April 10, 2025

Medicaid in Context: Payment and Financing

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Medicaid and CHIP Payment and Access Commission

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Overview

- Federal-state partnership
- Non-federal financing structure
- Provider payment mechanisms
- Impact to provider finances

Federal-State Partnership

Background

- The Social Security Act (the Act) established Medicaid as a joint federal-state program, with states receiving federal matching funds toward allowable expenditures
- Each state administers its own program within federal guidelines and with federal approval
- Medicaid accounted for 17.9 percent of national health care spending in calendar year 2023
  - Less than Medicare (21.2 percent) or private insurance (30.1 percent)
- The federal share of Medicaid spending in fiscal year (FY) 2024 was 64.5 percent nationally, varying by state

Sources: Centers for Medicare & Medicaid Services (CMS). 2024. National Health Expenditure Data. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data; MACPAC preliminary analysis of CMS-64 financial management report data as of March 20, 2025.

Federal Match

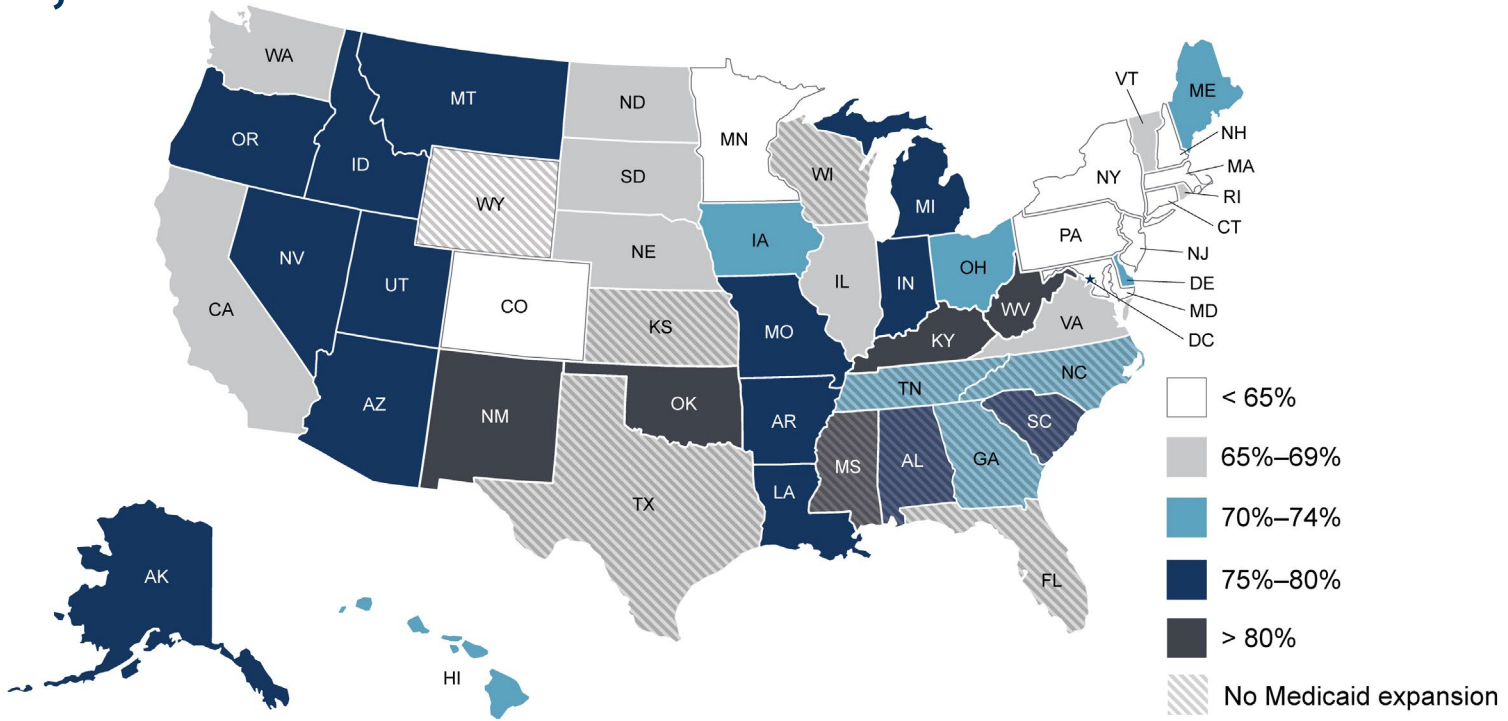
- The federal share for most Medicaid service costs is determined by the federal medical assistance percentage (FMAP)
  - FMAP is calculated based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average
- FMAPs have a statutory minimum of 50 percent and maximum of 83 percent, but certain exceptions apply
- There is no pre-set limit to Medicaid federal financial participation (FFP) for states, excluding the five U.S. territories

Financing Medicaid Administrative Costs

- Medicaid administrative costs typically are approximately 4 percent of total Medicaid spending (4.2 percent in FY 2024)
- Most state administrative costs receive 50 percent federal match, with enhanced rates for certain functions

Example Medicaid administrative activity	Federal match rate
General Medicaid eligibility determination and redetermination processes	50 percent
Survey and certification of nursing facilities	75 percent
Operation of a state Medicaid Fraud Control Unit	75 percent
Quality review of Medicaid managed care organizations performed by an external quality review organization	75 percent
Design, development, and implementation of an approved Medicaid management information system (MMIS)/ongoing operations of MMIS	90 percent/75 percent

