Order Code RS22101
March 30, 2005

State Medicaid Program Administration: A Brief Overview

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Summary

Medicaid is jointly financed by the federal and state governments, but each state designs and administers its own program within broad federal guidelines. This report provides a brief overview of Medicaid program administration at the state level and includes information on organization, responsibilities, and expenditures. It also describes policy issues and proposals related to state Medicaid program administration that have attracted recent attention. It will be updated as legislative or other activity warrants.

Organization

The Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for Medicaid program administration at the federal level, but individual state Medicaid agencies administer their own programs on a day-to-day basis. Federal law requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. This agency, which is usually part of a welfare, health, or umbrella human resources agency, will often contract with other public or private entities to perform various program functions. An August 2000 survey (the most recent available) by the American Public Human Services Association (APHSA) on operational responsibility for 16 key functions found that only five states had Medicaid agencies that administered (or shared in the administration of) all 16. However, most functions not directly administered by the Medicaid agency were handled by another state agency or department. One exception was the operation of Medicaid Management Information Systems (MMISs), which are used for claims and other data processing purposes. The APHSA survey found that 29 states contracted with the private sector to administer this function.[1]

Responsibilities

[1] American Public Human Services Administration, "Organizing Medicaid Responsibilities: A Look at Current State Agency Structure," *Washington Memo* 12, no. 4 (July-Sep. 2000). The other 16 functions in the survey were related to eligibility and benefits, hearings, managed care, quality assurance, provider issues, third-party liability and collections, and fraud and abuse.

State Medicaid programs are obligated to pay for covered services rendered by qualified providers to eligible individuals, using methods of administration that are found to be proper and efficient by the Secretary of HHS. To this end, a state must

- allow individuals to apply for assistance and determine their eligibility;
- determine the benefits it will cover;
- determine which providers are qualified to furnish covered benefits, and how much they will be reimbursed;
- have a system for processing claims submitted by providers;
- maintain control mechanisms designed to minimize improper payments resulting from unintended errors, as well as fraud and abuse;
- have a system for resolving grievances by applicants, beneficiaries, and certain providers; and
- collect and report required program information to CMS.

While some federal guidelines for state Medicaid program administration (e.g., nursing facility standards, quality control requirements for monitoring eligibility determinations, data collection and reporting) are specific, other guidelines are broad, allowing states to have some discretion in fulfilling administrative responsibilities.[2]

Expenditures

The federal government pays a share of every state's spending on Medicaid services and program administration. For Medicaid services, this share is called the federal medical assistance percentage (FMAP). The FMAP is based on a formula that provides higher reimbursement to states with lower per capita incomes (and vice versa); it has a statutory minimum of 50% and maximum of 83%. All states receive a 90% match for providing family planning services and supplies. The federal match for administrative expenditures does not vary by state and is generally 50%, but certain administrative functions have a higher federal match. Functions with a 75% federal match include

- compensation or training of skilled professional medical personnel (and their direct support staff) of the state Medicaid or other public agency;
- preadmission screening and resident review for individuals with mental illness or mental retardation who are admitted to a nursing facility;
- survey and certification of nursing facilities;
- operation of an approved MMIS for claims and information processing;
- performance of medical and utilization review activities or external independent review of managed care activities; and
- operation of a state Medicaid fraud control unit (MFCU).

In the case of MMISs and MFCUs, the federal match is 90% for startup expenses. There is a 100% match for the implementation and operation of immigration status

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[2] For a more thorough discussion of state responsibilities and federal requirements (including references to the Social Security Act), see Andy Schneider et al., *The Medicaid Resource Book* (Kaiser Commission on Medicaid and the Uninsured, July 2002), pp. 134-144.

verification systems.[3] Section 1903(a)(7) of the Social Security Act specifies that a 50% match will be provided for remaining expenditures that are found necessary by the Secretary of HHS for the proper and efficient administration of the state Medicaid program. In recent years, expenditures for state program administration have grown at about the same rate as expenditures for Medicaid services. As a result, administrative expenditures have remained a relatively constant share of total Medicaid expenditures. For example, between FY1999 and FY2003, expenditures for state program administration grew at an average annual rate of 9.4% while expenditures for services grew at an average annual rate of 9.8%. Over the same period, the share of total Medicaid expenditures attributable to state program administration decreased slightly, from 5.0% to 4.9%.[4] Detail on FY2003 expenditures is shown in **Table 1** at the end of this report.

Policy Issues

In light of ongoing budget concerns at both the federal and state levels, many policy issues and proposals related to state Medicaid program administration center on controlling program expenditures. The following discussion focuses on those that have attracted recent attention. It is not intended to be an exhaustive treatment of all policy issues and proposals related to state Medicaid program administration.

Allocation of Common Administrative Costs. Because of the overlap in eligible populations, states often undertake administrative activities that benefit more than one program. Under the former Aid to Families with Dependent Children (AFDC) cash welfare program, AFDC and Medicaid program eligibility were linked, and many AFDC families also qualified for food stamps. As a result, states often collected necessary eligibility information for all three programs during a single interview or performed other shared administrative tasks and charged the full amount of the cost to AFDC as a matter of convenience. Since the federal government reimbursed states for 50% of administrative expenditures for all three programs, total federal spending was not affected by the way in which states allocated the programs' common administrative costs.

