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Medicaid Financing and Expenditures

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Summary

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term services and supports (LTSS). Medicaid is a federal and state partnership that is jointly financed by both the federal government and the states.

The federal government's share for most Medicaid expenditures is called the federal medical assistance percentage (FMAP). Generally determined annually, the FMAP formula is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes). Federal Medicaid funding to states is open ended.

The federal government provides states flexibility in determining the composition of the state share (also referred to as the nonfederal share) of Medicaid expenditures. As a result, there is significant variation from state to state in how the state share of Medicaid expenditures is financed.

In 2023, Medicaid represented 18% of national health expenditures; in that year, private health insurance and Medicare accounted for 30% and 21% of national health expenditures, respectively. Medicaid is a significant payer in the categories of health spending that includes LTSS and hospital expenditures. For the other services (such as durable medical equipment, physician and clinical services, prescription drugs, and dental services), Medicaid accounts for a smaller share of the national expenditures.

In FY2023, Medicaid expenditures totaled $894 billion, with the federal government paying $614 billion, or about 69% of the total. Spending on managed care comprised 56% of Medicaid expenditures on benefits in FY2023, and LTSS accounted for 19% Medicaid expenditures on benefits. Per-enrollee Medicaid expenditures for individuals with disabilities and the elderly are significantly higher than per-enrollee expenditures for adults and children, due in part to the higher utilization of LTSS among individuals with disabilities and the elderly.

Medicaid expenditures are influenced by economic, demographic, and programmatic factors. Economic factors include health care prices, unemployment rates, and individuals' wages. In addition, state-specific factors, such as programmatic decisions and demographics, affect Medicaid expenditures and cause Medicaid spending to vary widely from state to state.

In recent years, Medicaid expenditures have increased significantly due to the Family First Coronavirus Response Act (FFCRA; P.L. 116-127) FMAP increase and the associated continuous coverage requirement. As a result, both Medicaid enrollment and Medicaid expenditures rose sharply from FY2020 through FY2023. With the expiration of the FFCRA FMAP increase and the continuous coverage requirement, Medicaid enrollment is estimated to have declined from 96 million in FY2023 to 83 million in FY2024—a decrease of almost 14%. This reduction in Medicaid enrollment is expected to result in slower growth in total Medicaid expenditures.

Currently, Congress is discussing policy options for reducing federal Medicaid expenditures. The House of Representatives adopted the House FY2025 budget resolution (H.Con.Res. 14) on April 10, 2025. H.Con.Res. 14 includes reconciliation instructions directing the Committee on Energy and Commerce to reduce the deficit by not less than $880 billion for FY2025 through FY2034. Some press reports suggest that much of the $880 billion in reductions could come from reductions to federal Medicaid expenditures.

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Introduction

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term services and supports (LTSS).[1] Medicaid is a federal and state partnership with both the federal government and the states financing Medicaid. In FY2023, Medicaid provided health care services to 96 million individuals at a total cost of $894 billion (including federal and state expenditures).[2]

Participation in Medicaid is voluntary. All states, the District of Columbia, and the territories choose to participate. The federal government sets some basic requirements for Medicaid, and states have the flexibility to design their own version of Medicaid within the federal government's basic framework.

States incur Medicaid costs by making payments to service providers (e.g., for beneficiaries' doctor visits) and performing administrative activities (e.g., making eligibility determinations). The federal government reimburses states for a share of each dollar spent in accordance with their federally approved Medicaid state plans.

Medicaid is an entitlement for both states and individuals. The Medicaid entitlement to states ensures that, so long as states operate their programs within the federal requirements, states are entitled to federal Medicaid matching funds. Medicaid is also an individual entitlement, which means that anyone eligible for Medicaid under their state's eligibility standards is guaranteed Medicaid coverage, should they apply.

This report's first section, "Medicaid Financing" provides an overview of Medicaid's financing structure, including both federal and state financing issues. The "Medicaid Expenditures" section of the report discusses Medicaid in terms of national health expenditures, trends in Medicaid expenditures, economic factors affecting Medicaid, and state variability in spending.

Medicaid Financing

The federal government and the states share the cost of Medicaid. The federal government reimburses states for a portion (i.e., the *federal share* or the *federal financial participation*) of each state's Medicaid program costs. Federal Medicaid funding is an open-ended entitlement to states, which means there is no upper limit or cap on the amount of federal Medicaid funds a state may receive.