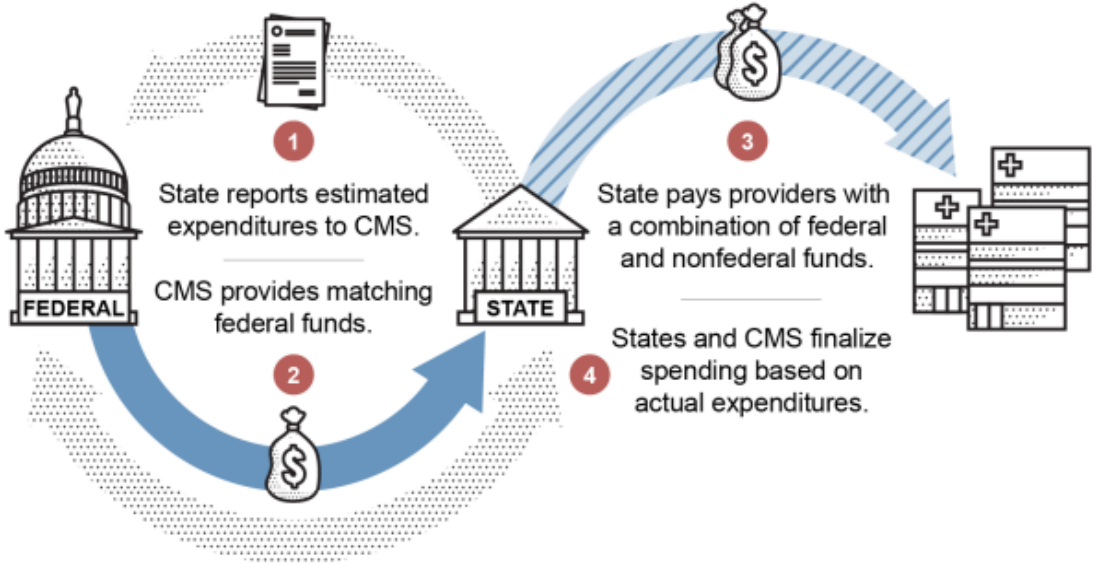
Federal Share of Total Medicaid Spending by State, FY 2023



Note: FY is fiscal year. The temporary increase in the FMAP from the Families First Coronavirus Response Act of 2020 (FFCRA, P.L. 116-127) was still in effect during FY 2023.
Source: MACPAC, 2024 Exhibit 16 in MACStats: Medicaid and CHIP Data Book, December 2024.

Federal Match Distribution Process

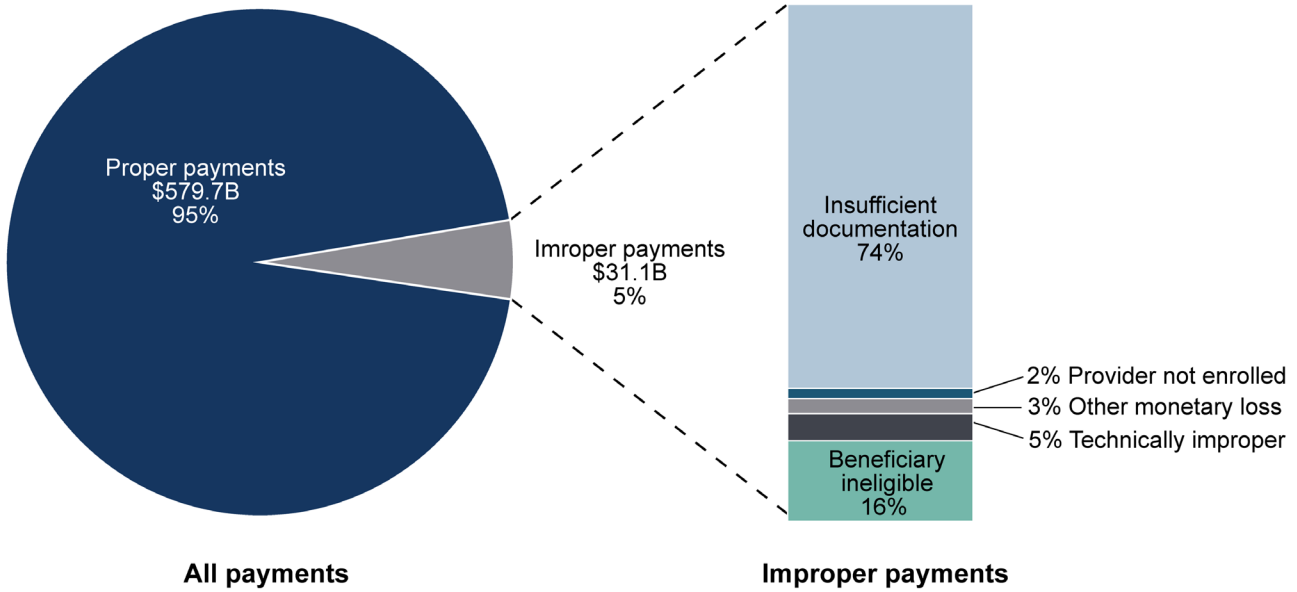
Figure 1: Federal Review and Matching of Estimated State Medicaid Expenditures



Source: U.S. Government Accountability Office (GAO). 2020. Figure 1 in *CMS needs more information on states' financing and payment arrangements to improve oversight*. Report no. GAO-21-98. Washington, DC: GAO. https://www.gao.gov/products/gao-21-98.

Medicaid Estimated Proper and Improper Payments, Review Year 2024

- Improper payments constituted 5 percent of total Medicaid payments
- Almost 75 percent of improper payments were due to insufficient documentation



Note: Improper payments occur when a payment is made in an incorrect amount under statutory or other legally applicable requirements. Technically improper payments mean a payment to the right recipient for the correct amount, but the payment process did not comply with applicable regulations and statutes. Review year 2024 includes all 50 states reviewed across three cycles between July 2020 and June 2023.
Source: Department of Health and Human Services (HHS). 2024. Fiscal Year 2024 Agency Financial Report. https://www.hhs.gov/sites/default/files/fy-2024-hhs-agency-financial-report.pdf

