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Medicaid and the Current State Fiscal Crisis

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Medicaid and the Current State Fiscal Crisis

Summary

Medicaid, a health insurance program funded jointly by the federal government and the states, is facing a period of quickly escalating costs at a time when the need among the population it serves — the low-income disabled, families and elderly — is rising. The pressures of quickly rising costs and increasing need are driving legislative attention both at the state and federal levels. Federal Medicaid expenditures grew 13% between FY2001 and FY2002, the fastest rate of growth since 1992.

States, which cannot use deficit spending, have been facing fiscal pressures from recent declines or slower growth rates for general state revenues due to the economic downturn and constraints on the states' use of creative financing mechanisms. Medicaid is frequently pointed to as a significant contributor to these fiscal pressures. This is not the first time that Medicaid has been a fiscal flash point. In the mid-nineties, the Congress passed legislation to repeal the Medicaid program and replace it with a fixed grant program. President Clinton vetoed this effort. The period of economic growth in the 1990s relieved some of the fiscal pressures. In recent years however, the fiscal pressures have returned.

The joint nature of the Medicaid program means that program policy changes can occur at either (or both) the federal and state level. For states, making significant cuts in the Medicaid program is challenging because some of the quickly growing cost items such as nursing facility care are federally required. In addition, cutting the program when unemployment is high and the number of uninsured is growing is politically unpopular. As a result, states have combined to lobby for fiscal relief from the Congress.

In the 108th Congress, the Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA, P.L. 108-027) provided temporary fiscal relief to states through a combination of grants and an increase in the federal medical assistance percentage. Alternatively, the Bush Administration has proposed various options to control Medicaid spending including waivers through the Health Insurance Flexibility and Accountability (HIFA) initiative and a Medicaid reform proposal. In addition, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) provided some fiscal relief to states by temporarily increasing disproportionate share to hospital (DSH) allotments and increasing the floor for DSH allotments for certain states. However, P.L. 108-173 also created a prescription drug benefit under the Medicare program. The prescription drug benefit, which will begin in 2006, will be partially funded by the states.

This report describes Medicaid financing mechanisms, some of the factors that contribute to the program's spending growth, how Medicaid fits into state budgets, what avenues some states are using to control Medicaid spending growth in their budgets, and current federal legislative and administrative proposals aimed at affecting the program's fiscal impact. This report will be updated as legislative activities warrant.

Contents

List of Figures

List of Tables

Medicaid and the Current State Fiscal Crisis

Medicaid

Medicaid is a health insurance program jointly funded by the federal government and the states. While states have considerable flexibility to design and administer their Medicaid programs, certain groups of individuals must be covered for certain categories of services. Generally, eligibility is limited to low-income children, pregnant women, parents of dependent children, the elderly, and people with disabilities. The federal government's share of Medicaid costs is determined by a formula included in statute; states must contribute the remaining portion of costs in order to qualify for federal funds.

In fiscal year (FY) 2003, Medicaid enrollment was estimated at 53.0 million including 24.8 million children, and 13.6 million aged, blind, or disabled individuals.[1] In FY2002,[2] total (state and federal) Medicaid assistance payments not including administration were $246.3 billion, and of this total, the four largest categories were: nursing facilities — 19.3% of the total; inpatient services (general and mental hospitals) — 14.3%; prepaid health care (capitation payments - managed care organizations) — 13.3%; and prescription drugs — 9.5%.

The 10 largest states in terms of total medical assistance payments in FY2002 were New York, California, Texas, Pennsylvania, Florida, Ohio, Illinois, Massachusetts, Michigan, and New Jersey. They accounted for 57.1% of total Medicaid medical assistance payments. Nine of the 10 are also in the top 10 states for total population.[3]

Medicaid Financing

Medicaid is jointly funded by the states and the federal government. Generally, the federal share of Medicaid is based on a matching percentage. A state must pay its share of Medicaid program costs to receive matching federal payments. However, the simple mechanism of a federal matching percentage for Medicaid program service costs becomes more complicated when combined with two special provisions for reimbursement: (1) the required payment adjustments for hospitals (disproportionate share payments to hospitals, known as DSH) that serve a large

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[1] Centers for Medicare and Medicaid Services, 2003 CMS Statistics, Table 11, available at the CMS website: [http://www.cms.gov/researchers/pubs/03cmsstats.pdf] The balance of the enrollees (14.6 million) are adults.

[2] Calculations by the Congressional Research Service based on preliminary Form 64 data (Financial Management Report) provided by the Centers for Medicare and Medicaid Services, Jan. 2004.

[3] Massachusetts ranks 13th in terms of population.

number of low-income or Medicaid patients; and (2) the upper payment limits for services by type of provider, and provider ownership (private or public). These two financing mechanisms allowed under law made it possible for states to finance their Medicaid programs with less than their required state match, in effect increasing their federal match rate. However, these sources of financing have been restricted, just as other sources of state revenues are also decreasing.

Federal Medical Assistance Percentage. The federal government's share of a state's expenditures for Medicaid is called the Federal Medical Assistance Percentage (FMAP). The FMAP for each of the 50 states and the District of Columbia is determined annually based by a statutory formula that uses the average per capita income of each state and the United States for the three most recent calendar years for which data are available from the Department of Commerce. This formula is designed to pay a higher FMAP to states with lower per capita income relative to the national average (and vice versa for states with higher per capita incomes). FMAPs must not fall below 50% or exceed 83%.[4] There is an FMAP of 50% for administrative expenses and a higher match for certain services and administrative functions. In FY2003 and FY2004 the Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA, P.L. 108-027) provided fiscal relief to the states through a temporary increase in the FMAP for states that met certain requirements. For the last two quarters of FY2003 and the first three quarters of FY2004, eligible states were held harmless (protected) from any decline in the FMAP from FY2002 levels, and the resulting FMAP was increased by 2.95 points for these quarters. In general a state would be eligible for the higher FMAP if the Medicaid program eligibility was not more restrictive than the program eligibility on September 2, 2003. **Table 1** provides the FMAP for each state, the District of Columbia, and the territories for FY20001-FY2005.

Table 1. FMAPs for FY2000 through FY2005

Region	FY2000	FY2001	FY2002	FY2003 (first 2 quarters)	FY2003 (last 2 quarters)	FY2004 (first 3 quarters)	FY2004 (last quarter)	FY2005
Alabama	69.57	69.99	70.45	70.60	73.55	73.70	70.75	70.83
Alaska	59.80	56.04	57.38	58.27	61.22	61.34	58.39	57.58
Arizona	65.92	65.77	64.98	67.25	70.20	70.21	67.26	67.45
Arkansas	72.85	73.02	72.64	74.28	77.23	77.62	74.67	74.75
California	51.67	51.25	51.40	50.00	54.35	52.95	50.00	50.00
Colorado	50.00	50.00	50.00	50.00	52.95	52.95	50.00	50.00
Connecticut	50.00	50.00	50.00	50.00	52.95	52.95	50.00	50.00
Delaware	50.00	50.00	50.00	50.00	52.95	52.95	50.00	50.38
District of Columbia	70.00	70.00	70.00	70.00	72.95	72.95	70.00	70.00
Florida	56.62	56.62	56.43	58.83	61.78	61.88	58.93	58.90
Georgia	59.88	59.67	59.00	59.60	62.55	62.55	59.58	60.44
Hawaii	51.01	53.85	56.34	58.77	61.72	61.85	58.90	58.47
Idaho	70.15	70.76	71.02	70.96	73.97	73.91	70.46	70.62

[4] For the District of Columbia, the FMAP was permanently set to 70.00% starting in FY1998. For Alaska, the state percentage is calculated using the three-year average per capita income for the state divided by 1.05, for FY2001 through FY2005 only.