Federal Share

A primary goal of the federal Medicaid matching arrangement is to share the cost of providing health care services to low-income residents with the states. The Medicaid financing structure

[1] For more information about the Medicaid program, see CRS In Focus IF10322, *Medicaid Primer*, and CRS Report R43357, *Medicaid: An Overview*.

[2] The enrollment figure is from the Centers for Medicare & Medicaid Services' (CMS) Office of the Actuary's analysis of Medicaid enrollment data from the Medicaid Statistical Information System, the Transformed Medicaid Statistical Information System, and the Form CMS-64 Data as reported by states to the Medicaid Budget and Expenditure System, provided to CRS on November 15, 2024. The expenditures information is from the Form CMS-64 Data as reported by states to the Medicaid Budget and Expenditure System, as of May 29, 2024, at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

represents a fiscal commitment on the part of the federal government toward paying at least half (but not all) of the cost of Medicaid.[3]

The federal government's open-ended financial commitment to Medicaid provides a fiscal incentive for states to extend Medicaid coverage to more low-income individuals than a state might choose to fund without the federal Medicaid funding. However, this incentive is counterbalanced by the requirement for states to share in the cost of Medicaid.[4]

Although most federal Medicaid funding is provided on an open-ended basis, certain types of federal Medicaid funding are capped. For instance, federal disproportionate share hospital (DSH) funding to states cannot exceed a state-specific annual allotment.[5] In addition, Medicaid programs in the territories (i.e., American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Virgin Islands) are subject to annual federal capped funding.[6] Another exception to open-ended federal Medicaid funding is the Qualified Individuals program.[7]

The Federal Medical Assistance Percentage

The federal government's share of most Medicaid expenditures is established by the federal medical assistance percentage (FMAP) rate, which generally is determined annually and varies by state according to each state's per capita income relative to the U.S. per capita income.[8] The formula provides higher FMAP rates, or federal reimbursement rates, to states with lower per capita incomes, and it provides lower FMAP rates to states with higher per capita incomes. FMAP rates have a statutory minimum of 50% and a statutory maximum of 83%. In FY2025, FMAP rates range from 50% (10 states) to 76.9% (Mississippi).[9]

The FMAP rate is used to reimburse states for the federal share of most Medicaid expenditures, but exceptions to the regular FMAP rate have been made for certain states (e.g., the District of Columbia and the territories), situations (e.g., during economic downturns), populations (e.g., individuals covered by the Patient Protection and Affordable Care Act's [ACA, P.L. 111-148 as amended] Medicaid expansion and certain women with breast or cervical cancer), providers (e.g., Indian Health Service facilities), and services (e.g., family planning and home health services). In addition, the federal share for most Medicaid administrative costs does not vary by state and is generally 50%.

[3] Andy Schneider and David Rousseau, *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured, Publication Number 2236, January 17, 2003; Teresa A. Coughlin and Stephen Zuckerman, *States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences*, The Urban Institute, June 2002.

[4] Ibid.

[5] The federal Medicaid statute requires that states make disproportionate share hospital (DSH) payments to hospitals treating a disproportionate share of low-income patients. For more information about Medicaid DSH payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*.

[6] For more information about the federal Medicaid funding for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*.

[7] States pay Medicare Part B premiums for Medicare beneficiaries with income between 120% and 135% of the federal poverty level (FPL) and limited assets (referred to as *qualifying individuals*), up to a specified dollar allotment.

[8] For more detail about the federal medical assistance percentage (FMAP), see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*.

[9] Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2024, Through September 30, 2025," 88 *Federal Register* 81090, November 21, 2023..

