



February 9, 2016

TO: Members, Subcommittee on Health

FROM: Committee Majority Staff

RE: Hearing: “Examining Medicaid and CHIP’s Federal Medical Assistance Percentage”

I. INTRODUCTION

On Wednesday, February 10, 2016, at 10:00 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled “Examining Medicaid and CHIP’s Federal Medical Assistance Percentage.”

II. WITNESSES

- Alison Mitchell, Analyst in Health Care Financing, Congressional Research Service (CRS);
- Carolyn Yocom, Director, Health Care, Government Accountability Office (GAO);
- Anne Schwartz, Executive Director, Medicaid and CHIP Payment and Access Commission (MACPAC); and,
- John Hagg, Director of Medicaid Audits, Office of Inspector General, U.S. Department of Health and Human Services (HHS OIG).

III. BACKGROUND

Medicaid Today

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services, as well as long-term care (services and supports) for eligible individuals. The Medicaid program today is a critical lifeline for some of our nation’s most vulnerable patients, as the program provides health care for children, pregnant mothers, the elderly, the blind, and the disabled.

Medicaid currently covers nearly 72 million Americans — more than Medicare — and up to 83 million may be covered at any one point in a given year.¹ The Federal government

¹ <https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/october-2015-enrollment-report.pdf> and <http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2015-03-Medicaid.pdf>

currently spends more general tax revenue on Medicaid than it does on Medicare. During fiscal year 2016, Federal and State Medicaid outlays are expected to be approximately \$545 billion. Today, Medicaid accounts for more than 15 percent of all health care spending in the United States and plays an increasingly large role in our nation's health care system.²

Representing roughly one in every four dollars in a State's average budget, Medicaid accounts for nearly half of national spending on long-term services and supports, and roughly a quarter of all mental health and substance abuse treatment spending. At the same time, Medicaid, along with the Children's Health Insurance Program (CHIP), pays for roughly half of all births in the United States each year.³

The Federal Medical Assistance Percentage

The Federal government's share of most Medicaid expenditures is determined by the Federal Medical Assistance Percentage (FMAP) rate. Section 1905(b) of the Social Security Act specifies the statutory formula for calculating FMAP rates.⁴

The current Medicaid FMAP formula has largely been the backbone of Medicaid since the creation of the program in 1965. In fact, the current formula is an outgrowth of variable rate matching formulas going back even further, to formulas first discussed by Congress in the late 1940s. As GAO has noted, Senate reports accompanying the Social Security Act Amendments of 1946 first articulated, in the case of public assistance, the rationale for a variable rate matching formula based on State per capita income.⁵ Then, in 1958, amendments to the Social Security Act that year established a per capita income-based variable rate matching formula, with certain maximums, for public assistance and reimbursement of medical providers. Under this formula, Federal matching rates ranged from a minimum of 50 percent for high-income States to a maximum of 65 percent for low-income States. Later, the Social Security Amendments of 1960 increased the maximum matching rate from 65 percent to 80 percent.

When Medicaid was created in 1965, Congress increased the Federal government's total nationwide share financed from 50 to 55 percent and raised the maximum Federal matching rate from 80 to 83 percent. Today, the FMAP formula compares each State's per capita income relative to U.S. per capita income. The formula provides higher reimbursement to States with lower per capita incomes and lower reimbursement to States with higher per capita incomes. Per capita income is used as a proxy for both State resources and the low-income population in need of Medicaid services in each State. Federal statute outlines a statutory maximum of 83 percent and a statutory minimum of 50 percent. The U.S. Department of Health and Human Services

² <https://www.macpac.gov/wp-content/uploads/2015/01/Table-16.-National-Health-Expenditures-by-Type-and-Payer-2012.pdf>

³ Alison Mitchell, Evelyne Baumrucker, and Elicia Herz, "Medicaid: An Overview," Congressional Research Service report R43357, August 3, 2015.