Non-Federal Financing Structure

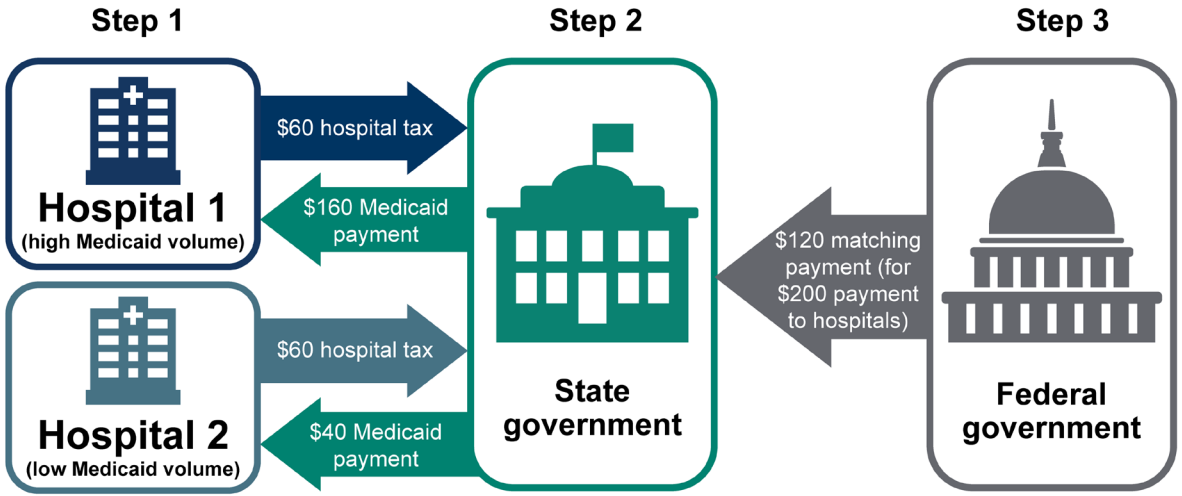
State Funding Sources

- At least 40 percent of the non-federal share of Medicaid must be financed by the state (up to 60 percent can be from local governments)
- The Medicaid statute permits states to finance the non-federal share of Medicaid spending from a variety of sources, including:
  - State general funds
  - Health care-related taxes (often referred to as provider taxes)
  - Intergovernmental transfers (IGTs)
  - Certified public expenditures (CPEs)
- The non-federal share contributed by providers is frequently used to finance additional payments to those providers

Provider Taxes

- Taxes for which at least 85 percent of the tax burden falls on health care providers
- Levied against all providers of the class in the state (not only those that accept Medicaid payments) and must be uniformly applied or show that the net cost and benefits are generally redistributive
  - Federal regulations allow states to impose provider taxes on 19 classes
  - The most frequently taxed classes are nursing facilities, hospitals, and intermediate care facilities for individuals with intellectual disabilities
- Providers cannot be held harmless through a direct or indirect guarantee that they will be repaid for all or a portion of the taxes
  - The indirect guarantee test does not apply if the tax rate falls within the safe harbor, currently set at 6 percent of net patient revenue

Illustration of Provider Tax-Financed Payments



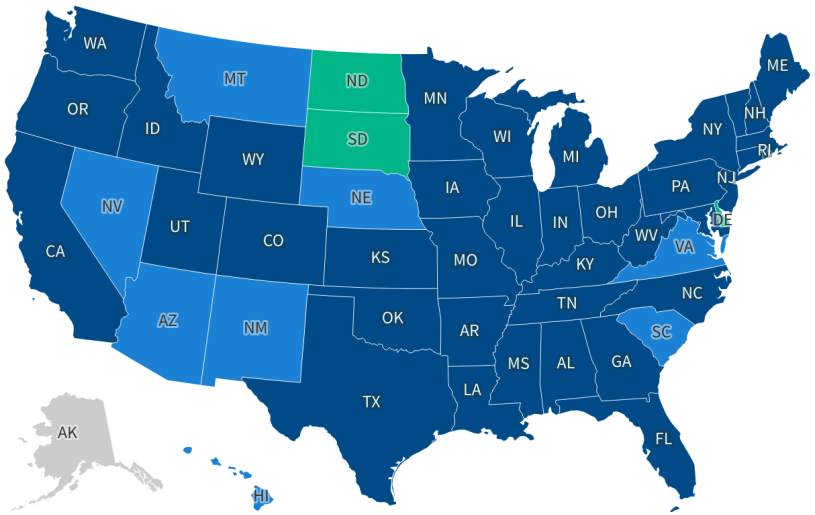
Note: FMAP is federal matching assistance percentage.

States with Provider Taxes or Fees in Place, FY 2024

States with Provider Taxes or Fees in Place in FY 2024

Number of Provider Taxes/Fees | Size of Provider Taxes/Fees

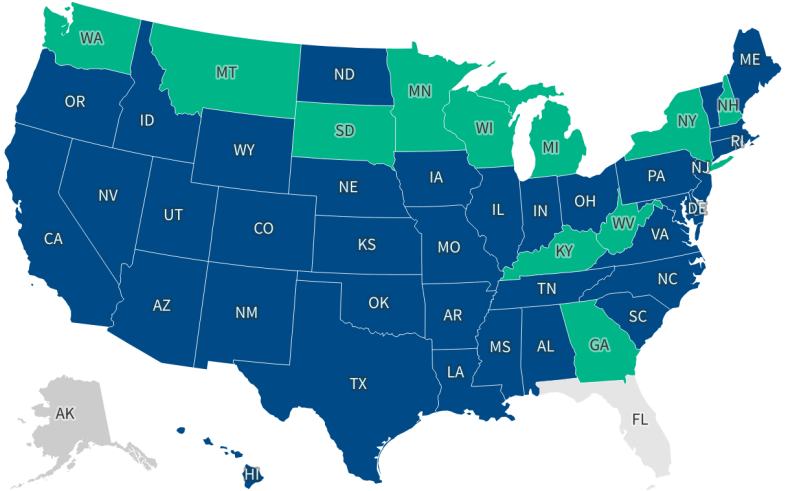
3+ Provider Taxes/Fees (39 states including DC) 2 Provider Taxes/Fees (8 states) 1 Provider Tax/Fee (3 states) No Provider Taxes/Fees (1 state)