During the Coronavirus Disease 2019 (COVID-19) public health emergency period, the Family First Coronavirus Response Act (FFCRA; P.L. 116-127) provided a 6.2-percentage-point increase to the regular FMAP rates for all states, the District of Columbia, and the territories that meet certain conditions.[10] The FFCRA FMAP increase of 6.2 percentage points began on January 1, 2020, and the FFCRA FMAP increase began to phase down on April 1, 2023, and ended December 31, 2023.[11]

Medicaid and the Federal Budget Process

As discussed above, Medicaid is a federal entitlement to states, and in federal-budget parlance entitlement spending is categorized as *mandatory spending*, which is also referred to as *direct spending*. Although most mandatory spending programs bypass the annual appropriations process and automatically receive funding each year according to either permanent or multiyear appropriations in the substantive law, Medicaid is funded in the annual appropriations acts. For this reason, Medicaid is referred to as an *appropriated entitlement*.[12]

The level of spending for appropriated entitlements, similar to other entitlements, is based on the benefit and eligibility criteria established in law. The amount of budget authority provided in appropriations acts for Medicaid is based on budget projections for meeting the funding needs of the program. Although most changes to the Medicaid program are made through statute, the fact that Medicaid is subject to the annual appropriations process provides an opportunity for Congress to place funding limitations on specified activities in Medicaid, such as the circumstances under which federal funds can be used to pay for abortions.[13]

Process for Federal Medicaid Funds Getting to States

States incur Medicaid costs by making payments for services (e.g., for beneficiaries' doctor visits or payments to managed care organizations) and performing administrative activities (e.g., making eligibility determinations). After a state has made Medicaid expenditures, it can draw down federal matching funds.

The Medicaid financing structure is set up so that states can draw down federal Medicaid matching funds on a real-time basis through commercial banks and the Federal Reserve System against a continuing letter of credit certified by the Secretary of the Treasury in favor of the state payee. Then, the federal government reconciles state Medicaid expenditures on a quarterly basis.

The Centers for Medicare & Medicaid Services (CMS) makes quarterly grant awards to states to cover the federal share of Medicaid expenditures based on the quarterly estimates states submitted to CMS on the Form CMS-37. Each state must submit a Form CMS-64 no later than 30 days after the end of each quarter with the state's accounting of actual recorded expenditures. CMS then reviews the expenditures reported on the CMS-64 to reconcile the states' estimates from the CMS-37 with the actual documented expenditures to ensure that the reported expenditures are allowable under the Medicaid statute and the Medicaid state plan.

If CMS is uncertain as to whether a particular state expenditure is allowable, then CMS must notify the state and provide an opportunity for a hearing. If the state does not comply, CMS may withhold payment or disallow claims for federal Medicaid matching funds until the issue has been resolved.

[10] For more information about the Family First Coronavirus Response Act (FFCRA; P.L. 116-127) FMAP increase and the conditions for states to receive this increase, see CRS Report R46346, *Medicaid Recession-Related FMAP Increases*.

[11] The 6.2-percentage-point FFCRA FMAP increase was in place from January 1, 2020, through March 31, 2023, but began phasing down starting April 1, 2023, as follows: 5 percentage points (April 1, 2023, through June 30, 2023); 2.5 percentage points (from July 1, 2023, through September 30, 2023); 1.5 percentage points (from October 1, 2023, through December 31, 2023).

[12] For more information about appropriated entitlements, see CRS Report RS20129, *Entitlements and Appropriated Entitlements in the Federal Budget Process*.

[13] This limitation is commonly referred to as the *Hyde Amendment*. For more information about the Hyde Amendment, see CRS In Focus IF12167, *The Hyde Amendment: An Overview*.

The appropriations bill usually provides Medicaid with (1) funding for the fiscal year considered in the appropriations bill and (2) an advance appropriation for the first quarter of the following fiscal year.[14] For instance, the Full-Year Continuing Appropriations and Extensions Act, 2025 (P.L. 119-4), provided Medicaid with funding for three quarters of FY2025 and an advance appropriation of $261.1 billion for the first quarter of FY2026.

State Share

The federal government provides broad guidelines to states regarding allowable funding sources for the state share of Medicaid expenditures. However, to a large extent, states are free to determine how to fund their share of Medicaid expenditures. As a result, there is significant variation from state to state in funding sources.

