Medicaid Financing 101

Advancing States HCBS Conference

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National Association of Medicaid Directors

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NAMD is a professional community of state leaders who provide health insurance to more than 80 million individuals and families through Medicaid and the Children's Health Insurance Program in each of the 50 states, the District of Columbia and the U.S. territories.

NAMD elevates thought leadership on core and emerging policy matters, amplifies the experience and expertise of Medicaid and CHIP directors, supports state programs in continuous improvement and innovation, and optimizes federal-state partnerships to help millions live their healthiest lives.

NAMD is led by a mission-focused 14-person Board of Directors that currently includes representation from the states of West Virginia, Georgia, Indiana, Kentucky, Virginia, California, Idaho, Iowa, Kansas, Oklahoma; the District of Columbia and the U.S. Virgin Islands.

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As of April, Medicaid was serving almost one in four Americans.

- 4 in 10 births. 35 million children. 2/3 of older adults and people with disabilities.
- A targeted study found that over 60% of Americans have a connection to the program.
- The Kaiser Family Foundation Health Tracking Poll found in its 2019 report that 75% of the public has a favorable view of Medicaid.

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Important program trends: models

The Kaiser Family Foundation 2022 Medicaid Budget Survey reveals that Medicaid programs:

- are predominantly utilizing capitated managed care models (per CMS, as of 2020 72% of members) but have continued to migrate to carve-out, standardization, and self-management of pharmacy
- are mobilized around a range of health equity strategies
- have had opportunities during the pandemic to enhance their programs through implementation of telehealth, benefit coverage expansions (behavioral health, post-partum eligibility, adult dental) and targeted rate increases (behavioral health, nursing home and home care)
- are concerned about maintaining current coverage and provider rates, as well as momentum with Medicaid care delivery and value-based payment reforms, following expiration of the public health emergency and pandemic-related financial resources and active uptake of "unwinding"

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Important program trends: spending

- According to the Kaiser Family Foundation (KFF), Medicaid reflects nearly 1 in 6 dollars spent in the US on health care, 1 in 2 dollars spent in the US on long-term services and supports, and it is the United States' single largest payer for behavioral health services, including mental health and substance use care

- The National Association of State Budget Officers State Expenditure Report indicates that in FY'22 total Medicaid benefits spending was $799.6 billion, which included $540.1 billion in federal spending (67.5% of the total)

- Medicaid's growth rate reached 12.5% in FY 2022 but is expected to slow to 4.2% in FY 2023

- NASBO also reports that in FY'22, Medicaid spending accounted for 27.6% of total state spending, which is the single largest component of total state expenditures; and 17.3 percent of general fund spending, which is the second largest category of spending after K-12 education

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Important program trends: enrollment

- Over the period from 2017 to 2019, enrollment in Medicaid declined, but dramatically increased during the pandemic, under continuous coverage requirements

- As of April, 2023, the CMS Medicaid and CHIP Enrollment Trends Snapshot indicates that Medicaid was serving 87.1 million people (35.3 million of whom were children), which represents an increase from February 2020 of nearly 23 million individuals (35.9%)

- The Congressional Budget Office has released updated estimates of the enrollment-related impacts of unwinding, anticipating that over an 18-month period starting in April, 2023, 15.5 million people will leave Medicaid

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Exhibit 4 Initial transitions in coverage in the 18 months beginning in April 2023, after the end of Medicaid continuous eligibility provisions