Size of Taxes as Percentages in Place in FY 2024

Number of Provider Taxes/Fees | Size of Provider Taxes/Fees

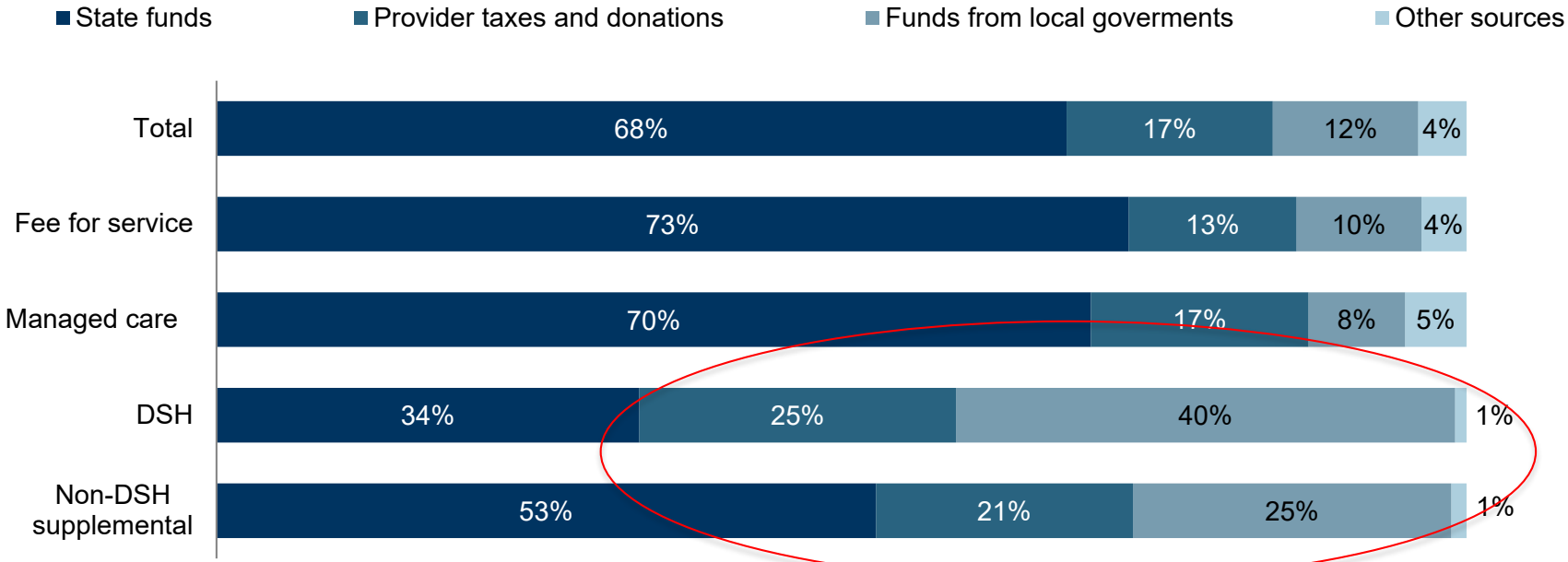
At Least 1 Provider Tax/Fee Over 5.5% (38 states including DC) No Provider Taxes/Fees Over 5.5% (11 states) No Provider Taxes/Fees (1 state) No response (1 state)



Notes: FY is fiscal year. Includes Medicaid provider taxes as reported by states. Size of tax is reported as a percentage of net patient revenue (as of July 1, 2024). FL did not respond to the 2024 survey; publicly available data was used to verify taxes in place.

Source: KFF. 2024. Figure 14 in *As Pandemic-Era Policies End, Medicaid Programs Focus on Enrollee Access and Reducing Health Disparities Amid Future Uncertainties: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2024 and 2025.* Washington, DC: KFF. https://www.kff.org/report-section/50-state-medicaid-budget-survey-fy-2024-2025-provider-rates-and-taxes/.

Share of Non-Federal Funds for Medicaid Payments from Different Sources, SFY 2018



Notes: SFY is state fiscal year. DSH is disproportionate share hospital. State funds include state general funds and interagency transfers. Funds from local governments include intergovernmental transfers and certified public expenditures. Other sources include funds, such as tobacco settlement funds, that are used to fund the state's non-federal share of Medicaid expenditures and are not considered to fit in the other categories listed. Numbers do not sum to 100 due to rounding. Data reflect all Medicaid payments, not just Medicaid payments to hospitals.

Source: U.S. Government Accountability Office (GAO). 2020. *CMS needs more information on states' financing and payment arrangements to improve oversight*. Report no. GAO-21-98. Washington, DC: GAO. https://www.gao.gov/products/GAO-21- 98.

Provider Payment Mechanisms

Provider Payment Mechanisms

- Base payments: standard payment rates for services delivered to Medicaid beneficiaries (e.g., fee-for-service rates set by state)
  - Tied to a specific beneficiary/service
- Supplemental payments: additional payments beyond base rates to certain providers; subject to aggregate limits based on Medicare rates
  - Typically made in a lump sum amount; not tied to a specific beneficiary/service
  - Allow states to target payments for different purposes
- Directed payments: allows states to direct managed care plans to pay providers according to specific rates or methods. Many directed payment arrangements are similar to supplemental payments

