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# The Mechanics of Medicaid

*How Medicaid's flawed financial design drives program costs*

KEY FACTS:

- **With a nationwide price tag of almost half a trillion dollars, Medicaid is the largest public health insurer in the United States. It currently serves over 72 million low-income patients.**
- **Medicaid's fundamental flaws stem from the way in which it is funded, as both state and federal government share the total bill. North Carolina's $14 billion program currently pulls down a 65 percent federal match — well above the national average.**
- **Each state's federal share, their Federal Medical Assistance Percentage (FMAP), is renewed every year. Federal funding creates a strong disincentive for North Carolina to flush out waste in the system, since a hefty portion of any savings reverts back to the feds.**
- **A prime example in which North Carolina uses Medicaid's federal share to its advantage is its Provider Assessment Act of 2011, which imposes taxes on certain classes of medical providers. The state uses this revenue to shell out enhanced reimbursements to medical providers, which in turn pulls down more federal funds. The state can use these excess federal funds for budget purposes not limited to Medicaid.**
- **If Medicaid's federal share was transferred to North Carolina as an annual block grant, the state would have to shoulder more program costs. But this injection of fiscal responsibility would allow lawmakers to exercise more control over the program and create a stronger incentive to sort out system waste and abuse.**
- **It would be ideal for a universal, refundable tax credit to be distributed to healthier, able-bodied Medicaid patients. This premium support model could cover the cost of private coverage, freeing up Medicaid funds to more effectively coordinate care for the most vulnerable medical assistance populations — the elderly, blind, and disabled and those in need of mental and physical long-term care.**

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Since its inception in 1965, Medicaid has evolved into a behemoth program. With a nationwide price tag of almost half a trillion dollars, Medicaid is the largest public health insurer in the United States.[1] It currently serves over 72 million low-income patients, surpassing the total number of Medicare beneficiaries.[2, 3]

Lawmakers across the nation who have vetoed Obamacare's optional Medicaid expansion claim that broadening the safety net would create serious state budgeting issues in the long run. Reforming Medicaid's already broken system ranks as a higher priority on their legislative agendas. Even without expansion, North Carolina continues to struggle with managing its Medicaid budget. Over the past four fiscal years, cost overruns have amounted to $2 billion.[4]

**Competing Plans**

Plans to reform North Carolina's Department of Health and Human Services (DHHS) medical assistance program are ongoing, but tensions remain between the Republican-controlled upper and lower chambers. Governor Pat McCrory vocally advocates for an Accountable Care Organization (ACO) initiative, where provider-led groups and hospitals delivering care to certain Medicaid populations would still be paid fee-for-service, as they are under the current Medicaid model. ACOs, however, would share with the state any savings or losses relative to a benchmark budget. The House has signaled support for this "managed care lite" approach as well. Meanwhile, the Senate believes that provider-led plans and/or for-profit managed care organizations bearing full financial risk minus enrollment shifts would better strengthen budget predictability.

Despite the divisiveness, North Carolina lawmakers and interest groups agree that it is paramount to rein in unnecessary Medicaid costs and improve patient health outcomes. If we examine the fiscal side of Medicaid, it's no secret that the program consumes a significant portion of North Carolina's DHHS budget. Of the $5 billion allocated to DHHS from the General Fund, Medicaid devours around $3 billion.[5] The program alone represents approximately 20 percent of the General Fund. But if we step back and account for Medicaid's total cost — state and federal funds combined — taxpayers foot the bill for a $14 billion program.[6]

**A Broken Funding System**

Medicaid *does* cost too much, but such a loaded statement needs some explanation.

Medicaid's fundamental flaws and ultimate cost drivers stem from the way in which it is funded, as both state and federal government share the total bill.[7, 8] The federal medical assistance percentage (FMAP), or federal match rate, operates based on a formula dependent on each state's average per-capita income. By statute, the match ranges from a minimum of 50 percent to a maximum of 83 percent. Wealthier states receive less aid from the federal government, while lower-income states receive more.

According to the Kaiser Family Foundation, the federal government on average pays 57 percent of the costs of Medicaid nationally.[9]

North Carolina currently pulls down a 65 percent federal match for the cost of medical services delivered to Medicaid beneficiaries, but federal shares vary for other aspects of Medicaid spending. Administrative services typically receive a 50 percent match, while Obamacare offers a generous 90 percent match until 2016 for the design and implementation of NC Tracks, the state's Medicaid billing system. Beyond 2016, the Obamacare match phases down to 75 percent.