States can use state general funds (i.e., personal-income, sales, and corporate-income taxes) and "other state funds" (e.g., provider taxes,[15] local government funds,[16] tobacco settlement funds) to finance the state share of Medicaid. Federal statute allows as much as 60% of the state share to come from local government funding.[17] Federal regulations also stipulate that the state share not be funded with federal funds (Medicaid or otherwise).[18] In state FY2024, on average, 68% of the state share of Medicaid expenditures was financed by state general funds, and the remaining 32% was financed by other state funds.[19]

A few funding sources have received a great deal of attention over the past couple decades because states have used these funds in financing mechanisms designed to maximize the amount of federal Medicaid funds coming to the state. For example, some states have used financing mechanisms that involve the coordination of fund sources, such as provider taxes, intergovernmental transfers (IGTs), or certified public expenditures (CPEs), and payment policies, such as DSH and non-DSH supplemental payments, to draw down federal Medicaid funds without expending much, if any, state general funds.[20]

[14] Advance appropriations become available for obligation one or more fiscal years after the budget year covered by the appropriations act. For more information about advance appropriations, see CRS Report R43482, *Advance Appropriations, Forward Funding, and Advance Funding: Concepts, Practice, and Budget Process Considerations*.

[15] Federal statute and regulations define a provider tax as a health care-related fee, assessment, or other mandatory payment for which at least 85% of the burden of the tax revenue falls on health care providers. For more information about Medicaid provider taxes, see CRS Report RS22843, *Medicaid Provider Taxes*.

[16] Local governments and local government providers can contribute to the state share of Medicaid payments through intergovernmental transfers (IGTs) or certified public expenditures (CPEs). For IGTs, a local government transfers funds to the state government to be used to finance Medicaid. When CPEs are used to fund the state share, the local government certifies its Medicaid expenditures to the state, and then the state claims the federal Medicaid matching funds.

[17] §1902(a)(2) of the Social Security Act.

[18] 42 C.F.R. 433.51(c).

[19] National Association of State Budget Officers, *2024 State Expenditure Report: Fiscal Years 2022-2024 State Spending*, at https://www.nasbo.org/reports-data/state-expenditure-report.

[20] *Supplemental payments* are Medicaid payments made to providers that are separate from and in addition to the standard payment rates for services rendered to Medicaid enrollees. Often, providers receive supplemental payments in a lump sum. For more information about Medicaid supplemental payments, see CRS Report R45432, *Medicaid Supplemental Payments*.

Medicaid Expenditures[21]

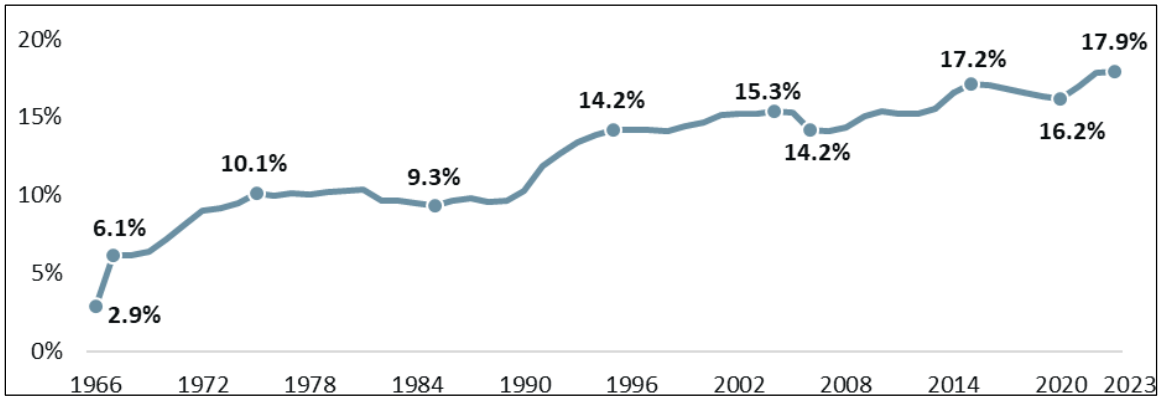
Medicaid expenditures account for a significant and growing portion of total health expenditures in the United States. Enrollment increases due to expansions of eligibility and economic downturns account for much of Medicaid's expenditure growth over time. However, Medicaid expenditures also are influenced by economic, demographic, and programmatic factors. In addition, there is considerable variation in Medicaid spending from state to state due to demographic differences, state policy choices, utilization of services, and provider payment rates.

Medicaid and National Health Expenditures

In 2023, Medicaid represented almost 18% of national health expenditures; in that same year, private health insurance and Medicare accounted for 30% and 21% of national health expenditures, respectively.[22] **Figure 1** shows Medicaid as a percentage of national health expenditures from 1966 (the first year Medicaid was in operation) through 2023.