Supplemental Payments Target Different Goals

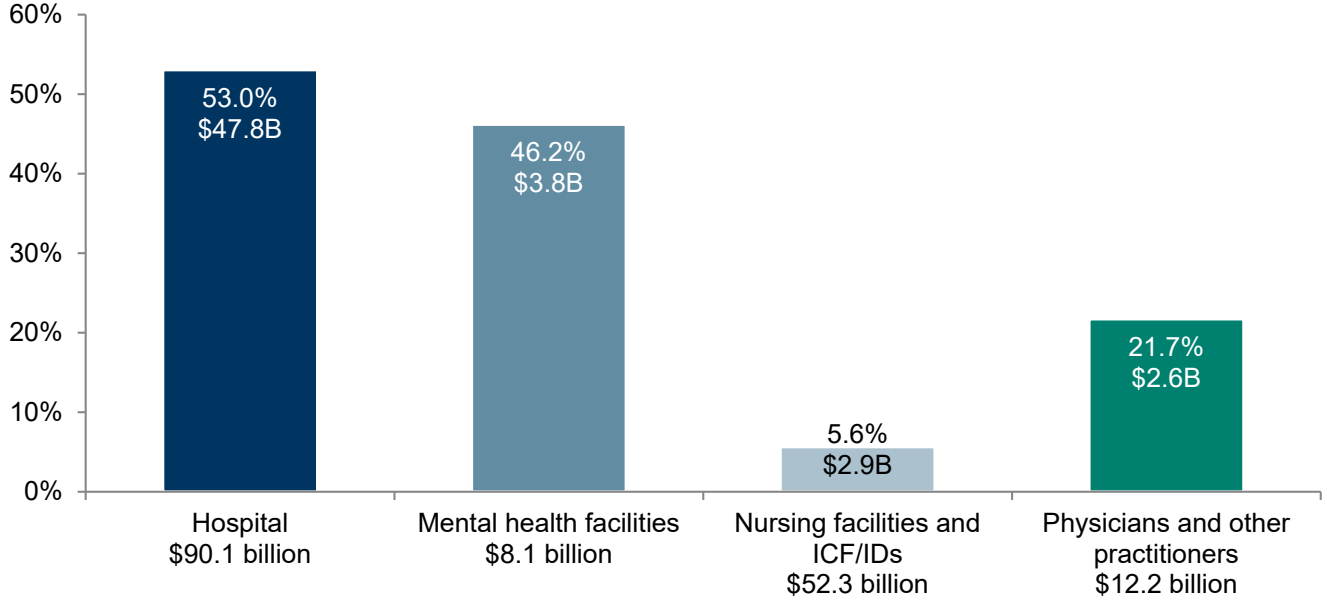
Type of supplemental payment	FY 2022 total spending (billions)	Number of states reporting spending	Intent of payment implied from federal rules			
			Reducing Medicaid shortfall	Paying for unpaid costs of care for uninsured individuals	Quality improvement	Support for specific types of hospitals
DSH	$15.0	47	✓	✓		
UPL	15.8	35	✓			
GME	4.9	35				✓
Uncompensated care pools	10.0	7	✓	✓		
DSRIP	0.2	7			✓	
Directed payments	47.8[1]	35	✓		✓	

Notes: FY is fiscal year. DSH is disproportionate share hospital. UPL is upper payment limit. GME is graduate medical education. DSRIP is delivery system reform incentive payment. Analysis excludes managed care payments and DSH payments to mental health facilities. Number of states reporting spending includes the District of Columbia but excludes the US territories.

[1] Spending total represents annualized amounts of projected spending from directed payment preprints, which may differ from actual FY 2022 spending.

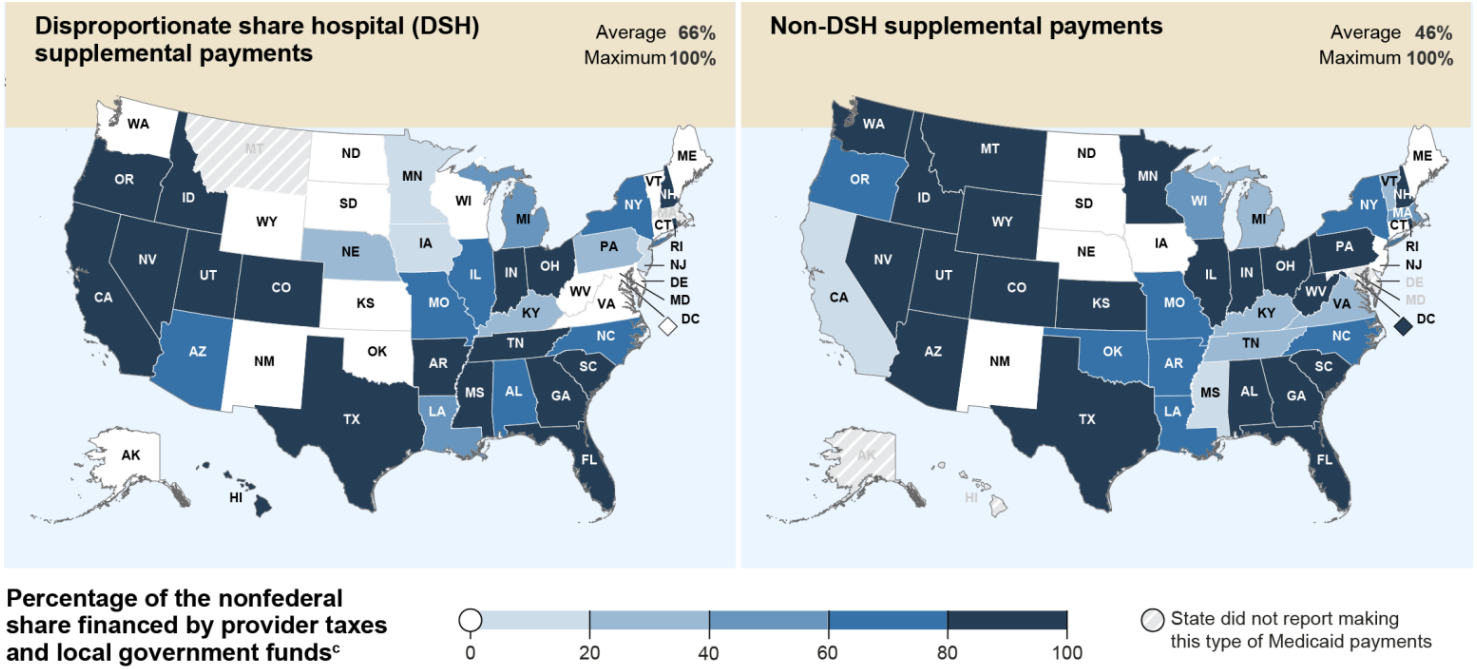
Source: MACPAC, 2024, analysis of CMS-64 FMR net expenditure data as of May 30, 2023; CMS-64 Schedule C waiver report data as of September 29, 2023; and directed payment arrangements approved through February 1, 2023.

