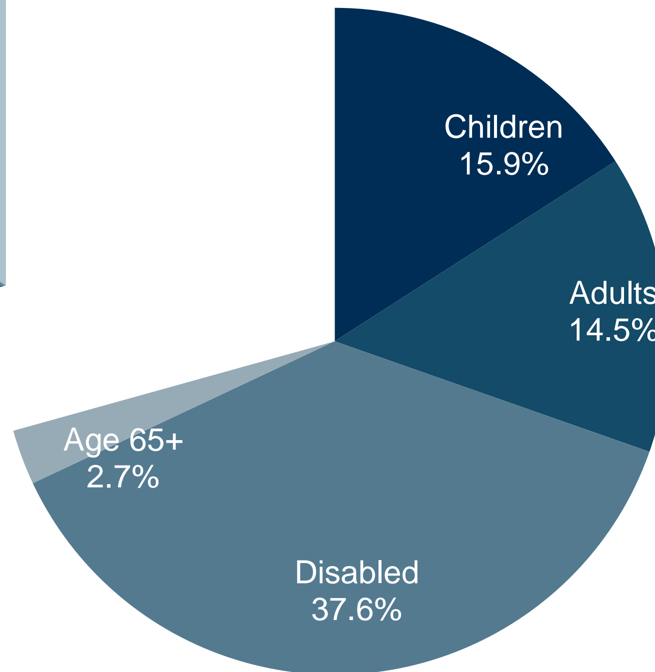


Components of Spending Growth: 1975-2012

- Number of enrollees (70.7% of real growth)
  - Eligibility expansion
  - Economic downturns
  - Population aging
- Spending per enrollee (29.3% of real growth)
  - Enrollment mix
  - Volume and mix of services used
  - Prices paid for items and services

Components of Growth in Real Medicaid Benefit Spending by Eligibility Group, FY 1975–2012





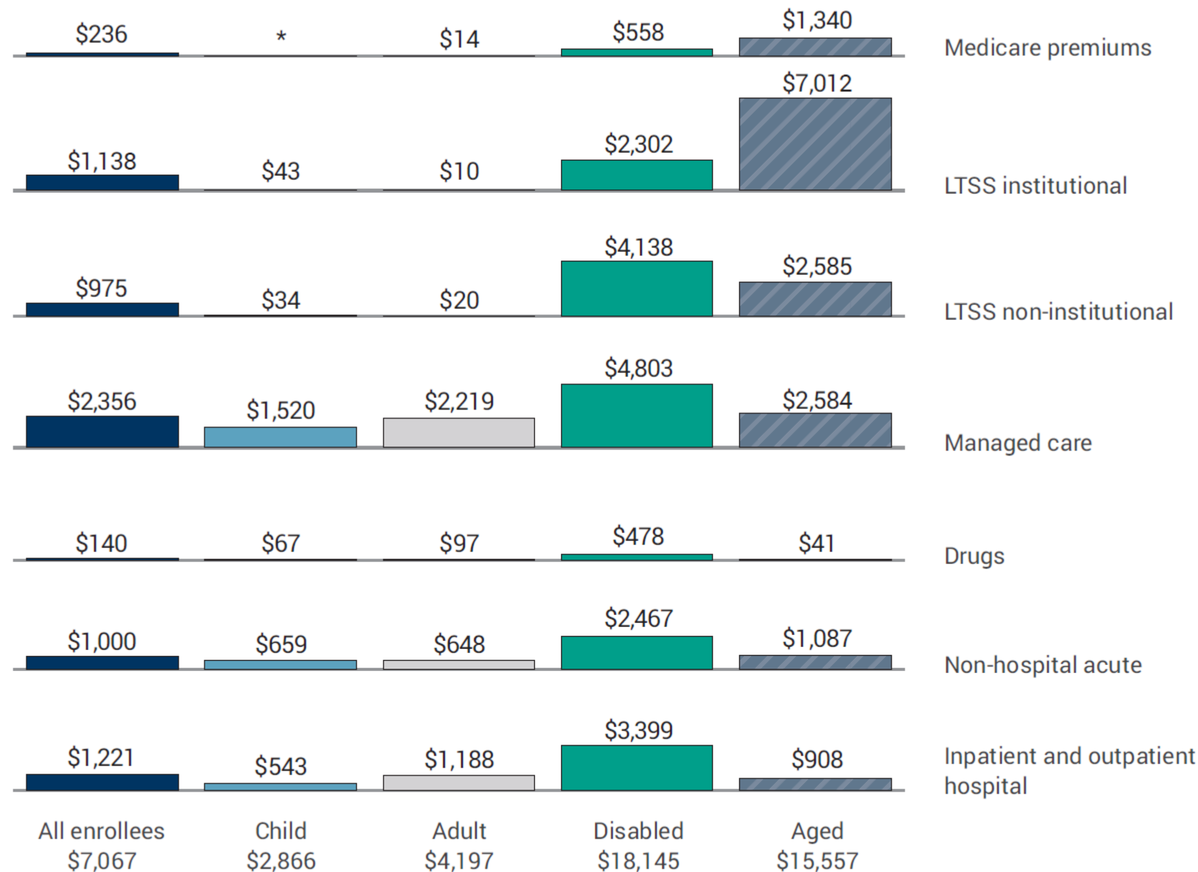
Note: Dollar amounts were adjusted for inflation using the gross domestic product (GDP) price deflator for health care.
Source: MACPAC June 2016 Report to Congress

Impact of Enrollment Mix

- Individuals eligible on the basis of disability and those 65 and older accounted for one quarter of Medicaid enrollees, but two thirds of program spending in FY 2013

- Reflects two factors:
  - Costs for acute care for populations with significant acute care needs
  - Costs for long-term services and supports

Medicaid Benefit Spending Per FYE Enrollee by Eligibility Group and Service Category, FY 2013



Notes: FYE is full-year equivalent. FY is fiscal year. LTSS is long-term services and supports. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Excludes Idaho, Louisiana, and Rhode Island due to data reliability concerns regarding completeness of monthly claims and enrollment data. Values less than $1 are not shown.
Source: MACPAC, 2016, *MACStats*, Exhibit 19, December 2016.

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