Region	FY2000	FY2001	FY2002	FY2003 (first 2 quarters)	FY2003 (last 2 quarters)	FY2004 (first 3 quarters)	FY2004 (last quarter)	FY2005
Illinois	50.00	50.00	50.00	50.00	52.95	52.95	50.00	50.00
Indiana	61.74	62.04	62.04	61.97	64.99	65.27	62.32	62.78
Iowa	63.06	62.67	62.86	63.50	66.45	66.88	63.93	63.55
Kansas	60.03	59.85	60.20	60.15	63.15	63.77	60.82	61.01
Kentucky	70.55	70.39	69.94	69.89	72.89	73.04	70.09	69.60
Louisiana	70.32	70.53	70.30	71.28	74.23	74.58	71.63	71.04
Maine	66.22	66.12	66.58	66.22	69.53	69.17	66.01	64.89
Maryland	50.00	50.00	50.00	50.00	52.95	52.95	50.00	50.00
Massachusetts	50.00	50.00	50.00	50.00	52.95	52.95	50.00	50.00
Michigan	55.11	56.18	56.36	55.42	59.31	58.84	55.89	56.71
Minnesota	51.48	51.11	50.00	50.00	52.95	52.95	50.00	50.00
Mississippi	76.80	76.82	76.09	76.62	79.57	80.03	77.08	77.08
Missouri	60.51	61.03	61.06	61.23	64.18	64.42	61.47	61.15
Montana	72.30	73.04	72.83	72.96	75.91	75.91	72.85	71.90
Nebraska	60.88	60.38	59.55	59.52	62.50	62.84	59.89	59.64
Nevada	50.00	50.36	50.00	52.39	55.34	57.88	54.93	55.90
New Hampshire	50.00	50.00	50.00	50.00	52.95	52.95	50.00	50.00
New Jersey	50.00	50.00	50.00	50.00	52.95	52.95	50.00	50.00
New Mexico	73.32	73.80	73.04	74.56	77.51	77.80	74.85	74.30
New York	50.00	50.00	50.00	50.00	52.95	52.95	50.00	50.00
North Carolina	62.49	62.47	61.46	62.56	65.51	65.80	62.85	63.63
North Dakota	70.42	69.99	69.87	68.36	72.82	71.31	68.31	67.49
Ohio	58.67	59.03	58.78	58.83	61.78	62.18	59.23	59.68
Oklahoma	71.09	71.24	70.43	70.56	73.51	73.51	70.24	70.18
Oregon	59.96	60.00	59.20	60.16	63.11	63.76	60.81	61.12
Pennsylvania	53.82	53.62	54.65	54.69	57.64	57.71	54.76	53.84
Rhode Island	53.77	53.79	52.45	55.40	58.35	58.98	56.03	55.38
South Carolina	69.95	70.44	69.34	69.81	72.76	72.81	69.86	69.89
South Dakota	68.72	68.31	65.93	65.29	68.88	68.62	65.67	66.03
Tennessee	63.10	63.79	63.64	64.59	67.54	67.54	64.40	64.81
Texas	61.36	60.57	60.17	59.99	63.12	63.17	60.22	60.87
Utah	71.55	71.44	70.00	71.24	74.19	74.67	71.72	72.14
Vermont	62.24	62.40	63.06	62.41	66.01	65.36	61.34	60.44
Virginia	51.67	51.85	51.45	50.53	54.40	53.48	50.00	50.00
Washington	51.83	50.70	50.37	50.00	53.32	52.95	50.00	50.00
West Virginia	74.78	75.34	75.27	75.04	78.22	78.14	75.19	74.65
Wisconsin	58.78	59.29	58.57	58.43	61.52	61.38	58.41	58.32
Wyoming	64.04	64.60	61.97	61.32	64.92	64.27	59.77	57.90
America Samoa	50.00	50.00	50.00	50.00	52.95	52.95	50.00	50.00
Guam	50.00	50.00	50.00	50.00	52.95	52.95	50.00	50.00
N. Marina Islands	50.00	50.00	50.00	50.00	52.95	52.95	50.00	50.00
Puerto Rico	50.00	50.00	50.00	50.00	52.95	52.95	50.00	50.00
Virgin Islands	50.00	50.00	50.00	50.00	52.95	52.95	50.00	50.00

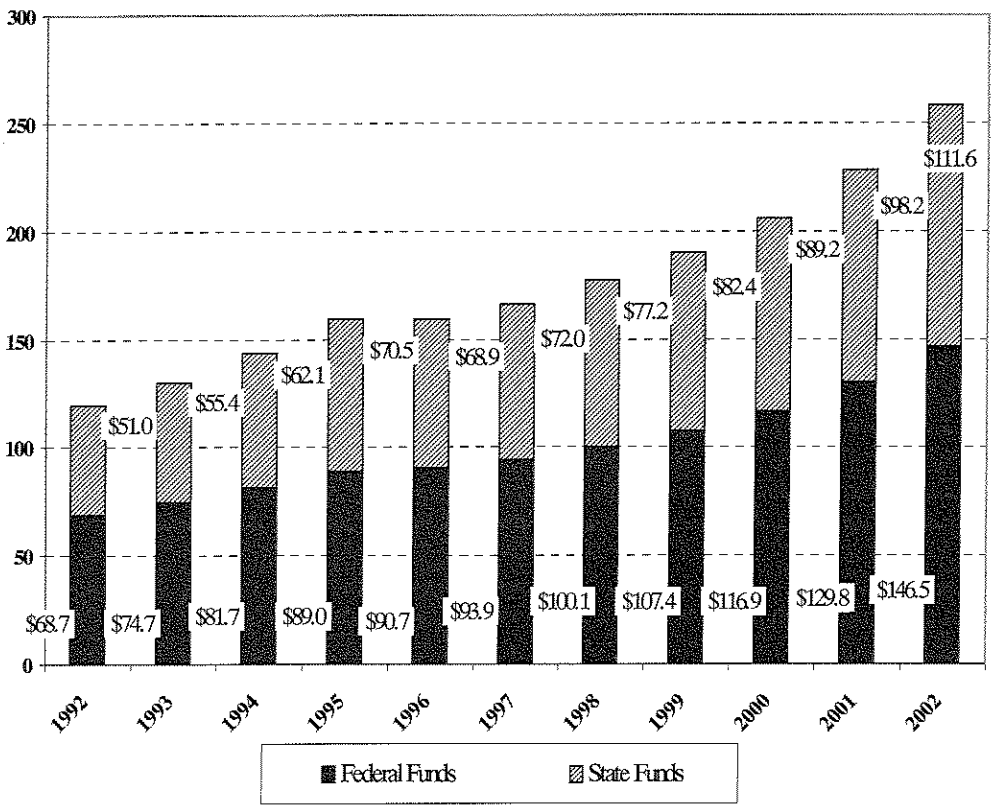
Source: Table prepared by the Congressional Research Service (CRS) from HHS regulations published in the *Federal Register;* letter to State Medicaid Directors SMDL #03-005, June 12, 2003.

In FY2002, total Medicaid expenditures (including administration) were $258.2 billion. The federal government share was $146.5 billion, or about 57%. For the period FY1992 through FY2002, the federal share of total Medicaid expenditures ranged from 56.5% to 57.4%, with the annual average share for the period being 56.7%. The temporary increase in the FMAPs provided by JGTRRA for FY2003 and FY2004 would not significantly increase the federal share. The Congressional Budget Office estimates that the temporary FMAPs changes only increased federal Medicaid expenditures in FY2003 by $4 billion or 2.5%[5].

In the 50 states and the District of Columbia, Medicaid is an individual entitlement. There are no limits on the federal payments for Medicaid as long as the state pays its share of the matching funds. In contrast, Medicaid programs in the territories are subject to federal spending caps.

Figure 1 illustrates total expenditures for Medicaid for FY1992-FY2002. For FY2002, total expenditures for Medicaid were $258.2 billion. The federal share of costs was $146.5 billion, while states spent $111.6 billion.

Figure 1. Federal and State Total Medicaid Expenditures, FY1992 - FY2002



Source: Congressional Research Service based on analysis from Centers for Medicare and Medicaid Services (CMS), Form 64.