North Carolina's children's health insurance program, Health Choice,[10] also has an enhanced federal match rate (EFMAP) of 75 percent and will be almost completely covered by the feds in 2015 due to the requirements of the federal health law — another incentive for states to expand Medicaid.[11, 12]

Because each state's federal match is renewed every year based on state and federal income data from the previous three years, a heavy reliance on federal money followed by spendthrift habits inevitably occurs. Such federal ties also create a strong disincentive for states to flush out waste from the system, since a hefty portion of any savings would revert back to the feds.[13] For example, if North Carolina eliminated its optional medically needy population (low-income individuals who would not otherwise qualify for Medicaid but are burdened with high medical expenses), total savings would reach $20.8 million, but the state's General Fund would only save approximately $7.1 million of this amount.[14]

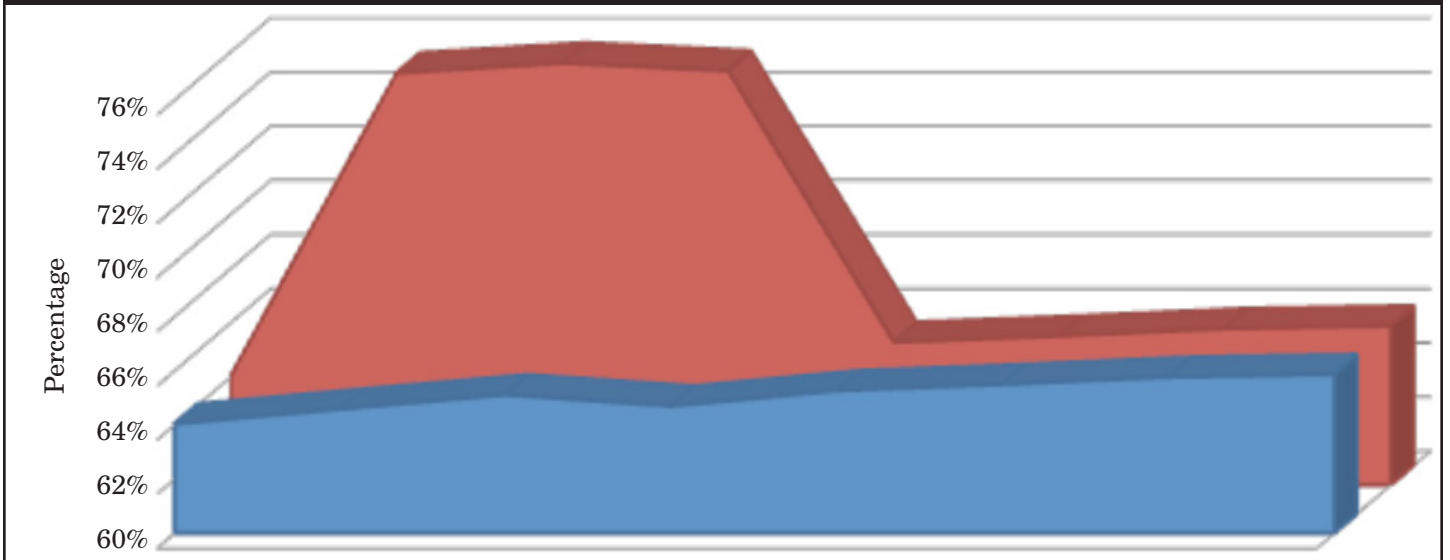
Avik Roy further outlines the perverse outcomes for a state with a 60 percent federal match rate in his must-read book, "How Medicaid Fails the Poor."

> That means that for every dollar a state spends on its Medicaid program, the federal government will kick in an additional $1.50. It's not every day that a state politician gets to spend one dollar of his constituent's money and gain credit for spending nearly $2.50 in return. But that's how Medicaid works. As a result, irresponsible officials in many states have ratcheted up their Medicaid spending, knowing that taxpayers in other states will be forced to foot a good chunk of the bill.[15]

Moreover, Medicaid's financial design generated further unfortunate consequences when Congress authorized enhanced federal aid during the severe economic slumps of 2002 and 2008. The federal stimulus package (American Recovery and Reinvestment Act) passed in 2009 increased the FMAP from a minimum of 6 percent across the board to as much as 14 percent for some states.[16] This temporary federal largesse was intended to help states manage increases in caseloads and assisted those that decided to expand eligibility and services.

But once the heightened match phased out in 2011, both conservative- and liberal-leaning states cut programs and increased costs for patients. Joseph Antos cites one such example:

**North Carolina's Medicaid Matching Rates**
**FY 2008 to FY 2015[17]**




| | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|---|---|
| FMAP | 64.1% | 64.6% | 65.1% | 64.7% | 65.3% | 65.5% | 65.8% | 65.9% |
| EFMAP | 64.1% | 75.2% | 75.6% | 71.3% | 65.3% | 65.5% | 65.8% | 65.9% |

Source: U.S Department of Health and Human Services, "Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures FMAP," FY 2008-15.