When Congress replaced AFDC with the Temporary Assistance for Needy Families (TANF) block grant program in 1996, the 50% federal match for expenditures related to cash welfare assistance ended and the automatic link between cash welfare and Medicaid eligibility was severed. Later, HHS clarified that states are required to allocate common administrative costs for TANF, Medicaid, and food stamps based on the relative benefits derived by each program.[5] A remaining issue of controversy stems from the fact that

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[3] Enhanced federal matches (above 50%) have also been provided on a temporary basis for certain administrative functions. For example, under Section 1903(a)(3)(D) of the Social Security Act, states could receive a 75% federal match during a quarter in 1991, 1992, or 1993 for expenditures attributable to the adoption of a required drug use review program.

[4] Percentages are based on Congressional Research Service analysis of data (excluding the territories) from Form CMS-64 accounting statements submitted by states to CMS. The data exclude administrative expenditures for MFCUs and nursing home survey and certification (which represented 0.1% of total Medicaid expenditures in FY2003). They also exclude administrative expenditures that are exclusively federal (e.g., CMS program staff salaries).

[5] States were required to comply with this policy as of the state fiscal year beginning on or after

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TANF block grants are calculated in part on the basis of pre-1996 federal welfare spending, including any amounts received by states as reimbursement for common administrative costs. As a result, TANF block grants are higher in many states than they would be if common administrative costs attributable to Medicaid and food stamps were excluded from block grant calculations. To compensate, Congress has permanently reduced federal reimbursement for food stamp administrative costs in most states by a flat dollar amount that reflects the administrative costs attributable to food stamps that are included in each state's TANF block grant (the annual reductions total nearly $200 million). Congress has not reduced federal reimbursement for Medicaid administrative costs in a similar manner, but proposals to do so continue to circulate.[6]

Allotments for Administrative Expenditures. In its FY2006 budget, the Bush Administration proposed establishing state-specific allotments for federal reimbursement of Medicaid administrative expenditures.[7] Currently, reimbursement for administrative activities is open-ended, meaning that all expenditures deemed necessary by the Secretary of HHS for the proper and efficient administration of the state Medicaid program are matched at the applicable federal rate. The Administration has stated that open-ended financing provides a diminished incentive for states to administer the program as efficiently as possible. Concern has been expressed that reducing federal reimbursement for administrative expenditures could lead states to cut back on activities that improve the functioning of their Medicaid programs, such as efforts to combat fraud and abuse.[8]

Targeted Case Management. Another proposal in the Administration's FY2006 budget would change the federal match for Medicaid targeted case management (TCM) services from the FMAP, which varies by state and can range from 50% to 83%, to a flat rate of 50%. Under current Medicaid law, case management is a benefit that includes services to assist individuals in gaining access to needed medical, social, educational and other services. The term "targeted case management" refers to situations in which these services are not provided statewide to all Medicaid beneficiaries but rather are provided only to specific classes of individuals (e.g., individuals with HIV/AIDS, tuberculosis, chronic physical or mental illness, developmental disabilities, or children in foster care) or persons who reside in a specific geographic area.

Regardless of the rate at which TCM expenditures are reimbursed by the federal government, a second issue is whether or not states are using the service as a vehicle to shift costs associated with other programs to Medicaid. In its FY2006 budget, the Administration proposes to clarify which services may be claimed as Medicaid TCM. In recent years, the HHS Office of Inspector General (OIG) has reported "excessive" payments for TCM services provided in school settings and has recommended that CMS

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[5] (...continued)
Oct. 1, 1998. See U.S. Department of Health and Human Services, *Office of Grants and Acquisition Management (OGAM) Action Transmittal 98-2*.

[6] See U.S. Congressional Budget Office, *Budget Options*, Feb. 2005, p. 171 and National Conference of State Legislatures, *Medicaid Cost Allocation — A Backgrounder*, Feb. 11, 2004.

[7] For information on all of the Administration's FY2006 proposals, see CRS Report RL32771, *Medicaid and SCHIP: The President's FY2006 Budget Proposals*, by April Grady, et al.

[8] U.S. Congressional Budget Office, *Budget Options*, Feb. 2005, p. 172.

consider reviewing states' use of TCM for foster care children to ensure that such care is consistent with federal requirements.[9]

Reducing Improper Payments to Providers. The Government Accountability Office (GAO) has noted that Medicaid's size and diversity makes it vulnerable to improper payments that can result from fraud, abuse, and inadvertent errors. States have taken various approaches to preventing and detecting improper payments to providers, such as tightening provider enrollment controls (performing on-site inspections and criminal background checks, requiring that certain providers be bonded to protect the state against financial loss, requiring probationary enrollment or periodic re-enrollment) and using advanced technologies to integrate provider, beneficiary, and claims information to conduct more efficient eligibility, utilization, and billing reviews.[10]