Figure 1. Medicaid as a Percentage of National Health Expenditures

(1966-2023)



Source: Centers for Medicare & Medicaid Services (CMS), "National Health Expenditures by Type of Service and Source of Funds, CY1960-2023," *National Health Expenditure Accounts,* December 18, 2024.

Over time, Medicaid has become one of the largest payers in the U.S. health care system. Since the start-up years (i.e., 1966 through 1971), Medicaid expenditures have grown as a percentage of national health expenditures, with just a few exceptions.[23] From 2015 through 2020, Medicaid expenditures as a percentage of national health expenditures decreased slightly each year. In each year from 2015 through 2020, Medicaid spending increased, but at slower rate than other categories of national health expenditures, mainly due to a slower rate of growth for Medicaid

[21] Data in this section are provided for different years (i.e., calendar year 2023, FY2022, or FY2023) because Medicaid data are collected from states at different times for different purposes. For each type of expenditure, the most recent data are provided.

[22] CMS, "National Health Expenditures by Type of Service and Source of Funds, CY 1960-2023," *National Health Expenditure Accounts,* December 18, 2024.

[23] For example, for the years 1982 through 1984, Medicaid expenditure growth decreased due to a three-year reduction to the federal Medicaid matching rate. In addition, Medicaid expenditures as a percentage of national health expenditures dropped from 15% in 2005 to 14% in 2006 due to prescription drug coverage for dual-eligible beneficiaries moving from Medicaid to Medicare Part D beginning on January 1, 2006, which resulted in a substantial reduction in Medicaid prescription drug spending.

enrollment.[24] For 2021 through 2023, Medicaid expenditures as a percentage of national health expenditures increased each year. This is primarily due to Medicaid enrollment increases for 2021 and 2022; for 2023, CMS attributed the increase to "provider rate or cost increases, as well as the growing use of state-directed payments to providers via managed care organizations."[25]

Medicaid is a major payer in some categories of national health expenditures and accounts for a smaller share of other categories of expenditures. **Figure 2** shows that in 2023, Medicaid was a major payer in the categories of spending that include LTSS,[26] with Medicaid paying 60% of expenditures in the other health, residential, and personal care category;[27] 35% of home health expenditures; and 30% of nursing care facilities and continuing care retirement communities.[28] Medicaid accounted for 19% of hospital expenditures. For the other services, in 2023, Medicaid accounted for a smaller share of the national expenditures, with Medicaid paying 14% of durable medical equipment, 12% of physician and clinical expenditures, 11% of prescription drugs, 11% of dental expenditures, and 8% of other professional expenditures. Medicaid did not have any expenditures for non-durable medical products in 2023.

[24] Micah Hartman et al., "National Health Care Spending in 2018: Growth Driven by Accelerations in Medicare and Private Insurance Spending," *Health Affairs*, December 5, 2019; Micah Hartman et al., "National Health Care Spending in 2020: Growth Driven by Federal Spending in Response to the COVID-19 Pandemic," *Health Affairs*, December 15, 2021.

[25] Anne B. Martin et al., "National Health Care Spending in 2021: Decline in Federal Spending Outweighs Greater Use of Health Care," *Health Affairs*, December 14, 2022; Anne B. Martin et al., "National Health Care Spending in 2022: Growth Similar to Prepandemic Rates," *Health Affairs*, December 13, 2023; Anne B. Martin et al., "National Health Expenditures in 2023: Faster Growth as Insurance Coverage and Utilization Increased," *Health Affairs*, December 18, 2024.