> The shift back to much lower match rates required most states to adopt aggressive cost-reducing policies. Illinois limited Medicaid enrollees to no more than four prescriptions a month, imposed a copayment for prescriptions for adults who are not pregnant, eliminated nonemergency dental care for adults, and cut 25,000 adults from the rolls. Other states cut pay for health care providers, eliminated coverage for optional services, imposed new fees for the routine use of hospital emergency rooms, and increased other payments made by Medicaid enrollees.[18, 19]

These kinds of scenarios again demonstrate that Medicaid's fluctuating federal funds make budgeting less predictable and therefore more difficult. Although enhanced match rates help states maintain their required balanced budgets, especially in times of economic crisis, this funding formula inadvertently entices states to provide generous Medicaid benefit packages — in some cases *more comprehensive than private coverage*[20] — that they are not always able to maintain. (See below the list of federally required Medicaid services along with North Carolina's optional benefits.)

**Services Covered by N.C. Medicaid by Mandatory and Optional Categories**[21]

| MANDATORY | OPTIONAL |
|---|---|
| • Ambulance and Other Medical Transportation<br>• Dental Services (children; includes dentures)<br>• Durable Medical Equipment<br>• Family Planning<br>• Clinic Services (Federally Qualified Health Centers and Rural Health Clinics)<br>• Health Check (EPSDT)<br>• Hearing Aids (children)<br>• Home Health<br>• Hospital Inpatient<br>• Hospital Outpatient<br>• Nurse Midwife<br>• Nurse Practitioner<br>• Nursing Facility<br>• Other Laboratory and X-ray<br>• Physician<br>• Psychiatric Residential Treatment Facility Services and Residential Services (treatment component only) for under age 21<br>• Routine Eye Exams and Visual Aids (children) | • Case Management<br>• Chiropractor<br>• Clinic Services (Health Department and Mental Health)<br>• Community Alternatives Programs (CAP)<br>• Dental and Dentures (adults)<br>• Diagnosis, Screening and Preventive<br>• Health Maintenance Organization (HMO) Membership<br>• Home Infusion Therapy<br>• Hospice<br>• Intermediate Care Facilities for the Mentally Retarded<br>• Nurse Anesthetist<br>• Orthotic and Prosthetic Devices (children and adults)<br>• Over-the-Counter Drugs<br>• PACE (Program of All-Inclusive Care for the Elderly)<br>• Personal Care<br>• Physical and Occupational Therapy and Speech/ Language Pathology<br>• Podiatrist<br>• Prescription Drugs<br>• Private Duty Nursing<br>• Rehabilitative (includes Behavioral Health)<br>• Respiratory Therapy (children)<br>• Routine Eye Exams and Visual Aids (adults)<br>• Transplants<br>• Transportation (non-medical) |

Note: All optional services are available to children under age 21 if they are medically necessary.

Source: North Carolina General Assembly, "Services Covered by N.C. Medicaid by Mandatory and Optional Coverage." Jan. 2010.

**Gaming the System**

Minimizing the use of state funds by maximizing federal money continues in other ways as well. This has become standard fiscal practice in most states. For example, in the mid 1980s, Medicaid providers could volunteer to be assessed, or taxed, by the state. In return, the state would shell out enhanced reimbursement rates, knowing that this would trigger federal payments. Joseph Antos of the American Enterprise Institute explains a scenario noted by the Congressional Research Service:

> For example, hospitals might agree to pay $10 million in provider taxes in exchange for the state increasing Medicaid hospital reimbursement by $20 million. On balance, hospitals gain $10 million in revenue. If the FMAP is 60 percent, the federal government would pay an extra $12 million. That gives the state budget an extra $2 million that it would not otherwise have received.[22]

This strategy not only benefited healthcare entities and providers, but also freed up money in state budgets that could then be used for purposes *not limited to Medicaid*.