⁴ The FMAP rate is also used in determining the phased-down State contribution (clawback) for Medicare Part D, the Federal share of certain child support enforcement collections, Temporary Assistance for Needy Families (TANF) contingency funds, a portion of the Child Care and Development Fund (CCDF), and foster care and adoption assistance under Title IV-E of the Social Security Act.

⁵ <http://www.gao.gov/new.items/d03620.pdf>, see Appendix I

(HHS) publishes FMAP rates for an upcoming fiscal year in the *Federal Register* during the preceding year.⁶

While the FMAP rate is used to reimburse States for the Federal share of most Medicaid expenditures for medical services and long-term services and supports, exceptions to the regular FMAP rate have been made for certain States, situations, populations, providers, and services. In this case, Federal financial participation for matching State Medicaid expenditures is determined either by specific matching rates outlined in statute or an enhanced FMAP, which is effectively a specified add-on to a base FMAP. For example, the Federal matching rate for Medicaid administrative services does not vary by State and is generally 50 percent, although certain administrative functions, such as the operation of certain information technology systems, have a higher Federal match rate.

Factors Affecting State FMAPs

There are several key factors that directly impact States' FMAP rates. For example, the relative health of a State's economy depends in large part upon the structure of the State economic outlook (State spending, tax rates, etc.) and its business sectors. Significant changes to business sectors within a State could impact the State's average per capita income, which could have a delayed impact on a State's FMAP.

Additionally, Medicaid's FMAP formula relies on per capita personal income *in relation to* the U.S. average per capita personal income. So, if a large region of the country experiences an economic decline, to some extent, the national economy reflects this decline. While the national decline would be offset by States with small decreases or even increases in per capita income, this relative change could have downstream calculations in later years on the FMAP rates. Nationally, per capita personal income changes only a modest amount each year. However, since the FMAP formula compares State changes in per capita personal income to the U.S. per capita personal income, this comparison can result in significant State FMAP rate changes.

Major Changes to FMAP In Recent Years

- **ARRA.** In response to the 2007 recession, Congress provided States with increased FMAP funding through the American Recovery and Reinvestment Act of 2009, which totaled an estimated \$89 billion through December 2010. Subsequently, Congress extended this source of funding through June 30, 2011, subject to certain modifications, which provided States additional Federal assistance.
- **PPACA.** In March 2010, the Patient Protection and Affordable Care Act (PPACA) provided States the option to expand Medicaid eligibility to include most individuals with incomes at or below 138 percent of the Federal poverty level (FPL) beginning in January

⁶ This time lag between announcement and implementation provides an opportunity for States to adjust to FMAP rate changes. Federal financial participation for current and preceding fiscal years can be accessed online: <https://aspe.hhs.gov/Federal-medical-assistance-percentages-or-Federal-financial-participation-State-assistance-expenditures>

2014 (or earlier for “early expansion” States). Under current law, the Federal financial participation for the newly eligible individuals is 100 percent through calendar year 2016. Next year, the Federal financial participation for this population is 95 percent. The percentage reduces in further years until it reaches 90 percent in 2020 and thereafter.

- **CHIP.** Section 2105(b) of the Social Security Act specifies an enhanced FMAP (E-FMAP) rate for both services and administration under CHIP, subject to the availability of funds from a State's Federal allotment for CHIP. When a State expands its Medicaid program using CHIP funds (rather than Medicaid funds), the E-FMAP rate applies and is paid out of the State's Federal allotment. The E-FMAP rate is calculated by reducing the State share under the regular FMAP rate by 30 percent.⁷ By statute, the E-FMAP can range from 65 percent to 85 percent. However, the Affordable Care Act included a provision to increase the E-FMAP rate by 23 percentage points (not to exceed 100 percent) for fiscal year 2016 through fiscal year 2019. Thus, for those years, the E-FMAP can range from 88 percent to 100 percent. This matching rate was kept when Congress extended the funding allotments for CHIP through September 30, 2017.