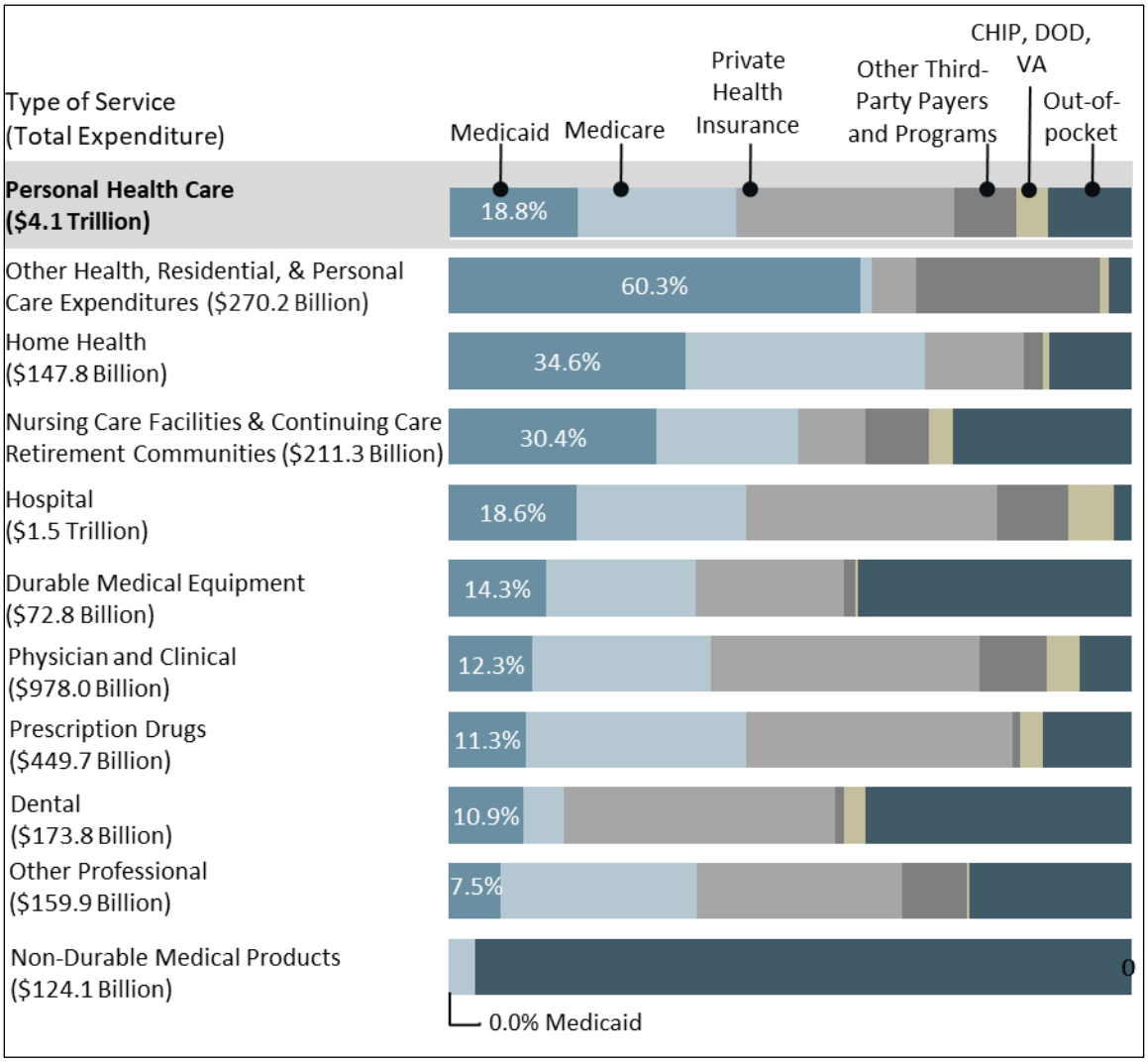
[26] Long-term services and supports (LTSS) refer to a broad range of health and health-related services and supports needed by individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or condition. For more information about coverage of LTSS, see CRS In Focus IF10343, *Who Pays for Long-Term Services and Supports?*

[27] The two largest components of the other residential and personal care category are (1) residential intellectual and developmental disability, mental health, and substance abuse facilities and (2) Medicaid home- and community-based services waiver[27] expenditures, which are both LTSS. The expenditures for each of these two categories make up a little less than a third of the total expenditures for the category.

[28] LTSS expenditures are included in the following national health expenditures categories: nursing care facilities and continuing care retirement communities; home health; and other health, residential, and personal care. However, the other health, residential, and personal care category includes non-LTSS expenditures, such as school health and worksite health care.

Figure 2. Percentage Distribution of National Health Expenditures by Type of Service and Source of Funds

(2023)



Source: CMS, "National Health Expenditures by Source of Funds and Type of Expenditure: Calendar Years 2011-2023," *National Health Expenditure Accounts,* December 18, 2024.