It took some time for federal regulators to recognize this shell game, but in 1991, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments placed restrictions on states that prevented them from running up the federal portion of the Medicaid tab in this way. Today, if states place assessments on health care entities to help pay for Medicaid programs, the fee must not exceed six percent of net patient revenues. Furthermore, they must be "broad based" and "uniform," meaning that the tax leveraged has to fall across an entire specified class of providers. Other restrictions require that providers cannot be "held harmless," or *guaranteed* that they will see a return of the taxed amount.[23]

Such provisions are why the Centers for Medicare and Medicaid Services (CMS) recently rejected North Carolina's proposed assessment on managed care organizations (LME-MCOs) that deliver care to those with mental health, substance abuse, and developmental disability needs. A tax of $30 million was to be levied on the state's 10 LME-MCOs. Once the $30 million was distributed back to these entities, the state would trigger a total federal match of $90 million, leaving the state with $60 million of federal taxpayer money ostensibly to be used for Medicaid. Confusion could have resulted from the fact that Medicaid managed care organizations were once considered their own provider class. However, the 2005 Deficit Reduction Act shifted the Medicaid managed care class into a class consisting of all types of managed care.[24, 25]

Regardless, North Carolina still enjoys benefits from provider taxes on hospitals, intermediate care facilities for the intellectually disabled (ICF-IDs), and nursing facilities.[26] In 2011, the Hospital Provider Assessment Act was passed under former Governor Beverly Perdue's administration.[27, 28] It imposed an upper payment limit (UPL) tax to offset the losses private and public hospitals endure when treating Medicaid and uninsured patients. Once the state collects a percentage of inpatient and outpatient costs from these hospitals, enhanced reimbursements are distributed with matching federal funds. Enhanced reimbursements usually equate to the maximum amount Medicaid services can be billed for, typically Medicare rates.

In addition, an equity tax would also be levied to make reimbursement payments for the state's private hospitals commensurate with those for the state's public hospitals. According to the North Carolina Hospital Association, hospitals are reimbursed by Medicaid at 63 percent of the cost for inpatient and outpatient services combined.[29]

The chart below outlines how the UPL and equity assessments bring in more federal dollars. For inpatient and outpatient services totaling $215 million for Fiscal Year 2011-12, North Carolina's General Fund would hold onto $43 million. Meanwhile, the remaining $172 million would be expended back to the taxed health systems that had brought in federal matching funds. This would offset the losses hospitals endured when providing care to those on medical

| SB32 — Hospital Assessment Plan[30] | | | | | |
|---|---|---|---|---|---|
| **Assessments to Hospitals** | **Amount to DHHS** | **State Share Medicaid** | **Federal Matching** | **Payments to Hospitals** | **Net Benefit to Hospitals** |
| $215,615,530 | $43,000,000 | $172,615,530 | $413,347,075 | $585,962,605 | $370,347,074 |
| Source: Department of Health and Human Services | | | | | |

assistance. This enacted law also provides North Carolina a hefty supply of federal cash for any desirable budgetary purpose. If the state decided to use the $43 million for Medicaid purposes, an additional $86 million from the feds would funnel into the General Fund.

Usually provider assessments benefit the hospitals, but not always.[31] Within the enacted budget for fiscal year 2014-15, the General Assembly plans to hold onto an increased portion of assessments, reducing the total amount of enhanced reimbursements for hospitals.

It's understandable that nonprofit hospitals engage in these financing schemes with the state to maintain fiscal solvency. Rural hospitals that largely depend on Medicare and Medicaid funds really do not have much choice but to be active players, as these public health insurance programs pay well under commercial payer rates.[32]

Yet the assessment game and the federal match rate are just two of many reasons why total Medicaid costs nationally are now over $465 billion.

**Recommendations**

If Medicaid's federal share was transferred to states as an annual block grant, states would obviously have to shoulder more program costs.[33] But this injection of fiscal responsibility would sever many federal strings and allow lawmakers to exercise more control over their programs, implement more efficient management practices, and have a stronger incentive to sort out system waste and abuse.[34] Hospitals and the state would no longer have to navigate through a sea of red tape to draw down more Medicaid federal match money.

Even with block grant funding, no Medicaid reform can be complete unless some type of patient responsibility is enforced. For starters, it would make sense for a universal, refundable tax credit to be distributed to healthier, able-bodied Medicaid patients. This premium support model (where resources could be derived from limiting employer sponsored health coverage tax exclusions) could cover the cost of private coverage premiums.[35] With access to better quality care, these patients could gain a further sense of empowerment by using their own health savings accounts, into which the government could initially deposit a defined contribution. Money is often spent more wisely when an individual has control over an allotted sum of resources that can be used to meet individual health needs. Work requirements in tandem with health care education counseling could further assist these individuals to climb the economic ladder and step out of the state's safety net.

This initiative would then free up Medicaid funds to more effectively coordinate care for the most vulnerable medical assistance populations — the elderly, blind, and disabled and those in need of mental and physical long-term care.

Real Medicaid reform is within reach.

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