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[5] *The Budget and Economic Outlook: Fiscal Years 2005 to 2014*, Congressional Budget Office, Jan. 2004, page 59.

Disproportionate Share Payments and Provider Taxes.[6] The disproportionate share hospital (DSH) adjustment was established in 1981 to give states greater flexibility to use payment methods for Medicaid other than the Medicare reimbursement principles and to provide protections for hospitals, particularly those with a high level of low-income and uninsured patients. In effect, hospitals designated as DSH hospitals receive a higher reimbursement for services than other providers. A portion of the reimbursement, paid to the state by the federal government through the FMAP funding mechanism, is called the DSH adjustment. Originally, there was no upper limit placed on DSH adjustments.

In the early 1990s the combination of a high growth rate in medical costs generally and an economic downturn resulted in states combining creative financing mechanisms, particularly provider taxes or donations, with DSH adjustments, which had no limit, to increase federal Medicaid payments. The increased federal payments, in effect, permitted the states to transfer part of the medical costs normally paid for by states (such as support for public hospitals) to the federal government. Between 1990 and 1992, DSH adjustments grew from less than $1 billion to $17.4 billion. After 1992 DSH adjustment growth slowed considerably, although the level of national DSH adjustments remains high — $15.4 billion in 2002.

Under provider taxes and donations, the state would impose a provider-specific tax or accept a "donation" from a Medicaid provider. These funds would be included as part of the state share of Medicaid funding and matched by the federal government. The providers would then have their taxes or donations returned by receiving higher payments than they would have otherwise received, including higher DSH adjustments, with any remaining funds retained by the state for other uses. Because DSH adjustments had no limit at the time and did not have to be tied to particular beneficiaries or services, they became a popular means of drawing down federal dollars. Not all states used this financing mechanism, but some states were very aggressive in their use of the mechanism with a large share of the federal payments diverted to other uses, including meeting the state's required matching rate.

An example of the financing mechanism using the provider tax would be as follows: the state Medicaid agency paid a DSH designated hospital $100 for services provided (reflecting a higher reimbursement level for a DSH adjustment), then claimed and received a $60 federal match (the state has a 60% FMAP). The hospital returned to the state, via a donation or tax, $80 of the $100 it was paid. At the end of the transaction, the hospital had been paid $20 by the state, but the federal government had reimbursed the state for $60, leaving an additional $40 the state could use for any purpose.

To curb the use of provider taxes and donations, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) restricted the use of donations to limited situations, and permitted states to impose any provider-specific taxes they wished. However, the federal match would be reduced dollar for dollar for any donations or taxes that did not meet specific

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[6] For a more complete history and analysis of DSH payments see CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne.

requirements. Specifically, the provider-tax had to be broad-based and subject to a cap on the amount of state Medicaid program expenses the taxes could be used to support.

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 also established national and state limits on DSH adjustments. The national limit was 12% of Medicaid costs in any year. The state limits were based on 1992 DSH adjustment levels. States with 1992 adjustment levels greater than 12% of the state's total Medicaid costs would receive adjustments at the 1992 levels until the adjustments became 12% of total Medicaid spending. States with 1992 adjustment levels below 12% of Medicaid costs could receive allotments increasing their adjustments up to a limit of 12%. In essence, states could continue to receive DSH adjustments, which are not based on actual services, up to 12% (generally) of Medicaid costs.

The size of total DSH adjustments and the lack of reliable data on what the adjustments accomplished focused attention on the payments, and they became a target of federal budget cutters. The Balanced Budget Act of 1997 (BBA 1997, P.L. 105-33) established specific levels of DSH adjustments for 1998 through 2002, with later years increasing by the growth in the Consumer Price Index (CPI). The annual limits were to decline over the 1998 to 2002 period, but the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554) relaxed the levels for 2001 and 2002. In 2003 the DSH allotment returned to the levels set by BBA 1997, resulting in a decline in the allotment compared to 2002. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) provided a 16% increase in adjustments for FY2004 and altered the calculation of future adjustments. In future years, if the calculated adjustment is equal to or does not exceed the FY2004 adjustment, the adjustment for that fiscal year will be the prior fiscal year adjustment increased by the CPI.

In FY2002 six states (New York, California, Texas, New Jersey, Louisiana, and Pennsylvania) accounted for over half of total DSH adjustments. DSH adjustments in FY2002 were $15.4 billion, or 6.2% of total net Medicaid payments.

Upper Payment Limits (UPL) and Intergovernmental Transfers (IGT).[7] In 1987 the Secretary of HHS issued regulations establishing upper payment limits (UPL) for different types of Medicaid covered services. Interacting with this policy was a provision of Medicaid law that allows state governments to fund up to 60% of the non-federal share of Medicaid expenditures with local government funds. It is this source of intergovernmental transfers that plays a role in state accounting practices for UPL and that has drawn the attention of Congress.

In 2000, it became apparent that some states were using the combination of UPL and intergovernmental transfers to receive payments in excess of what the federal

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[7] For a more detailed history and analysis of UPL and IGT see CRS Report RL31021, *Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action*, by Lisa Herz.

share of payments would have been based on the actual rate paid for services.[8] Those states were paying county or city service providers at rates above the usual payment rates to claim a higher federal match. The local providers would be required to return the excess payments to the state to cover part of the state Medicaid expenditures or for other purposes.

In the 1987 rules, states were allowed to pay all providers, regardless of ownership, up to 100% of the Medicare payment rate. As part of the financing mechanism, populations in private and public (city or county) hospitals were combined to determine the total expenditures for federal match, up to 100% of the Medicare rate. The private facilities were paid the normal Medicaid reimbursement rate (below 100% of the Medicare rate) with the excess (the amount that would bring total expenditures up to 100% of Medicare) going to public (city or county) facilities which were required to return the excess to the state through an IGT.

As part of the new rules imposed during the Clinton administration, public (city or county) hospital reimbursements had a UPL of 150% of the Medicare payment rate while private facilities remained at 100%. States had to treat private and public (city or county) patient populations separately in calculating total expenditures for the federal match. The Bush Administration changed the rules to impose the 100% of Medicare payment rates on these facilities, a move that has reduced this source of revenue for states during the current period of budget pressures.

However, because states can still "charge" the federal government at the UPL for the matching percentage, to the extent the UPL is above actual service costs, the state will receive additional or excess revenues. Intergovernmental transfers are still permitted for use in calculating state Medicaid expenditures within the program match requirements. This is because of the nature of state and local government relations. Local governments derive their authority, including taxing authority, from the state government, and can be viewed as units of state government. Therefore, funds the local government transfers to be used for Medicaid are no different from state funds used for Medicaid.

The Administration's FY2005 budget proposal contains two provisions which would impact state Medicaid financing through the use of the UPL and intergovernmental transfers[9]. In the budget, there are two new proposed initiatives to ensure the proper use of federal Medicaid payments: (1) limiting federal reimbursement to the cost of services provided; and (2) restricting the use of certain types of intergovernmental transfers. The budget proposal does not provide specifics on the two initiatives.

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[8] *Ibid*, pp 2-3

[9] U.S. Department of Health and Human Services, Budget in Brief: FY2005, Jan. 2004, p. 6.

Federal Medicaid Expenditure Growth

It has been noted that the history of Medicaid expenditures growth has five distinct periods.[10] These periods are defined as:

- 1965-1972. This was the period when Medicaid was introduced and states began to develop programs resulting in a growth rate for federal Medicaid spending of 53% a year. By 1972 every state except Alaska and Arizona had a program.
- 1973-1980. During this period the Supplemental Security Income (SSI) program for aged and disabled persons began and states had new options for institutional coverage. Federal Medicaid expenditures grew at a 15% annual rate.
- 1981-1989. During this period there were a number of legislative changes to Medicaid at the federal level, some to reduce costs and others to expand eligibility. The annual growth for federal Medicaid expenditures was 11%.
- 1990-1992. During this period federal Medicaid expenditures grew at a 28% annual rate reflecting the states use of creative financing mechanisms to maximize federal payments, particularly DSH payments at a time of economic downturn.
- 1993-1998. During this period reforms were made to DSH payments, welfare reform took place, and Medicaid spending restrictions were imposed on DSH, provider taxes, and provider donations to reduce federal Medicaid expenditures. The average annual rate of growth was 6%, but between 1995 and 1998 the rate of growth was only 3.7%.