Notes: Personal health care expenditures are outlays for goods and services relating directly to patient care, such as hospital care, physicians' services, prescription drugs, and nursing home care.

Other third-party payers and programs includes worksite health care, Indian Health Services, workers' compensation, the Maternal and Child Health program, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration grants, other state and local programs, and school health.

The categories of spending that include long-term services and supports expenditures are other health, residential, and personal care expenditures; home health expenditures; and nursing care facilities and continuing care retirement communities.

Medicaid estimates are based primarily on financial information reports filed by the state Medicaid agencies on Form CMS-64. These data have a category for capitated payments (including managed care), but the information does not break down managed care spending by service. For the National Health Expenditure Accounts (NHEA), Medicaid managed care payments are reduced by administrative costs and then allocated to NHEA service categories based on the distribution of Medicaid fee-for-service spending for selected services in the state.

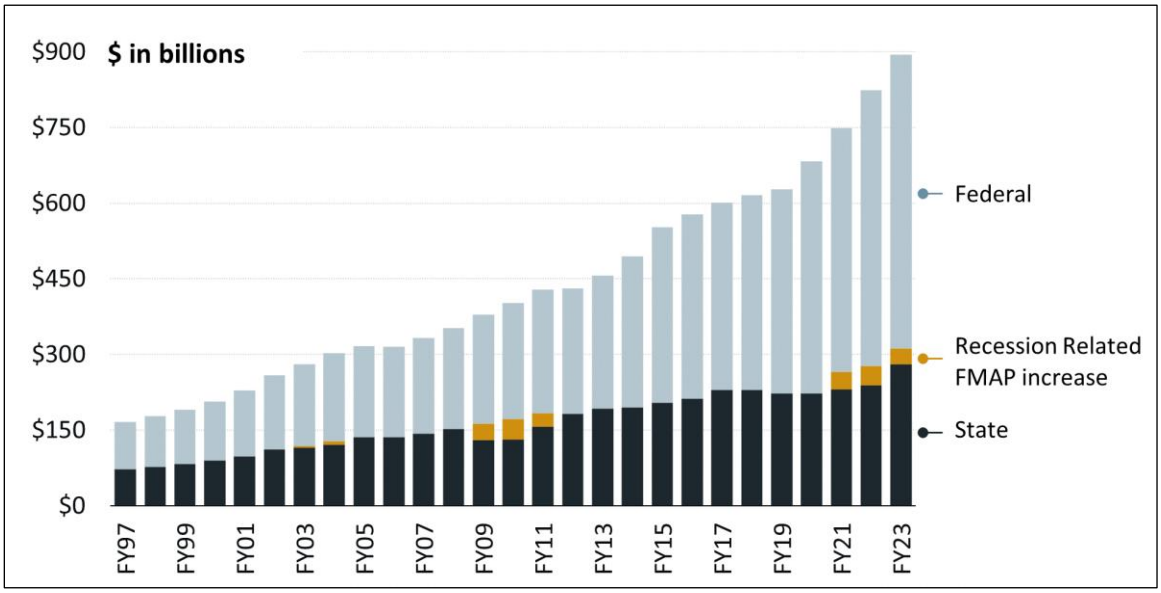
CHIP: State Children's Health Insurance Program

DOD: Department of Defense
VA: Department of Veterans Affairs

Trend in Medicaid Expenditures

Figure 3 shows Medicaid expenditures from FY1997 through FY2023 broken down by state and federal expenditures. In FY2023, Medicaid spending on services and administrative activities in the 50 states, the District of Columbia, and the territories totaled $894 billion (see **Table A-1** for FY2023 state-by-state expenditures). Of this amount, federal Medicaid expenditures totaled $614 billion and state Medicaid expenditures were $280 billion.

Figure 3. Federal and State Actual and Projected Medicaid Expenditures
(FY1997 to FY2023)



Source: CMS, Form CMS-64 Data as reported by states to the Medicaid Budget and Expenditure System, as of May 29, 2024, at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

Notes: The expenditures shown in this figure include all Medicaid expenditures, which include both administrative and benefit spending. These expenditures exclude state Medicaid Fraud Control Units, Medicaid survey and certification of nursing and intermediate care facilities, and the Vaccines for Children program. Recession-related additional federal Medicaid funding was provided in response to the 2001 recession, the 2007-2009 recession, and the COVID-19 public health emergency period. For more information about the recession-related additional federal Medicaid funding, see CRS Report R46346, *Medicaid Recession-Related FMAP Increases*.

