



ISSUE BRIEF



From ANCOR's Government Relations Division

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Issue Brief No. 9 December 2008

Knowing the Basics About

Medicaid's FMAP will help providers assure that the public policy affecting the needs of people with disabilities and the providers that support them will be formulated soundly to meet the opportunities, issues, and challenges ahead.

Medicaid is a means-tested individual entitlement program that is jointly financed by both federal and state governments and administered by state governments. Medicaid provides health coverage and long term supports and services. It provides financing for a range of providers within communities across the country, supporting jobs, income and economic activity. The federal government matches state spending at least dollar for dollar for allowable state Medicaid spending. Consistent with the federal guarantee of Medicaid coverage for all eligible individuals, federal Medicaid matching dollars are guaranteed to states as needed, on an uncapped basis. With no cap on the

amount the federal government pays to a state—the more a state spends, the more it receives from the federal government. This approach directs funding based on actual, rather than predicted need. Demand for Medicaid increases when the economy is weak, requiring states to manage the increase in enrollment and program spending just as state budget conditions are most constrained.

Background

The Medicaid program provides health coverage and long term supports and services to 44.5 million people in low-income families and nearly 14 million individuals who have disabilities or are elderly. It provides financing also for a range of providers within communities, supporting jobs, income, and economic activity.

Medicaid is financed jointly by the federal government and the states, but is administered by states within broad federal guidelines. The federal medical assistance percentage (FMAP) is the share of total Medicaid expenditures the federal government pays. The federal share of total Medicaid expenditures the federal government pays is based on the FMAP rate for each state and the state's spending on the enrollment of mandatory and optional beneficiaries, mandatory and optional services and supports, provider reimbursement rates and a host of other decisions left up to each state. This joint financing arrangement is designed to provide an incentive for states to commit resources to their Medicaid programs—the higher the FMAP, the stronger the incentive.

The FMAP is determined annually by a statutory formula based on state per capita income. It varies from state to state. The FMAP is at least 50% in every state and is higher in less affluent states. For fiscal year 2009, the FMAP ranges from 50 percent in California and several other states to 75.84 percent in Mississippi. The FMAP for each state is determined annually by a statutory formula based on state per capita income.

With an FMAP of 50 percent, for every dollar a state spends on Medicaid, the federal government contributes \$1; with an FMAP of 75%, the federal contribution is \$3 dollars per state dollar. Likewise, whenever a state cuts its Medicaid spending, it will forgo its federal share. For example, a state with an FMAP of 75 percent will lose \$3 in federal dollars for every state dollar it cuts, for a total reduction of \$4 in Medicaid spending.

The FMAP formula was established in law when Medicaid was authorized in 1965. It is designed to pay a higher FMAP to states with lower per capita income relative to the national average. Personal income is the key variable in the FMAP formula. The formula is based on rolling three-year average per capita income data for each state and the

United States. This means that there is a time lag for data collection and calculation. As a result, FMAP percentages are based on income data from three to six years earlier.

- **The Medicaid law establishes a minimum FMAP of 50% for states, stipulating that no state shall bear more than 50% of total costs of their Medicaid program—regardless of the result of applying the FMAP formula. (The law sets a 70% FMAP for the District of Columbia.) The law also contains an upper FMAP limit of 85%.**
- **Medicaid’s financial arrangement provides an incentive for states to commit resources to their Medicaid programs.**
- **Medicaid’s current financing structure, with uncapped federal matching funds, gives states flexibility to respond to changing and emergency Medicaid needs.**
- **The federal medical assistance percentage (FMAP) varies from state to state, but by law, the FMAP is at least 50%.**
- **The FMAP applies to state expenditures for most medical services and medical insurance services with some exceptions for certain services (e.g. family planning and administrative costs) and certain populations (Native Americans) which are specified separately under federal law.**
- **The federal government matches state spending on allowable Medicaid administrative costs at a uniform matching rate of 50% across all states for most types of costs.** Federal payments for administrative costs are also open-ended.
- **The federal government funds about 57% of all Medicaid spending, supporting states’ ability to meet the health needs of its low-income population.** The Medicaid program accounts for 8% of total federal outlays and 44% of all federal grants to state and local governments.
- **States commit substantial resources to Medicaid.** On average, states spend about 18% of their general funds on Medicaid—making Medicaid the second largest item in state budgets following elementary and secondary education.
- **Medicaid is a major engine in state economies.** The infusion of federal matching dollars into state and local economies generates economic activity—including the creation of jobs and additional income and state tax revenues.

Medicaid and the Economy

With the nation in a recession, states are faced with slower than anticipated state revenue growth and significant budget shortfalls. Demand for Medicaid increases when the economy is weak, requiring states to manage the increase in enrollment and program spending just as state budget conditions are most constrained.

During an economic downturn, unemployment rises—placing upward pressure on Medicaid. As individuals lose employer sponsored insurance and incomes decline, enrollment and, therefore, Medicaid spending increase. At the same time, increases in unemployment have a negative impact on state revenues making it even more difficult to pay the state share of Medicaid spending. However, unlike the federal government, states are legally required to balance their budgets.

Due to Medicaid’s matching structure (receiving at least 50% FMAP), states must cut at least \$2 in program spending to save \$1 in state Medicaid spending. Given the negative effects on federal revenues and jobs, cutting Medicaid during a downturn can worsen the economy. States look to several options to close their Medicaid budget shortfalls. Unfortunately, provider rate cuts or freezes tend to have a more immediate effect on slowing Medicaid spending and nearly half of all states were planning to freeze provider rates in FY 2008 and/or 2009. However, this state option jeopardizes provider participation in Medicaid and access to services and supports.