Since 1998 Medicaid costs appear to have entered a new phase of growth, particularly for certain services. Estimates from the Office of the Actuary at the CMS[11] suggest that prescription drug expenditures for Medicaid (federal and state) grew at an annual rate of 22.7% between 1998 and 2001, and are projected to grow by 14.5% between 2001 and 2002, and at an annual rate of 15-17% for 2003 and 2004. The projections by the Office of the Actuary also reflect an increase in total (public and private) expenditures for prescription drugs of 84.1% between 1998 and 2002, with the public share of prescription drug expenditures increasing over this period from 21.1% to 21.7%. The growth in Medicaid expenditures for prescription drugs therefore reflects general changes in the price and usage of prescription drugs and is not a by-product of the Medicaid program rules. Medicaid expenditures for nursing home care grew between 1998 and 2001 by 17.1% and are projected to grow

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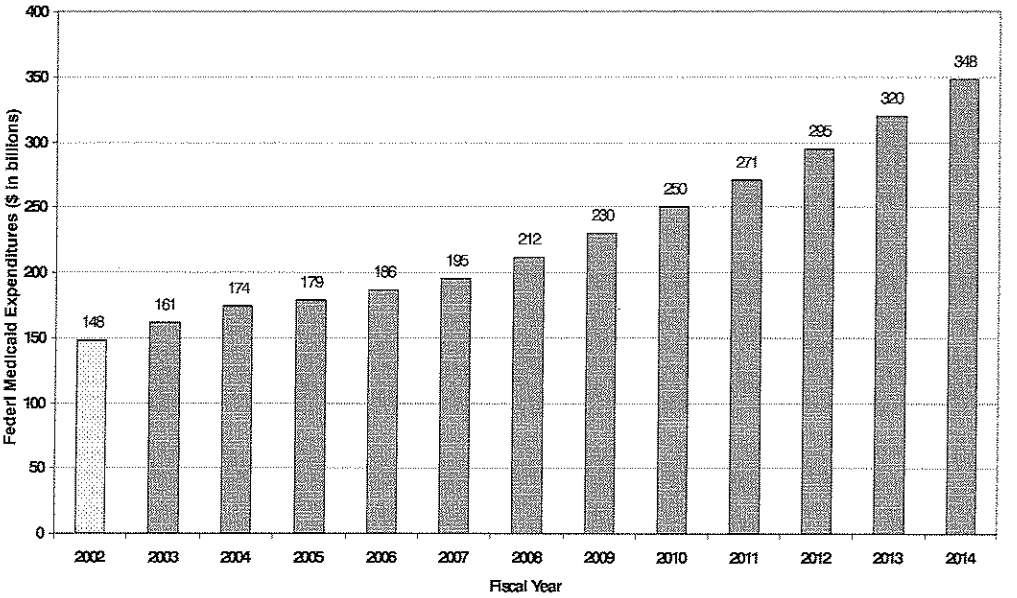
[10] Andy Schneider, and David Rousseau, "Medicaid Financing," The Medicaid Resource Book, The Kaiser Commission on Medicaid and the Uninsured, July 2002, Chapter 3, pp. 81-127.

[11] Office of the Actuary, Centers for Medicare and Medicaid Services, National Health Care Expenditures Projections: 2002-2012. Available on the CMS website at: [http://www.cms.hhs.gov/statistics/nhe/projections-2002/proj2002.pdf].

by 8.1% in 2002 and at annual rate of about 6% for 2003 and 2004. The public share of total nursing home expenditures is projected to increase from 58.7% in 1998 to 63.0% in 2002. The impact of these growth rates is significant because in FY2001, prescription drugs and nursing home facilities represented 9.2% and 19.9% of federal Medicaid assistance payments.

While the growth in total federal Medicaid expenditures was 8.8% between FY2002 and FY2003, the Congressional Budget Office (CBO) projects[12] a slower annual average growth rate of about 4% for the FY2004 through FY2007 period. This is because during this period the higher temporary FMAPs will expire, the Medicare prescription drug benefit program[13] will begin, and there have been changes to state programs which reduce growth in costs. After this period of slow growth, CBO projects that increasing medical prices and enrollment for Medicaid will result in an average annual rate of growth for total federal Medicaid expenditures of about 8.6% for the FY2008 through FY2014 period. **Figure 2** shows CBO actual and forecasted federal Medicaid expenditures for FY2002 through FY2014.

Figure 2. Actual and Forecasted Federal Medicaid Expenditures, FY2002-FY2014



Source: Congressional Research Service (CRS) based on information provided in the Congressional Budget Office Report *The Budget and Economic Outlook: Fiscal Years 2005 to 2014.*

Note: Fiscal year 2002 reflects actual federal Medicaid expenditures, all other fiscal years are estimates.

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[12] Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2005 to 2014*, Jan., 2004.

[13] For more information on the new Medicare benefit see CRS Report RL31966, *Overview of the Medicare Drug, Improvement and Modernization Act of 2003,* by Jennifer O'Sullivan, Hinda Chaikind, Sibyl Tilson, Jennifer Boulanger, and Paulette Morgan.

Beginning in 2006, the Medicare prescription drug benefit program will shift federal expenditures for drug benefits for the Medicaid population known as "dual eligibles" - those eligible for both the Medicaid and Medicare programs — from the Medicaid program to the Medicare program. This shift from Medicaid to Medicare however does not provide significant relief to the states for Medicaid prescription drug expenditures for dual eligibles. Currently, the Medicare program does not cover prescription drugs, but state Medicaid programs do include prescription drugs as an optional coverage not required by the federal government. Under a provision of the new Medicare prescription drug benefit program known as the "claw-back", states will be required to remit funds to the Medicare prescription drug benefit program based on a base amount - their FY2003 per person funding for prescription drugs for dual eligibles. While the share of this base amount that the states must pay declines over time from 90% to 75%, in effect the states will continue to pay for a share of the prescription drug benefits for dual eligibles.

Comparing Medicaid and Medicare Growth. A common comparison is that of personal health care expenditures for Medicaid and Medicare[14], which would show that while Medicare spending between FY1998 and FY2001 grew at an annual rate of 5.0%, Medicaid's annual spending growth for the same time period was 10.5%. However, the two programs differ in scope and coverage and are not directly comparable. The addition of the Medicare prescription drug benefit program will alter the growth rates of both programs in the future, but long term care for the elderly and disabled remains a Medicaid expenditure, and therefore partially a state responsibility.

Medicaid and State Budgets

There are two measures that can be used to assess the role of Medicaid in state budgets:

- total Medicaid expenditures as a share of total state expenditures; and
- state Medicaid expenditures as a share of total state-funded expenditures.

The first measure, 20.8% in state fiscal year (SFY) 2002, measures the total administrative size of the Medicaid program. Since it includes both federal and state expenditures, the fiscal responsibility of the states for Medicaid represents a smaller portion of this total.