While the focus of this report is on Medicaid program administration at the state level, CMS is engaged at the federal level in several initiatives designed to support states' program integrity efforts, including efforts to reduce improper payments. However, GAO noted in a recent report that there may be a disparity between the level of CMS resources devoted to Medicaid program integrity activities and the program's vulnerability to significant financial losses. In response, CMS asserted that GAO did not place enough emphasis on the importance of its financial oversight activities, including the work of its financial management staff and its auditing contract with the HHS OIG.[11]

A proposal in the Administration's FY2006 budget would increase CMS' allocation from the Health Care Fraud and Abuse Control (HCFAC) Account (which was established in 1996 by the Health Insurance Portability and Accountability Act) for Medicaid and State Children's Health Insurance Program (SCHIP) program integrity activities from $17 million in FY2005 to $20 million in FY2006. It would also provide an additional $5 million in HCFAC discretionary funds. These amounts would be used for continuing efforts to find erroneous and fraudulent uses of Medicaid and SCHIP funds and increasing the number of audits and evaluations of state Medicaid programs. The proposal would increase funding for administrative activities at the federal level. It would not affect funding for Medicaid program administration at the state level.

Privatization of Eligibility Determinations. States may contract with both public and private entities to administer various Medicaid, food stamp, and TANF program functions. However, federal laws governing these programs only allow "privatization" of actual eligibility determinations for the TANF program. Unless a waiver is granted, states must use government workers to perform Medicaid and food stamp eligibility determinations. Proponents of extended privatization authority contend

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[9] U.S. Department of Health and Human Services, Office of Inspector General, *Review of Vermont Medicaid School-Based Services for the Period October 2001 Through September 2002*, A-01-03-00004 (Jan. 2005); *Foster Care Children's Use of Medicaid Services in Oregon*, OEI-02-00-00363 (June 2004); *Office of Inspector General's Partnership Plan — New York State Comptroller Report on Controlling Medicaid Payments for School and Preschool Supportive Health Services*, A-02-01-01024 (Oct. 2001).

[10] U.S. Government Accountability Office, *Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments*, GAO-04-707, July 2004.

[11] Ibid.

that it could increase efficiency and generate cost savings, and that it is difficult to privatize administration of only one of the three major programs, which often serve the same populations. Opponents express concerns about the potential for denial of help to those in need due to cost concerns, administrative problems and financial risks associated with privatizing eligibility determinations, and the potential for a net loss of jobs.[12]

Table 1. Expenditures for State Medicaid Program Administration and Services, FY2003

(in millions)

Category	Total	Federal	State
Administration	$13,853	$7,815	$6,039
Medicaid Fraud Control Units (MFCUs)[a]	$160	$120	$40
Nursing facility survey and certification	$220	$162	$57
Medicaid Management Information Systems (MMISs)[b]	$2,136	$1,627	$510
TANF-related[c]	$212	$166	$47
Other functions with a federal match greater than 50%[d]	$715	$538	$177
Functions with a federal match of 50%[e]	$10,436	$5,218	$5,217
Collections[f]	-$26	-$17	-$10
Services[g]	$261,788	$153,032	$108,756
Total	**$275,642**	**$160,847**	**$114,795**

Source: Congressional Research Service, based on Form CMS-64 accounting statements submitted by states to the Centers for Medicare and Medicaid Services (CMS) for all expenditures with the exception of MFCUs (Department of Health and Human Services, Office of Inspector General) and nursing facility survey and certification (CMS, Center for Medicaid and State Operations).

Notes: Excludes Vaccines for Children expenditures, the territories, and administrative expenditures that are exclusively federal (e.g., CMS program staff salaries). The CMS-64 data include current year expenditures as well as increasing and decreasing adjustments for expenditures in prior quarters.

a. Forty-eight states received federal funds for MFCUs in FY2003. Total and state expenditures were estimated using actual federal expenditures from Department of Health and Human Services, Office of Inspector General, *State Medicaid Fraud Control Units: Annual Report, Fiscal Year 2003*, Appendix B. The estimates assume that each state receives a 75% federal match (MFCUs may receive a 90% match if they are in their first three years of operation).
b. Includes design and development (90% federal match), operation of approved MMISs (75% federal match), and operation of non-approved systems (50% federal match).
c. Under Section 1931(h) of the Social Security Act, a $500 million federal fund was made available (beginning in 1997 and continuing until exhausted) to provide states with an enhanced federal match for administrative expenditures attributable to eligibility determinations that would not have been made were it not for the implementation of the Temporary Assistance for Needy Families program.
d. Skilled medical professional, immigration status verification, preadmission screening and resident review, medical and utilization review, and external independent review.
e. Excluding non-approved MMISs matched at 50%, which appear earlier in the MMIS category.
f. Offsetting amounts (e.g., donations made by a hospital to compensate for the cost of on-site stationing of state or local Medicaid agency personnel to determine eligibility or provide outreach).
g. Includes family planning (which is categorized as an administrative expenditure in Form CMS-64 data) and offsetting collections (e.g., amounts obtained through estate and overpayment recovery).

[12] See CRS Report RS22043, *Privatization and Welfare Administration*, by Joe Richardson.