Selected Challenges with the FMAP

There are a number of practical challenges with the current FMAP that have been previously identified and studied by numerous nonpartisan entities. Numerous parties have testified before Congress that the current formula does not address wide differences among States in their ability to fund their Medicaid programs and that the formula’s reliance on per capita income is the primary cause.

States’ Funding Ability. For example, in 2003, GAO reported that the Medicaid formula narrows the average difference in States’ funding ability by 20 percent, but often widens the gap between individual States and the national average.⁸ If the goal of Medicaid’s statutory formula is to narrow differences among States in their ability to fund Medicaid services, GAO noted that there are two factors constraining the formula from being fully effective in this regard: (a) per capita income is not a comprehensive indicator of a State’s total available resources and is a poor measure of the size of and cost to serve a State’s people in poverty, and (b) the statutory provision that guarantees no State will receive less than a 50 percent matching rate benefits many States that already have above-average resources to fund health care for their populations in poverty.⁹

Countercyclical Dynamic. In general, Medicaid enrollment rises in inverse relation to economic growth and business development – meaning that more people generally become eligible for the program during economic downturns. This dynamic presents a challenge for States, since they have responsibility to pay for part of the program, but usually face additional budgetary pressures during such a downturn. Examining specific examples in recent history, GAO explained that “as economic activity slowed during the 2001 and 2007 recessions, States’

⁷ Alison Mitchell, “Medicaid’s Federal Medical Assistance Percentage (FMAP), FY2016, CRS report R43847, January 5, 2015.

⁸ <http://www.gao.gov/assets/240/238910.pdf>

⁹ <http://www.gao.gov/assets/240/238910.pdf>

revenues decreased, which hampered States' ability to fund their existing Medicaid services and support new enrollment."¹⁰ In 2011, GAO summarized the challenges well, noting:

Past recessions hampered States' ability to fund increased Medicaid enrollment and maintain existing services. Within this broad national trend, however, there was significant variation among States in terms of their increases in Medicaid enrollment and revenue losses. Further, these enrollment increases and revenue declines continued after the national recessions ended, and States made additional adjustments to their Medicaid programs.¹¹

Value for Beneficiaries and Taxpayers. It is well known that per capita income — the key data source for calculating a State's FMAP — does not accurately represent States' populations in need of Medicaid services or States' ability to finance services, and does not account for geographic cost differences among States. Over a number of years and reports, GAO identified multiple data sources that could be used to develop measures to allocate Medicaid funding to States more equitably than the current FMAP.¹² GAO summarized the benefit of alternate approaches which could be more equitable, fair, and efficient than the current FMAP. As GAO summarized, "to be equitable from the perspective of beneficiaries and allow states to provide a comparable level of services to each person in need, a funding allocation mechanism should take into account the demand for services in each state and geographic cost differences among states."¹³ To be ensure taxpayers are treated equitably, GAO noted "an allocation mechanism should ensure that taxpayers in poorer states are not more heavily burdened than those in wealthier ones, by taking into account state resources."¹⁴

In recent years, GAO not only examined alternate metrics, but it developed a prototype formula as well. Interestingly, GAO also compared the hypothetical performance of its prototype formula against the spending levels and FMAP allocations Congress appropriated to address the Great Recession. Under GAO's prototype formula, States would have received up to 15 quarters of assistance (beginning in January 2008 and extending through September 2011) at a cost of \$36 billion, which would have been billions of dollars less than what was actually spent by Congress.¹⁵

Program Integrity. For fiscal year 2015, HHS OIG identified the top management and performance challenges facing HHS as "protecting an expanding Medicaid program from fraud, waste, and abuse." HHS OIG noted that "protecting the integrity of Medicaid takes on heightened urgency as expenditures and beneficiaries served continue to grow," especially Medicaid's "long-standing program integrity issues."¹⁶ According to HHS, the national fiscal year 2015 Medicaid improper payment rate was 9.78 percent. HHS calculated and reported the