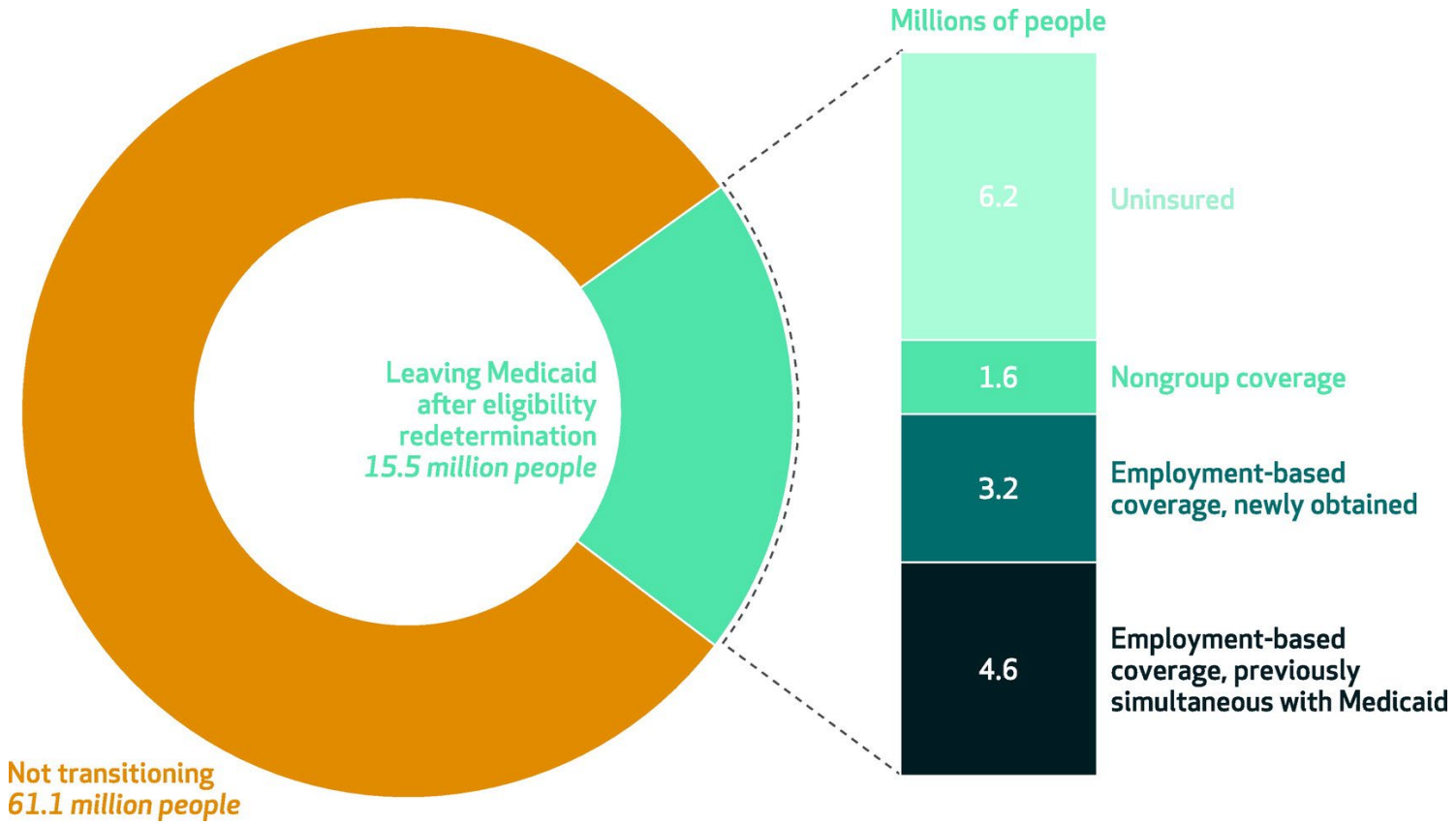