Fee-For-Service Supplemental Payments as a Share of Total Medicaid Spending by Provider Type, FY 2023



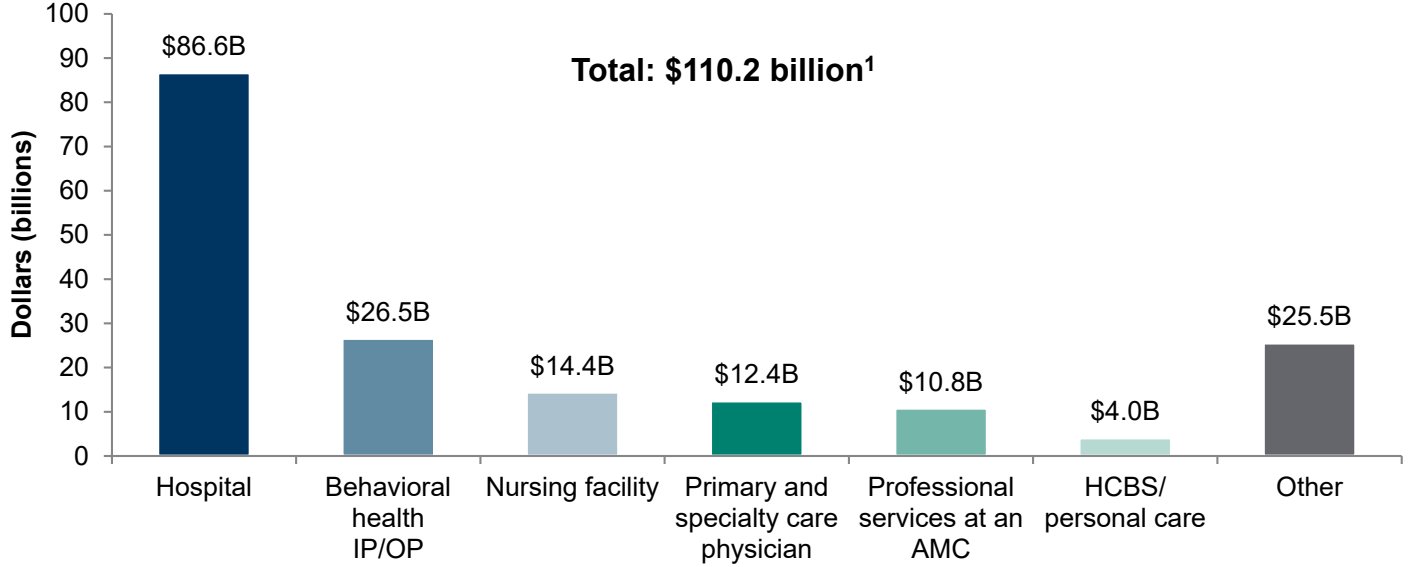
Notes: FY is fiscal year. ICF/ID is intermediate care facility for persons with intellectual disabilities. Includes federal and state funds. Supplemental payments include Disproportionate Share Hospital (DSH) payments, payments made under institutional upper payment limit rules, and other non-DSH supplemental payments made under waiver expenditure authority of Section 1115 of the Act. Excludes payments made under managed care arrangements. All amounts in this table are as reported by states in CMS-64 data during the fiscal year to obtain federal matching funds; amounts include expenditures for the current fiscal year and adjustments to expenditures for prior fiscal years that may be positive or negative. Amounts reported by states for any given category (e.g., nursing facilities) sometimes show substantial annual fluctuations.
Source: MACPAC, 2024, analysis of CMS-64 FMR net expenditure data as of May 29, 2024, and CMS-64 Schedule C waiver report data as of August 2, 2024.

Non-federal Share of Medicaid Supplemental Payments Financed with Provider and Local Government Funds in SFY 2018, by State



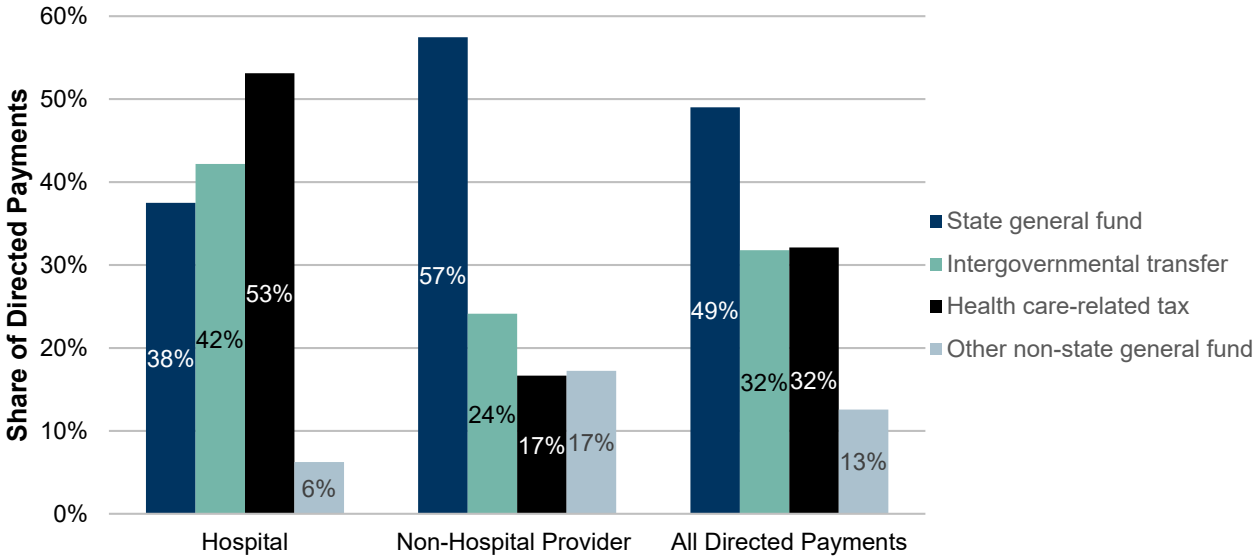
Notes: SFY is state fiscal year. Information is based on questionnaire responses received from 50 states and the District of Columbia.
Source: U.S. Government Accountability Office (GAO). 2020. Figure 4 in *CMS needs more information on states' financing and payment arrangements to improve oversight*. Report no. GAO-21-98. Washington, DC: GAO. https://www.gao.gov/products/gao-21-98.