However, because total state budgets include federal revenues for transportation and other federal grant programs in addition to Medicaid, the second measure is more reflective of the fiscal exposure that states face due to Medicaid. **Figure 3** illustrates the role that Medicaid has played in state budgets for SFY1989- SFY2002.[15] As **Figure 3** illustrates, Medicaid spending comprised 6.3% of state spending in

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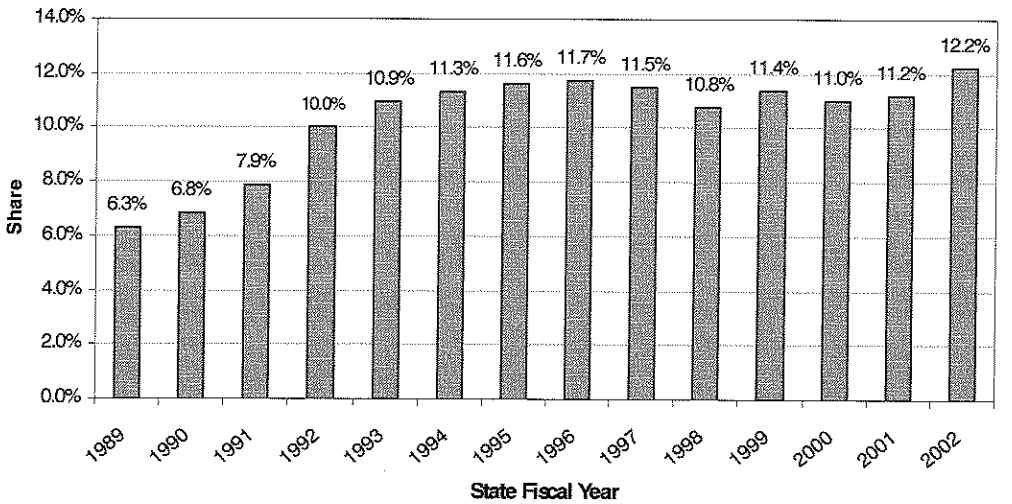
[14] *Ibid.*

[15] National Association of State Budget Officers, State Expenditures Report, various years. Information was not reported for certain states in some years.

SFY1989, and grew to 12.2% by SFY2002. The major growth period for Medicaid spending as a share of state-funded spending was in the early 1990s. The economic downturn, high growth in medical costs, and the use of DSH and other financing mechanisms (provider taxes or donations and intergovernmental transfers count as state expenditures) contributed to an increase in Medicaid's share from 6.3% in SFY1989 to 10.0% in SFY1992.

Figure 3. States Medicaid Expenditures as a Share of State-Funded Total Expenditures, State Fiscal Years 1989-2002



Source: Congressional Research Service (CRS) based on data collected by the National Association of State Budget Officers (NASBO). State expenditures do not include expenditures from federal revenues. The District of Columbia is not included.

During the mid to late 1990s Medicaid spending as a share of state-funded expenditures was 11.3% to 11.7%, with the share increasing to 12.2% in SFY2002. During the SFY1995 to SFY2000 period, total state-funded expenditures increased by an average annual rate of 6.5% while state-funded Medicaid expenditures increased by an average annual rate of 5.1%. During the SFY2000 to SFY2002 period this changed, and state-funded total expenditures increased by only 2.2% annually while state-funded Medicaid expenditures increased by 4.7%.

During the SFY1995 to SFY2000 period, state-funded expenditures for some functions - elementary and secondary education and corrections - increased at an annual rate higher than that of total state-funded expenditures, while state-funded expenditures for public assistance had a negative annual growth rate. For the SFY2000 to SFY2002 period, only the annual growth rates for Medicaid and higher education expenditures were higher than that of total state-funded expenditures, while the annual growth rates for both public assistance and transportation were negative.

In SFY2002 the Medicaid share of total state-funded expenditures ranged from 4.5% in Hawaii to 21.4% in Ohio. Actual expenditure data for SFY2003 is not yet available, but NASBO provides estimates of expenditures by category. Based upon

the NASBO expenditure estimates, Medicaid will increase to 12.6% of state-funded total expenditures in SFY2003. The state shares for Medicaid expenditures for selected years are shown in **Table 2.**

Table 2. State Medicaid Expenditures as a Share of State-Funded Total Expenditures by State, Selected State Fiscal Years

State	1990	1995	2000	2001	2002	2003(est)
Alabama	6.2%	7.3%	8.0%	8.5%	8.6%	7.4%
Alaska	2.8%	3.9%	N/A	N/A	N/A	N/A
Arizona	6.2%	7.7%	6.1%	6.4%	8.6%	8.2%
Arkansas	4.6%	6.1%	5.9%	6.3%	7.3%	6.5%
California	7.2%	11.1%	9.5%	9.5%	11.7%	11.4%
Colorado	7.2%	11.2%	10.7%	10.7%	10.7%	11.6%
Connecticut	5.5%	9.3%	20.7%	20.6%	19.2%	19.9%
Delaware	3.3%	6.1%	5.8%	6.0%	6.6%	6.9%
Florida	5.6%	8.9%	9.1%	9.4%	12.4%	13.6%
Georgia	5.9%	9.7%	9.3%	12.1%	13.8%	13.1%
Hawaii	3.3%	5.9%	4.9%	5.0%	4.5%	4.7%
Idaho	3.4%	5.9%	7.7%	8.5%	7.6%	8.1%
Illinois	7.9%	16.2%	14.2%	14.5%	14.8%	15.0%
Indiana	8.1%	9.2%	9.1%	9.9%	12.0%	12.0%
Iowa	4.4%	7.2%	6.9%	7.9%	11.2%	7.2%
Kansas	5.1%	5.8%	7.6%	7.9%	8.1%	8.6%
Kentucky	4.3%	7.7%	8.3%	8.4%	9.6%	9.6%
Louisiana	5.9%	6.2%	9.5%	10.2%	11.3%	9.3%
Maine	6.5%	10.0%	12.4%	12.0%	12.3%	13.2%
Maryland	6.7%	11.3%	10.7%	10.4%	11.4%	12.1%
Massachusetts	9.7%	11.5%	11.7%	9.9%	10.9%	11.5%
Michigan	9.3%	10.5%	11.2%	10.9%	10.9%	11.8%
Minnesota	8.3%	12.0%	11.5%	11.5%	12.6%	12.6%
Mississippi	4.6%	6.9%	7.3%	7.6%	9.8%	9.5%
Missouri	5.3%	10.6%	13.4%	14.9%	17.5%	18.6%
Montana	3.7%	6.7%	6.7%	6.3%	7.2%	6.7%
Nebraska	4.5%	7.3%	8.6%	9.5%	9.8%	9.4%
Nevada	N/A	6.6%	9.4%	10.3%	10.9%	8.6%
New Hampshire	10.2%	24.3%	16.7%	18.8%	18.6%	19.3%
New Jersey	8.6%	15.6%	12.2%	13.8%	13.1%	13.7%
New Mexico	2.5%	4.8%	4.8%	5.5%	7.1%	8.1%
New York	9.6%	22.2%	12.9%	12.2%	12.9%	14.3%
North Carolina	4.8%	4.7%	9.0%	10.0%	12.8%	12.9%
North Dakota	5.2%	6.7%	8.4%	8.5%	8.8%	9.0%
Ohio	7.0%	20.6%	18.5%	19.7%	21.4%	23.1%
Oklahoma	5.0%	6.3%	6.2%	6.9%	7.8%	8.5%
Oregon	3.3%	7.6%	6.1%	7.6%	7.9%	8.5%
Pennsylvania	8.1%	16.3%	18.4%	19.0%	18.7%	19.3%
Rhode Island	10.9%	17.9%	16.9%	16.5%	16.9%	16.5%
South Carolina	3.1%	8.1%	8.8%	8.9%	10.5%	11.1%

State	1990	1995	2000	2001	2002	2003(est)
South Dakota	6.3%	9.5%	8.4%	9.4%	10.5%	11.2%
Tennessee	7.8%	12.1%	15.1%	17.4%	19.3%	17.9%
Texas	6.6%	11.9%	13.2%	11.1%	12.8%	11.9%
Utah	2.8%	4.3%	4.8%	5.2%	5.9%	6.1%
Vermont	6.6%	11.7%	14.1%	12.0%	12.6%	N/A
Virginia	4.7%	7.5%	7.1%	7.2%	9.3%	8.5%
Washington	6.0%	9.0%	12.7%	13.3%	7.9%	8.2%
West Virginia	4.0%	9.9%	8.2%	8.0%	7.2%	7.2%
Wisconsin	6.9%	6.8%	4.9%	4.8%	5.5%	8.4%
Wyoming	2.0%	3.5%	5.8%	6.9%	7.9%	9.0%
TOTAL	6.8%	11.6%	11.0%	11.2%	12.2%	12.6%

Source: Congressional Research Service (CRS) based on data collected by the National Association of State Budget Officers (NASBO). State expenditures do not include expenditures from federal revenues. N/A indicates that data was not available for that fiscal year. SFY2003 is based on estimated expenditures data from NASBO. The District of Columbia is not included. For SFY2002 and SFY2003, Massachusetts reported all Medicaid expenditures as state expenditures. To more accurately reflect state-funded expenditures for Medicaid, the SFY2002 and SFY2003 state-funded Medicaid expenditures (for Massachusetts) are based on the SFY2001 state-funded share of total Medicaid expenditures.