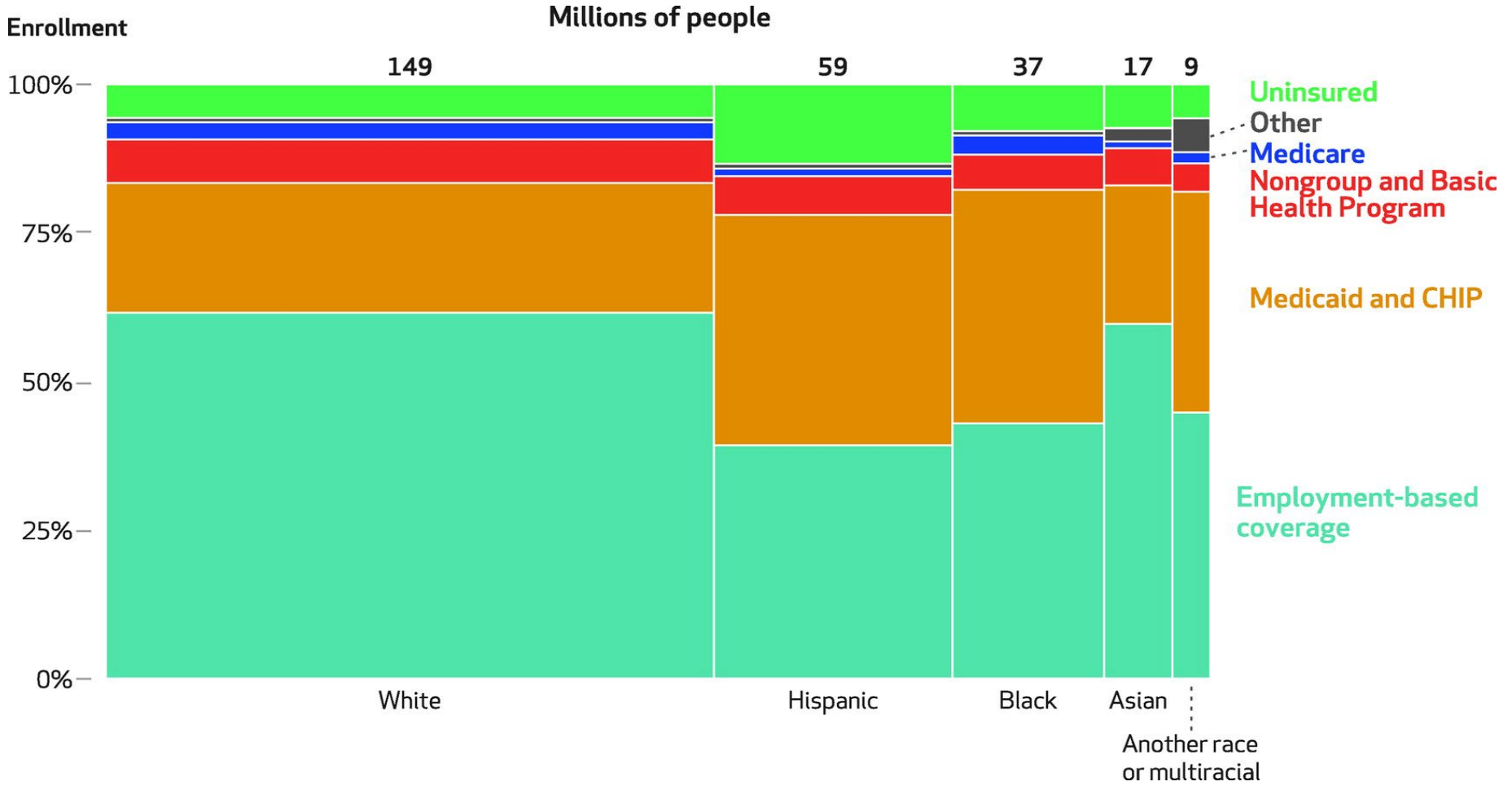