Directed Payment Spending by Service Category, 2024



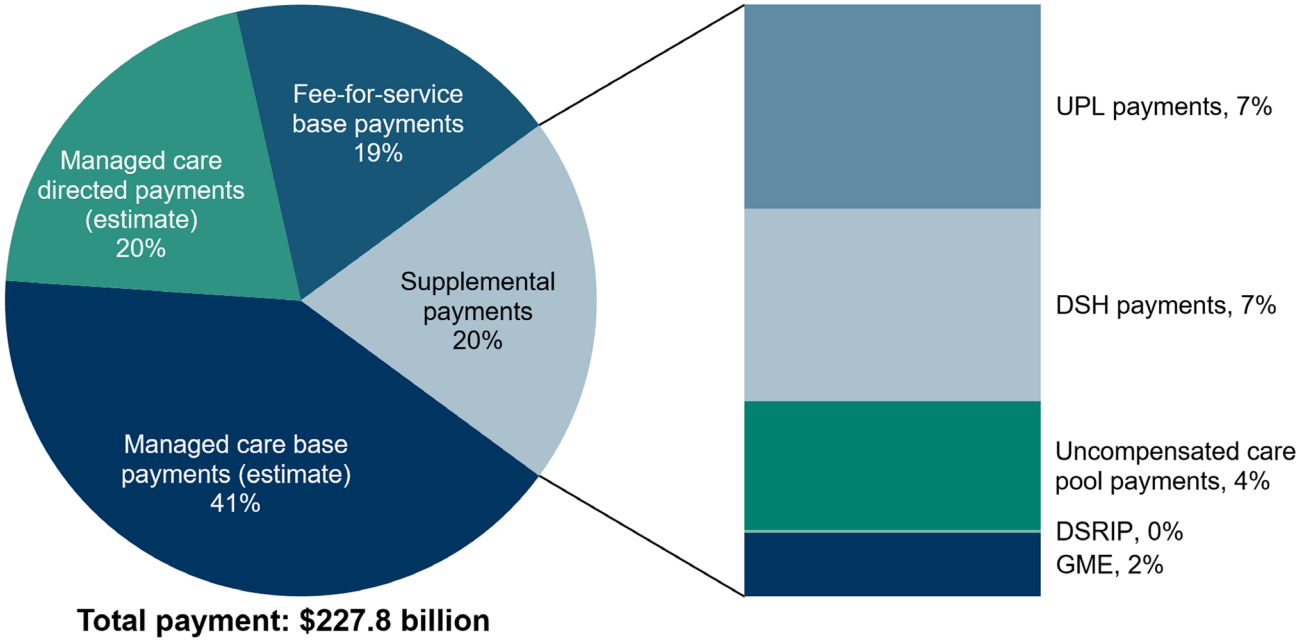
Notes: AMC is academic medical center. HCBS is home and community-based services. IP is inpatient. OP is outpatient. This analysis is based on a review of unique directed payment arrangements approved between February 1, 2023 and August 1, 2024. Analysis excludes prior versions of directed payment arrangements that were subsequently renewed or amended (n = 198) and directed payments approved after February 1, 2023 that did not use CMS's new template (n = 6). The sum of the type of service categories may be greater than the total because a directed payment arrangement may target more than one provider type. Projected directed payment spending is duplicated for each type of service indicated for a particular arrangement.
[1] Projected payment amounts represent annualized amounts for the most recent rating period, which may differ from calendar year or fiscal year 2023 or 2024. In addition, projected spending reported in directed payment approval documents may differ from actual spending.
Source: MACPAC, 2024, analysis of directed payment preprints approved through August 1, 2024.

Share of Directed Payment State Financing Sources by Provider Type, 2024



Notes: This analysis is based on a review of unique directed payment arrangements approved between February 1, 2023 and August 1, 2024. Analysis excludes prior versions of directed payment arrangements that were subsequently renewed or amended (n = 198) and directed payments approved after February 1, 2023 that did not use CMS's new template (n = 6). Totals do not sum because a single directed payment arrangement can have multiple funding sources. Other non-state general fund sources include tobacco settlement funds, state trust funds, and state funds equivalent to the amount of federal funds attributable to the increased FMAP in accordance with Section 9817 of the American Rescue Plan.
Source: MACPAC, 2024, analysis of directed payment preprints approved through August 1, 2024.

Types of Payments as a Share of Medicaid Hospital Spending, FY 2022



Notes: FY is fiscal year. DSH is disproportionate share hospital. UPL is upper payment limit. DSRIP is delivery system reform incentive payment. GME is graduate medical education. DSRIP and uncompensated care pool payments must be authorized under Section 1115 waivers. Managed care payments to hospitals are estimated based on total managed care spending reported by states. DSRIP spending is a non-zero amount that rounds to 0%.
Sources: MACPAC, 2024, analysis of CMS-64 net expenditure data as of May 30, 2023; CMS-64 Schedule C waiver report data as of September 29, 2023; and directed payment arrangements approved through February 1, 2023.

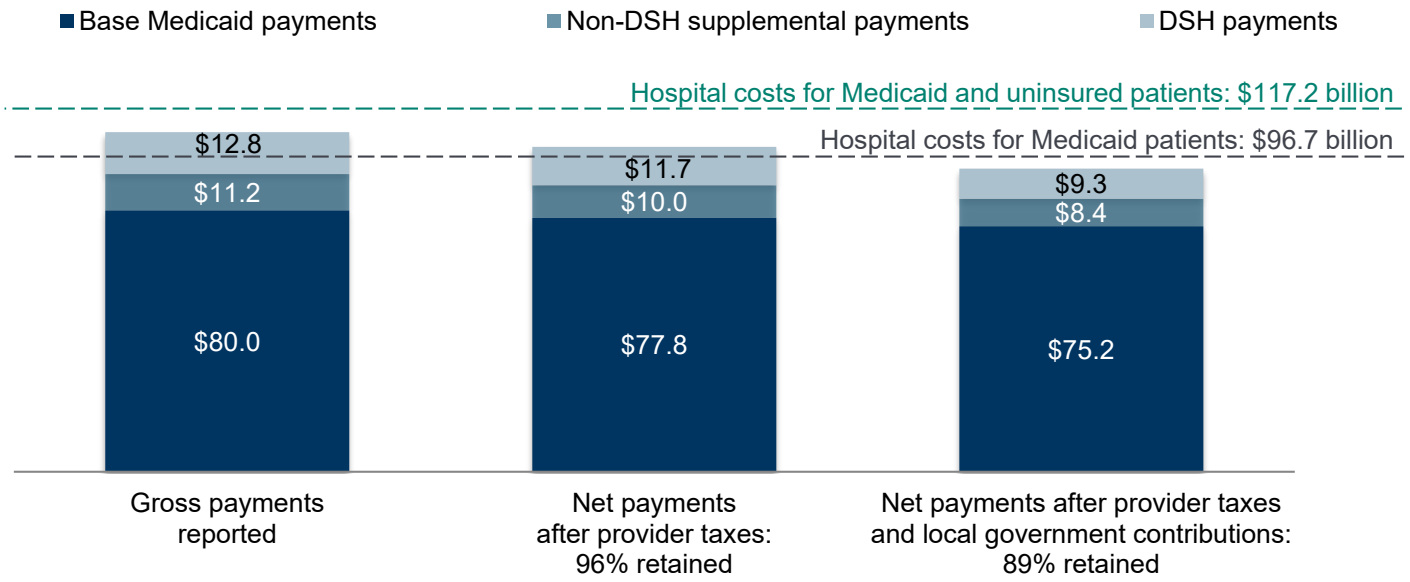
Rural Hospital Targeting Characteristics of Non-DSH Supplemental Payments, FY 2022