Medicaid is not the largest share of state-funded expenditures in state budgets. The share for each function of state-funded expenditures will vary across states reflecting the executive and legislative priorities in each state. Excluding the unclassified or all other category, across all states, elementary and secondary education is the largest share of state-funded expenditures followed by higher education and Medicaid. A breakdown of the share of total state funded expenditures by function for SFY2002 is shown in **Table 3**.

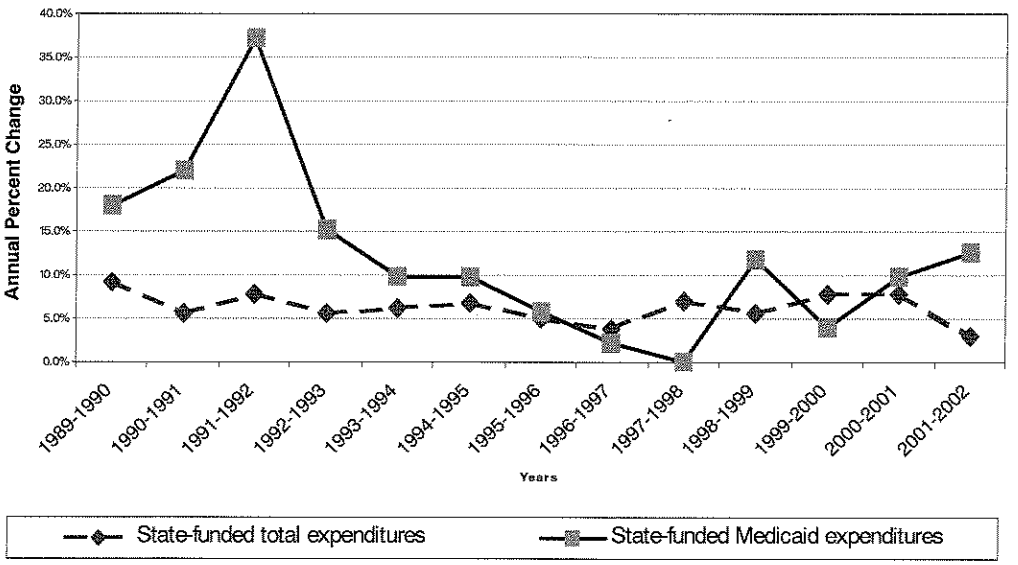
Table 3. Share of Total State Funded Expenditures by Function, State Fiscal Year 2002

Function	% of total
Medicaid	12.2%
Transportation	7.9%
Elementary and secondary education	25.9%
Higher education	13.5%
Public assistance	1.5%
Corrections	4.8%
Other (includes public health programs, economic development, general government, etc., not categorized elsewhere)	34.1%
Total	100.0%

Source: Congressional Research Service (CRS) based on data collected by the National Association of State Budget Officers (NASBO). State expenditures do not include expenditures from federal revenues. The District of Columbia is not included. Detail may not add to total due to rounding.

A comparison of the growth rates between state Medicaid expenditures and state-funded total expenditures, as in **Figure 4**, shows the impact of the economic downturn in the early 1990s and the economic boom of the late 1990s. In the early 1990s state Medicaid expenditures grew at very high annual rates, partially reflecting the use of financing mechanisms (provider taxes or donations and intergovernmental transfers are counted as state expenditures) to maximize the federal payments. In the late 1990s, the rates of growth for state Medicaid expenditures were generally lower than that of total state-funded expenditures reflecting the expansion of other state programs, particularly education, during the economic boom. In the most recent period, 2000 to 2002, Medicaid expenditures have grown at a faster rate than total state-funded expenditures reflecting a combination of the faster rate of growth in Medicaid service costs and the entitlement nature of the program.

Figure 4. Annual Growth Rates for State Medicaid Expenditures and State-Funded Total Expenditures



Source: Congressional Research Service (CRS) based on data collected by the National Association of State Budget Officers (NASBO). State expenditures do not include expenditures from federal revenues. The District of Columbia is not included.

Impact of the Medicare Prescription Drug Benefit Program

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) created a Medicare prescription drug benefit beginning in 2006 that will impact both state and federal financing of the Medicaid program. The financing for the drug program includes funds from state Medicaid programs. States will be required to provide funding for the drug program based on their level of Medicaid spending in FY2003 on prescription drugs for the portion of the Medicaid population known as "dual eligibles".

Dual eligibles are those persons eligible for both the Medicare and Medicaid programs[16]. Medicare does not currently have a prescription drug program, but all state Medicaid programs provide prescription drug coverage as an optional benefit (not required by the federal government). As a result, low-income elderly or disabled individuals eligible for Medicare may currently find it advantageous to join a state Medicaid program to receive prescription drug benefits as well as other Medicaid benefits.

Under the Medicare prescription drug plan, states must pay a percentage (90%, declining each year to 75%) of their FY2003 Medicaid spending on a per person basis for prescription drugs, for each dual eligible person enrolled in the Medicare prescription drug program. In effect, the states will be required to continue spending on prescription drugs for the dual eligibles.

The ultimate impact on state budgets and Medicaid programs of the Medicare drug program cannot be determined at this time, in part because the program does not begin until 2006. There are at least three areas of concern for Medicaid programs and financing in state budgets:

- *Medicaid Drug Coverage.* Medicaid drug coverage (and costs) for dual eligibles will change because states are prohibited from providing those drugs covered under the Medicare drug program. Until the Medicare drug program coverage is defined (the specifics are determined by the private sponsors of the plans), the impact on Medicaid plans and costs for dual eligibles is unknown.
- *Medicaid Drug Prices.* Under current law, Medicaid drugs are required to be purchased at the "best price" available. Under MMA the Medicare drug prices are set independently. There is no guarantee that they will be equal to, or higher than Medicaid drug prices, and may actually be lower. This may cause a conflict for Medicaid with the requirement for "best prices". The impact of this provision on Medicaid drug prices for individuals continuing to receive drug benefits under Medicaid is unknown.

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[16] For more specific information on individuals eligible for the new Medicare drug program see CRS Report RL31966, *Overview of the Medicare Drug, Improvement and Modernization Act of 2003,* by Jennifer O'Sullivan, Hinda Chaikind, Sibyl Tilson, Jennifer Boulanger, and Paulette Morgan.

- *Participation.* An individual eligible for Medicare may choose not to join the Medicaid program even if the individual is eligible. Under current law, participation in Medicaid programs by dual eligibles has traditionally been low. Once MMA is implemented, an individual applying for the new drug program, who is also eligible for Medicaid will be automatically enrolled in Medicaid. This could increase state Medicaid expenditures for two reasons: (1) utilization of services by the new enrollees; and (2) funding for the new enrollees in the drug program is partially paid by the state from the Medicaid portion of the state budget (even if the person would never have otherwise joined the Medicaid program).

In contrast to these unknowns, there is one impact on state Medicaid budgets that is certain: because every state will pay based on their FY2003 per capita spending, a state that had a more generous Medicaid drug benefit (in FY2003) will pay more per person from the state's budget than a state that had a less generous Medicaid drug benefit (in FY2003), for the same Medicare drug benefit in FY2006.