Exhibit 3 Health insurance coverage for people younger than age 65, by type of coverage and race and ethnicity, 2023



Financing - structure

Medicaid is structured as a federal-state/territory equity partnership:

- Under the federal law, states are required to pay an identified percentage of total program costs and the Federal government pays the remainder
- The federal share, referred to as federal financial participation (FFP), or federal match, is calculated using a Federal Medical Assistance Percentage (FMAP).

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Financing - FMAP

FMAP:

- Varies by state and is inversely related to per capita income
- Generally ranges from **a minimum of 50% to a maximum of 83%** - state must cover the balance through non-federal sources
- Also supports specific functions:
  - 75% match for the salaries of certain state staff
  - 90% match to support new/updated IT systems and 75% match for operations
- Is also used by the federal government:
  - to address urgent/emergent needs (e.g., natural disasters, public health emergencies)
  - to incent states to implement policy preferences (e.g. expansion, health homes)

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Financing – Sources of State Share

- **State General Fund revenue**

- **Intergovernmental Transfers (IGTs)**

A transfer of funds from another governmental entity, including government-operated providers, to the Medicaid agency

- **Certified Public Expenditures (CPEs)**

Expenditures made by a governmental entity, including government-operated providers, under state's approved Medicaid state plan

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- **Provider Taxes**

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 states to be able to draw down federal Medicaid matching funds:

- the provider tax must be both broad-based (i.e., imposed on all providers within a specified class of providers) and uniform (i.e., the same tax for all providers within a specified class of providers)
- states are not allowed to hold the providers harmless for the cost of the provider tax (i.e., states cannot guarantee that providers receive their money back)

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Provider Reimbursement - principles

Medicaid programs must adhere to the following guidelines in reimbursing providers for services:

Payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population.

§1902(a)(30)(A) of the Social Security Act

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Provider Reimbursement – sources

State reimbursement staff use a variety of primary data sources to determine Medicaid reimbursement:

- Costs and cost reconciliation as reported through annual provider cost reports
- Inflation index
- Prospective or historical costs
- Consumer price index
- Wages and geographic index
- Cost-of-living adjustments
- Acuity
- Market Basket Index

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Provider Reimbursement - obligations

State staff must also ensure that costs:

- are “proper and efficient”
- are allocated in accordance with the benefits received by each participating program
- do not reflect general public health initiatives that are made available to all people
- do not duplicate payment for activities that are being paid through other programs
- are not funded through other federal sources
- have adequate source documentation

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Provider Reimbursement – provider type

States reimburse providers through diverse means, including, but not limited to, the following:

- **Clinicians (i.e. physicians, physician assistants, nurse practitioners, nurses, licensed behavioral health providers)** receive payments that are specific to the service codes that are used to claim for payment

- **Federally-qualified health centers** receive “encounter rates” that are set based on a method identified in federal law and their cost reports

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- **Residential institutional providers** (skilled nursing homes, ICF-IID facilities) receive per diem payments that have historically been cost-based and are set using a statutory method, but are migrating to an acuity-based approach

- **Hospitals** receive Diagnosis Related Group (DRG) payments for most inpatient services, and Ambulatory Payment Classification (APC) payments for most outpatient services

- **Hospitals and nursing homes** often receive lump-sum "supplemental" payments that are not directly tied to individual services

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Upper Payment Limit (UPL)

For providers including hospitals, nursing facilities, ICF/IID's and non-hospital clinics, federal regulations prohibit FFP for Medicaid fee-for-service (FFS) payments in excess of upper payment limits that reflect what Medicare would pay for those services.

States calculate their aggregate spend on these services, compare spend to the UPL, and can then claim up to the UPL and re-distribute federal funding to providers as supplemental payments.

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Value-Based Payment

The Centers for Medicare and Medicaid Services (CMS) define **value-based purchasing** as a method that provides for:

Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

An **Alternative Payment Model (APM)** is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

https://www.healthcare.gov/glossary/value-based-purchasing-VBP/
https://qpp.cms.gov/apms/overview