Hospital targeting characteristics	Number of states reporting non-DSH spending	Total non-DSH spending (millions)	Non-DSH Hospital Spending to Rural Hospitals		
			Sum of spending (millions)	Mean spending per state (millions)	Share of total non-DSH spending
Total	**48**	**$18,766.9**	**$1,446.8**	**$30.1**	**7.7%**
Rural (including CAH)	15	7,106.9	792.8	52.9	11.2
CAH	11	3,285.3	595.7	54.2	18.1
No rural targeting	33	11,660.0	654.0	19.8	5.6

Notes: Non-DSH payments include upper payment limit supplemental payments, graduate medical education payments, and DSRIP supplemental payments in Texas authorized through Section 1115 demonstration authority. FY is fiscal year. CAH is critical access hospital. DSH is disproportionate share hospital. DSRIP is Delivery System Report Incentive Program. Total spending includes state and federal funds.
Source: MACPAC, 2025, analysis of FY 2022 non-DSH supplemental payment data submitted to the Centers for Medicare & Medicaid Services and Medicaid state plans.

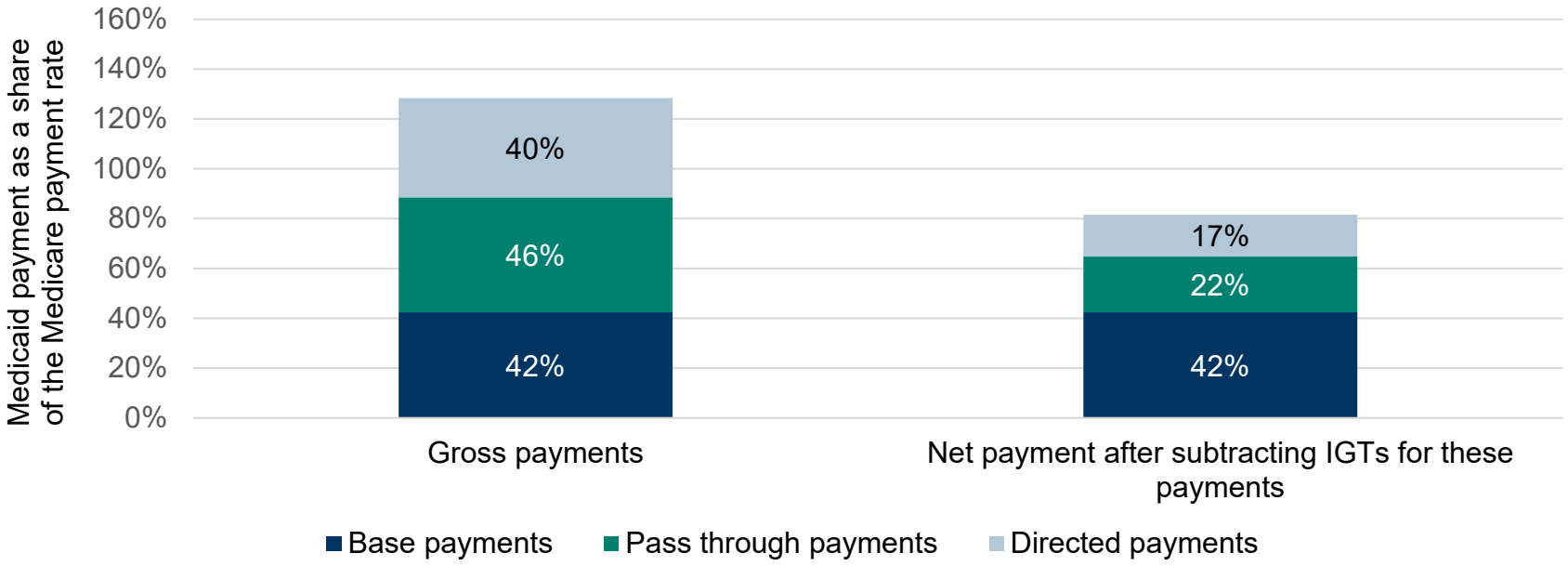
Provider Impact

Gross and Net Medicaid Payments to Disproportionate Share Hospitals, 2011 (billions)



Notes: DSH is disproportionate share hospital. This analysis excludes institutions for mental diseases.
Source: Nelb, R., J Teisl, A. Dobson, et al, 2016, For disproportionate share hospitals, taxes and fees curtail Medicaid payments, *Health Affairs,* 35, no. 12:2277–2281, https://doi.org/10.1377/hlthaff.2016.0602.

Example of Gross and Net Medicaid Managed Care Payments for a Public Texas Hospital, 2022



Notes: IGT is intergovernmental transfer. Analysis excludes fee-for-service base and supplemental payments.
Source: MACPAC, 2024, analysis of managed care directed payment pre-print and Rider 15(b) annual report

Questions or Comments?

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