At the federal level, the new Medicare drug benefit may result in some funds shifting from the Medicaid program to the Medicare program. The CBO forecast for Medicaid reflects a lower growth rate (about 3%) in Medicaid spending for FY2005 through FY2007 reflecting the end of the temporary FMAP increases, the new Medicare drug program, and recent reductions in state Medicaid programs. The CBO forecast however, expects rising prices and greater consumption of services to raise the growth rate for federal Medicaid spending to increase to about 9% a year beginning on FY2008.

The Current State Fiscal Crisis

Forty-nine states have some form of a balanced budget requirement which is either constitutional, statutory or traditional interpretation.[17] These requirements can take one of the following forms:

- the governor's proposed budget must be balanced;
- the enacted budget must be balanced; or
- the budget must be balanced at the end of the fiscal year or biennium.

During the latter portion of the 1990s, states were experiencing a growth period in revenues. Revenues associated with a growing economy such as income taxes, and in particular capital gains, grew faster than official state predictions.[18] A survey of states by the National Conference of State Legislatures (NCSL) reported 30 states for SFY1998, and 24 for SFY1999 with revenues exceeding expectations, mostly

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[17] Vermont has no constitutional or statutory requirement for a balanced budget. The District of Columbia is not included in this discussion of the current state fiscal crisis due to the lack of data.

[18] National Conference of State Legislatures, State Fiscal Outlook for 1998, Jan. 1998. National Conference on State Legislatures, State Fiscal Outlook for 1999, Jan. 1999.

from sales and income taxes. In addition, states negotiated with the tobacco manufacturers a settlement that allocates funds to states based on several factors including Medicaid expenditures and the smoking rate. The tobacco companies are estimated to pay states that are part of the settlement approximately $200 billion between 1998 and 2023.[19]

As the economy has declined in recent years, so has the growth in the associated revenue streams. From a combination of the economic decline and tax cuts, some states may see an actual reduction in tax collections rather than a slowing of the growth rate in collections. In addition, expenditures for social and health services, such as Medicaid have increased due to growth in enrollments and inflation. A 2003 NCSL survey[20] reported that 16 states had revenues below forecasted levels for SFY2004 by November 2003 and that 22 states reported expenditures exceeding budgeted levels for some portion of the budget. In the survey, 13 of the 22 states reported that Medicaid or other health programs were over budget. The cumulative budget gap for SFY2004 was $2.8 billion by November 2003, compared to a budget gap (for SFY2003) a year earlier of $17.5 billion and 30 states reporting revenues below forecasted levels. This indicates that the fiscal pressures faced by states may not be as strong as a year ago, but the pressures are still present.

State and Federal Responses to the Current State Fiscal Crisis

States. To close a budget gap a state must either reduce expenditures, increase revenues, or both. Reducing expenditures for programs or general government operations will be based upon state priorities as determined by the governor and legislature. To the extent that states determine that other programs, such as education, are a higher priority than Medicaid, Medicaid expenditures may be reduced (through changes such as limiting eligibility or benefits). Prior to cutting programs, states generally use administrative and other tools to reduce program costs and eliminate any fraud or waste in the program. The federal changes beginning in the 1990s to restrict the use of certain financing mechanisms and limit federal cost increases closed off one avenue of relief states used in the fiscal crisis of the early 1990s.

A recent survey by the National Association of State Budget Officers[21] showed that by December 2003, states had undertaken a number of actions, including across-the board program cuts to close the projected budget gaps for SFY2003 and

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[19] Four states (Mississippi, Florida, Texas, and Minnesota) are not part of the national settlement as they reached separate settlements with the tobacco companies. The annual payment to the settlement parties (46 states, the District of Columbia, Puerto Rico, and the territories) is $6.5 billion in 2003 and $8 billion in 2004 through 2007 before adjustments for inflation and consumption changes.

[20] "State Budget Update: Nov. 2003," National Conference of State Legislatures, Nov. 19, 2003.

[21] "The Fiscal Survey of States", National Association of State Budget Officers, Dec. 2003.

SFY2004. **Table 4** shows by type of action taken for SFY2003 and SFY2004, the number of states choosing to undertake that action.

Table 4. Actions Taken by States to Close Budget Gaps in SFY2003 and SFY2004

Action	Number of States	
	SFY2003	SFY2004
Fee changes	16	8
Layoffs	16	10
Furloughs	9	1
Early retirement	13	3
Across-the-board percentage cuts	32	11
Reduction in local aid	11	8
Reorganization of programs	13	9
Privatization	0	0
Rainy Day Fund usage	29	6
Other	29	11

Source: Table prepared by the Congressional Research Service. Original data is provided by the National Association of State Budget Officers in The Fiscal Survey of States, Dec. 2003, Table A-5 and Table A-6.

Another recent survey[22] of state Medicaid administrators by the Kaiser Commission on Medicaid and the Uninsured showed that in FY2003 and FY2004, almost all of the jurisdictions (50 states plus the District of Columbia) included provider payment changes as a cost containment action in FY2003 and FY2004. The other cost containment strategy used by a majority of jurisdictions in FY2003 and FY2004 is pharmacy controls. **Table 5** shows, by type of Medicaid cost containment action taken for SFY2003 and SFY2004, the number of states choosing to under take that kind of action. Examples of some of the eligibility and benefit actions most frequently proposed or undertaken by states to reduce Medicaid costs or programs for SFY2003 and SFY2004 are shown in **Table 6**.

[22] "States Respond to Fiscal Pressure: State Medicaid Spending Growth, and Cost Containment in Fiscal Years 2003 and 2004, Results from a 50 State Survey", Kaiser Commission on Medicaid and the Uninsured, Sept. 2003.

Table 5. Medicaid Cost Containment Actions Taken by States in SFY2003 and SFY2004

Action	Number of States	
	SFY2003	SFY2004
Provider payments	50	49
Pharmacy controls	46	44
Co-pays	17	21
Benefit reductions	18	20
Fraud and abuse	19	19
Eligibility cuts	25	18
Disease/case management	13	18
Managed care expansions	6	11
Long term care	10	5

Source: Table prepared by the Congressional Research Service (CRS) from information provided in *States Respond to Fiscal Pressure: State Medicaid Spending Growth, and Cost Containment in Fiscal Years 2003 and 2004, Results from a 50 State Survey*, Kaiser Commission on Medicaid and the Uninsured, Sept. 2003.

Table 6. Examples of State Benefit and Eligibility Changes to Reduce Medicaid Costs in SFY2003 and SFY2004

Type of Action	States
Restriction or elimination of some (or all) dental service (including orthodontia and dentures) benefits (for some or all Medicaid populations)	California, Florida, Georgia, Indiana, Massachusetts, Michigan, Minnesota, Mississippi, Montana, New Hampshire, New Jersey, North Dakota, Oklahoma, Oregon, Utah, Vermont, Washington
Restrict or eliminate certain services: chiropractic, naturopathic, occupational therapy, physical therapy, speech therapy, or psychology for some (or all) Medicaid populations	Connecticut, Massachusetts, Michigan, New Jersey, North Dakota, Ohio, Pennsylvania, Utah, Vermont,
Restrict or eliminate vision services for some (or all) Medicaid populations	Florida, Mississippi, Montana, Nebraska, Pennsylvania, Oregon, Texas, Utah,
Restrict eligibility, including changes to income limitations and eliminating continuous eligibility - for some (or all) Medicaid populations	Alaska, Connecticut, Florida, Indiana, Minnesota, Missouri, Nebraska, Texas, Washington

Source: Table prepared by the Congressional Research Service (CRS) from information provided in *States Respond to Fiscal Pressure: State Medicaid Spending Growth, and Cost Containment in Fiscal Years 2003 and 2004, Results from a 50 State Survey*, Kaiser Commission on Medicaid and the Uninsured, Sept. 2003.