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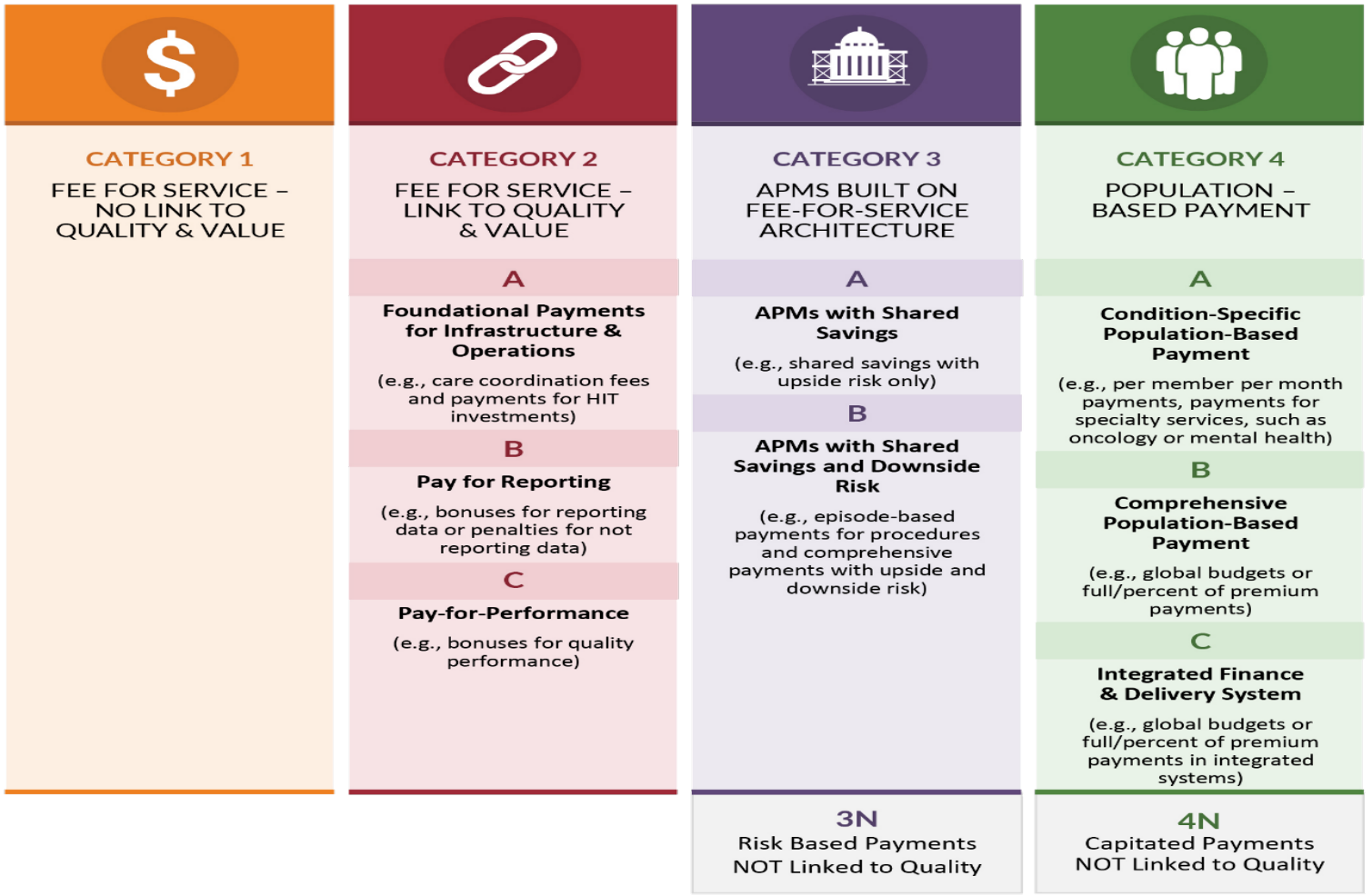
Value-Based Payment