¹⁰ <http://www.gao.gov/assets/320/317266.pdf>

¹¹ <http://www.gao.gov/assets/320/317266.pdf>

¹² <http://www.gao.gov/products/GAO-13-434>

¹³ <http://www.gao.gov/products/GAO-13-434>

¹⁴ <http://www.gao.gov/products/GAO-13-434>

¹⁵ <http://www.gao.gov/products/GAO-12-38>

¹⁶ <http://oig.hhs.gov/reports-and-publications/top-challenges/2015/2015-tmc.pdf>

national Medicaid error rate based on measurements that were conducted in fiscal years 2013, 2014, and 2015.¹⁷

State Actions That Inflate Federal Costs. While the costs and responsibilities for administering it have been shared between the States and the Federal Government, HHS OIG has issued a number of reports citing examples of State policies that distort the cost-sharing arrangement, causing the Federal Government to pay more than its share of Medicaid expenditures. As the HHS OIG notes, such mechanisms “do not result in any increase in benefit to beneficiaries, and while they increase States’ funds, they do so at the expense of the Federal Government and, ultimately, Federal taxpayer.”¹⁸ For example, some State taxes levied on health care providers or Medicaid managed care organizations have appeared to be an “impermissible health-care-related tax” under Federal requirements.¹⁹ Other HHS OIG work has identified repeated concerns regarding Medicaid reimbursement rates to State-owned residential rehabilitation services centers and State-owned developmental centers.²⁰

Targeting Enhanced Federal Financial Participation. Many who support increased Federal financial participation and enhanced matching rates for certain services, populations, or activities argue that such rates are an effective way to ensure States implement or adopt certain policies or practices. However, analysis of one recent experiment with an increased level of Federal financial participation suggests a higher match rate may not always yield the desired outcome. PPACA included a provision that required that all State Medicaid programs increase payment for certain primary care services to Medicare payment levels during calendar years 2013 and 2014. As the Medicaid and CHIP Payment and Access Commission noted, this increase in payment rates was fully Federally funded, and while the Federal government has spent \$7.1 billion on increased payments for services to date, the total may grow as States continue processing eligible claims.²¹ The payment increase was intended to address the need to maintain provider networks for those currently enrolled in Medicaid in light of the PPACA expansion of Medicaid eligibility. Yet, after a review of some available data and broad conversations with officials in various States, the Commission concluded “there is not enough evidence to definitively determine whether the payment increase had an effect on provider participation or enrollee access to primary care in Medicaid.”²²

IV. ISSUES IN FOCUS

Members have an opportunity to consider the advantages and disadvantages of the current FMAP system. For example, Members may be interested in discussing:

¹⁷ <http://www.hhs.gov/afr/>

¹⁸ <http://oig.hhs.gov/newsroom/spotlight/2014/inflated-federal-costs.asp>

¹⁹ <http://oig.hhs.gov/newsroom/spotlight/2014/inflated-federal-costs.asp>

²⁰ <http://oig.hhs.gov/newsroom/spotlight/2014/inflated-federal-costs.asp>

²¹ <https://www.macpac.gov/wp-content/uploads/2015/03/An-Update-on-the-Medicaid-Primary-Care-Payment-Increase.pdf>

²² <https://www.macpac.gov/wp-content/uploads/2015/03/An-Update-on-the-Medicaid-Primary-Care-Payment-Increase.pdf>

- What are the key challenges to States and the Federal government due to the lag between data being collected and its use for the FMAP being determined?
- What are the relative incentives and disincentives for State Medicaid programs based on how the FMAP operates today?
- What is known about the degree to which enhanced rates of Federal financial participation have improved the program integrity, provider participation, quality of care, or health outcomes for patients in Medicaid?
- What improvements or modifications to the FMAP and current Federal financing of Medicaid could improve States' Medicaid spending predictability, accountability, equity, or efficiency?

V. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Josh Trent or Michelle Rosenberg of the Committee staff at (202) 225-2927.