By December 2003, states had also undertaken a number of actions that would have an impact in SFY2004 revenues. States may have made more than one change for a specific revenue source, or made changes for more than one revenue source. **Table 7** shows the total revenue change enacted in states by revenue source, and the state or states with the single largest change (positive and negative) for SFY2004. Note that in **Table 7,** a state may be listed with the largest single negative and still have an overall positive change because: (1) revenues were shifted from one source to one or more others; and (2) offsetting increases.

Table 7. Total Revenue Changes Enacted by States By Type of Revenue, SFY2004

Type of Revenue	Total Revenue Change Among All States ($ in millions)	State(s) with Single Largest Negative Revenue Change Enacted ($ in millions)	State(s) with Single Largest Positive Revenue Change Enacted ($ in millions)
Sales Taxes	$2,569.7	Connecticut (-$115.7)	New York ($449.0)(*) New York ($451.0)
Personal Income Taxes	$2,461.4	West Virginia (-$9.0)	New York ($1,400.0) Connecticut ($428.3)
Corporate Income Taxes	$601.0	Florida (-$46.9)	New York ($174.6) Massachusetts ($174.0)
Cigarette and Tobacco Taxes	$751.1	None	Connecticut ($73.5) Nevada ($68.3)
Alcoholic Beverages	$46.5	None	Nevada ($13.9)
Motor Fuels Taxes	$132.9	None	Ohio ($129.9)
Other Taxes	$1,196.8	Nevada (-$60.9)	Illinois ($255.0) Delaware ($123.0) New Jersey ($111.0)
Fees	$1,809.5	None	Illinois ($414.0) Massachusetts ($218.0) Michigan ($178.7) Ohio ($130.6)

Source: Table prepared by the Congressional Research Service. Based on information contained in the National Association of State Budget Officers in *Fiscal Survey of the States*, Dec. 2003, Table A-11.

(*) New York enacted two large sales tax changes: an increase in the tax rate and a limitation on the exemption for clothing.

In addition to adjusting state expenditures and revenues, states can encourage the federal government to increase federal transfers to states for programs such as Medicaid.

Federal. During the 107th Congress, the Senate passed legislation (S. 812) to provide fiscal relief to the states through a temporary increase in the federal government's share of Medicaid program costs by increasing each state's FMAP. The Senate-passed bill would have maintained a state's FY2002 FMAP for FY2003 if the FY2003 FMAP was lower ("hold-harmless"). In addition, each state would have received an increase in its FMAP of 1.35 percentage points for FY2003. Although bills were introduced in the House to also provide a temporary increase in the FMAP, no further action occurred. Other proposals were considered that would have provided grants to states for general fiscal relief but did not specify that funds would be for Medicaid purposes.

In the 108th Congress, a number of bills have been introduced which would change the FMAPs by providing specific percentage point increases in the FMAPs.[23] JGTRRA (P.L. 108-027), the budget reconciliation bill, provided temporary fiscal relief to states through a combination of grants and an increase in the FMAP. The FMAPs for the last two quarters of FY2003 and the first three quarters of FY2004 are held harmless for declines from the prior year, and 2.95 percentage points are added to the FMAPs. In addition, the spending caps for the territories are raised by 5.9% for the last two quarters of FY2003 and first three quarters of FY2004. JGTRRA also provided $5 billion in grants to the states (including the District of Columbia, Puerto Rico, and the territories)in both FY2003 and FY2004 based on population. The grant funds must be used for improving education or job training, health care services, transportation or other infrastructure, law enforcement or public safety, and maintaining essential government services.

JGTRRA provided that to qualify for the increased FMAP payments, a state cannot have a Medicaid plan with more restrictive eligibility rules than the plan in effect on September 2, 2003. If a state restores program eligibility to the levels in effect on September 2, 2003, then the state would qualify for increased matching payments for the entire quarter in which eligibility was reinstated. Later legislation (H.R. 2854), P.L. 108-074, clarified the reinstatement provisions by providing that if a state reduces eligibility after September 2, 2003, and later restores eligibility to the September 2, 2003 levels, the state would qualify for the higher payments from the date of the eligibility restoration rather than for the entire calendar quarter.

If a state expands eligibility rules after the beginning of the higher payments (April 1, 2003) and before September 2, 2003, under JGTRRA the state would not be eligible for the higher payments for the period beginning on April 1, 2003 to the date that eligibility was expanded. P.L. 108-074 provided that under these circumstances, the state would be eligible for the higher payments.

In addition to legislation that would change the FMAPs, H.R. 328, a bill introduced by Representative Whitfield, would maintain the DSH allotments of BIPA 2000, preventing the decline in DSH allotments scheduled for FY2003. The bill would also increase the DSH allotment for the District of Columbia to $49 million. The Medicare Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-

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[23] For more information on legislation related to the FMAPs see CRS Report RS21262, *Federal Medical Assistance Percentage (FMAP) for Medicaid*, by Christine Scott.

173) included a provision to temporarily increase of 16% in DSH allotments for FY2004, altered the future calculation of allotments, and increased the floor for DSH allotments to certain "low DSH" states.

The Bush Administration Medicaid Reform Proposal.[24] As part of the FY2004 budget, the Bush Administration proposed Medicaid reform. Under the Medicaid reform proposal, states would have the option of operating their Medicaid programs under current rules with the current financing system, or under alternative rules with a federal allotment system of financing. Under the alternative, states would be required to provide comprehensive benefits for those individuals considered mandatory beneficiaries by the federal government, and this portion of the program would continue to be financed under FMAP rules. States would be granted flexibility to design benefits for individuals and services considered optional by the federal government. Based on the information provided in press releases by the Secretary of HHS, it is not clear exactly what limits would be placed on the flexibility being granted states. No legislation for the proposal has been introduced in the 108th session of Congress.

For the portion of the program related to optional beneficiaries, the administration proposal would have replaced the current entitlement to states for federal financing support with annual federal allotments for the Medicaid and SCHIP programs. There would be two annual allotments, one for acute care health insurance and one for long-term care and community services. States would be able to transfer funds between the two allotments. For FY2004 the allotments for each state for the portion of the program for optional beneficiaries would be based on the state's spending for Medicaid and SCHIP in 2002. The FY2004 allotment would be higher than what would be expected under the current Medicaid financing structure. The allotments would increase or decrease in future years based on an unspecified formula. For seven years, the allotments would be higher than the states would have received under current financing, but would be lower in the next three years and thereafter.

Other Recent Proposed Federal Initiatives. The Administration's FY2005 budget proposal contains two provisions which would impact state Medicaid financing through the use of the UPL and intergovernmental transfers[25]. In the budget, there are two new proposed initiatives to ensure the proper use of federal Medicaid payments: (1) limiting federal reimbursement to the cost of services provided; and (2) restricting the use of certain types of intergovernmental transfers. The budget proposal does not provide specifics on the two initiatives.

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[24] For more information on the impact of the reform proposal see CRS Report RL32020, *The Bush Administration's Medicaid Reform Proposal: Using Data to Estimate Mandatory and Optional Beneficiaries and Expenditures*, by Karen Tritz and Evelyne Baumrucker.

[25] U.S. Department of Health and Human Services, Budget in Brief: FY2005, Jan. 2004, p. 6.

In addition to the budget proposals, On January 7, 2004, CMS issued a notification of changes to Form CMS-37, the Medicaid Program Budget Report[26]. States must currently submit to CMS a quarterly financial statement, the Form CMS-37, containing funding requirements for the state Medicaid program and certifying that the necessary state and local funds will be available for the quarter. CMS then provides a grant to the state authorizing federal funding for the quarter. As part of the filing of the CMS-37 form, the state must provide the assumptions used by the state in developing their fiscal year budget for Medicaid expenditures. Under the proposed form changes, beginning in FY2005, states must provide with the Form-37 filing documentation supporting the assumptions used in developing the fiscal year budget and Medicaid expenditures prior to the beginning of the fiscal year. The purpose of the changes is to identify and correct and funding or expenditure issues before the fiscal year begins and Medicaid expenses have been incurred.

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[26] *69 Federal Register 923*, Jan. 7, 2004, vol. 69, no. 4.