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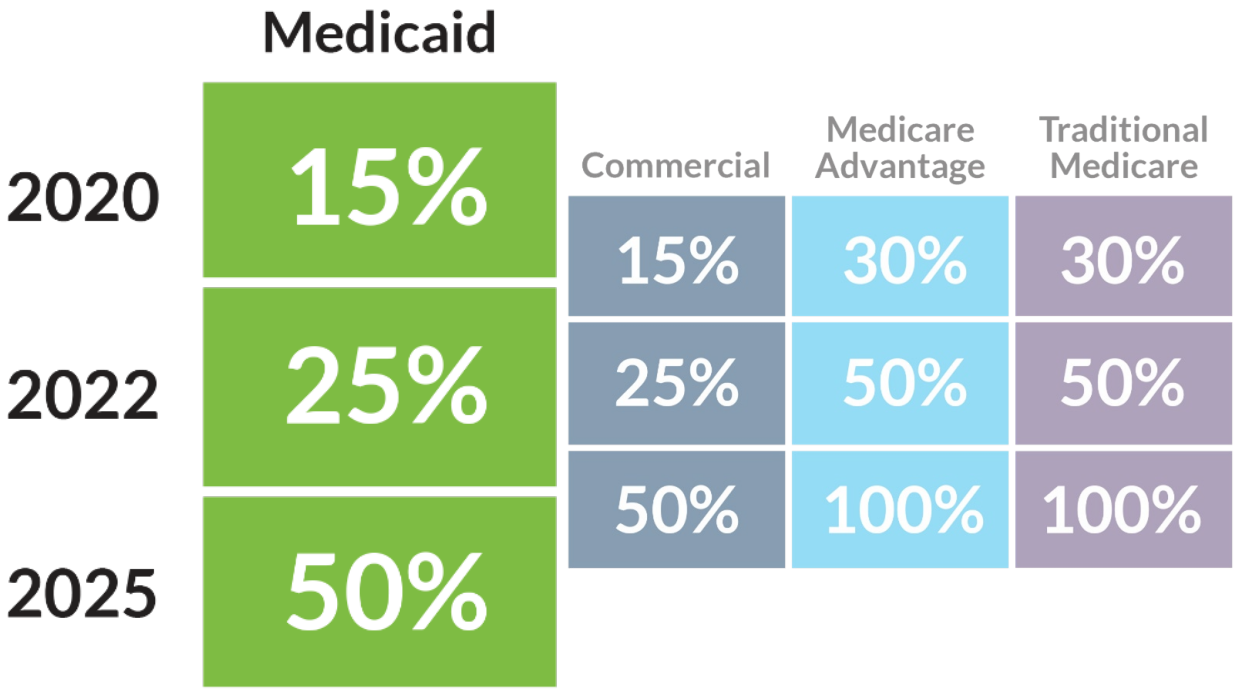
Learning and Action Network Goals



Percentage of Medicaid payments flowing through two-sided risk models (Categories 3B & 4* in the LAN APM Framework)

2017	7.4%
2018	8.3%

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Payment and Program Integrity

Payment and program integrity activities are a requirement of all state Medicaid plans:

- A means of detecting and deterring fraud, waste, and abuse
- Supports effective program administration and ensures that federal and state dollars are spent appropriately
- Core activities include reporting, pattern recognition, investigations, referral and prosecution, recovery, and remediation, avoidance, and prevention

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Payment and Program Integrity (cont.)

Working definitions:

- **Abuse** includes:
  - provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program; and
  - reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care

- **Fraud** reflects intentionally deceiving or making misrepresentations to obtain money or property of any health care benefit program

- **Waste** reflects inappropriate utilization of services or misuse of resources

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In conclusion

- Medicaid reflects an equity partnership between states/territories and the federal government
- Medicaid financing is complex and subject to many federal requirements
- States have choices:
  - how they make up the state share of program spending
  - at what rate and through which means they reimburse health care providers
  - about optimizing federal funding to incent improvement in quality of care or enhance the overall level of reimbursement payments to providers
- The single state Medicaid agency is responsible financial integrity of program spending even when sister state agencies manage day-to-day operations

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