Over time, much of Medicaid's expenditure growth has been due to federal or state expansions of Medicaid eligibility criteria. For instance, the implementation of the ACA Medicaid expansion increased Medicaid expenditures for FY2014 and FY2015.[29]

During the COVID-19 public health emergency period, Medicaid enrollment increased significantly. Initially, the recession at the beginning of the pandemic caused Medicaid enrollment

[29] Rachel Garfield et al., *Enrollment-Driven Expenditure Growth: Medicaid Spending during the Economic Downturn, FFY2007-2010*, Kaiser Commission on Medicaid and the Uninsured, Publication #8309, May 2012; Christopher J. Truffer, Kathryn E. Rennie, Lindsey Wilson, et al., *2018 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, CMS, HHS, 2020, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/MedicaidReport.

to increase. Then, the continuous coverage requirement for the FFCRA FMAP increase drove Medicaid enrollment increases for FY2020 through FY2023.[30] These enrollment increases also contributed to a significant increase in Medicaid expenditures. The FFCRA FMAP increase ended December 31, 2023, and, with the end of the continuous coverage requirement, Medicaid enrollment is expected to decrease; this is expected to slow the growth in Medicaid expenditures.

Federal and State Shares of Expenditures

The FFCRA FMAP increase impacted the federal and state shares of Medicaid expenditures. Historically, the federal government financed about 57% of total Medicaid expenditures, but the federal share has increased since FY2014 due to the enhanced federal matching rate for the ACA Medicaid expansion.[31] From FY2014 through FY2019, the federal share of total Medicaid expenditures ranged from 60% to 65%.

The federal share of total Medicaid expenditures increased further with the FFCRA FMAP increase in effect from January 1, 2020, through December 31, 2023. The federal share of Medicaid expenditures rose to 67% in FY2020, 69% in FY2021, and 71% in FY2022. The FFCRA FMAP increase began to phase down on April 1, 2023, resulting in a reduction in the federal share of Medicaid expenditures to 69% of total Medicaid spending in FY2023.[32]

The federal share of Medicaid expenditures is expected to decrease in FY2024 because the FFCRA FMAP increase ended on December 31, 2023. The Congressional Budget Office projects federal Medicaid expenditures will decrease slightly in FY2024 and FY2025,[33] and the state share of Medicaid expenditures is expected to increase over this time period.

Medicaid Expenditures by Service Type

Most Medicaid expenditures (i.e., 96% in FY2023) are for medical assistance (or non-administrative) payments. **Figure 4** shows medical assistance payments by service type for FY2023. Managed care, which includes payments to managed care organizations,[34] primary care case management,[35] and non-comprehensive prepaid health plans,[36] accounted for 56% of Medicaid expenditures. The remaining expenditures are fee-for-service expenditures.[37] LTSS,

[30] The Families First Coronavirus Response Act (FFCRA; P.L. 116-127) provided a 6.2-percentage-point increase to the regular FMAP rates for all states, the District of Columbia, and the territories that meet certain conditions, such as providing continuous coverage of Medicaid enrollees. For more information about the FFCRA FMAP increase, see CRS Report R46346, *Medicaid Recession-Related FMAP Increases*.

[31] The federal government reimburses states for 90% of the Medicaid expenditures for newly eligible individuals who gained Medicaid eligibility due to the ACA Medicaid expansion. For more information about the ACA Medicaid expansion, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*.

[32] CMS, Form CMS-64 Data as reported by states to the Medicaid Budget and Expenditure System, as of May 29, 2024, at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

[33] CBO, "Medicaid – CBO's June 2024 Baseline," June 2024, https://www.cbo.gov/system/files/2024-06/51301-2024-06-medicaid.pdf.

[34] States contract with managed care organizations to provide a comprehensive package of benefits to enrolled Medicaid beneficiaries, primarily on a capitated basis (i.e., a set amount per enrollee regardless of the services utilized).

[35] Under primary care case management, states contract with primary care physicians to provide case management services to Medicaid enrollees. For these enrollees, other services generally are provided on a fee-for-service basis.

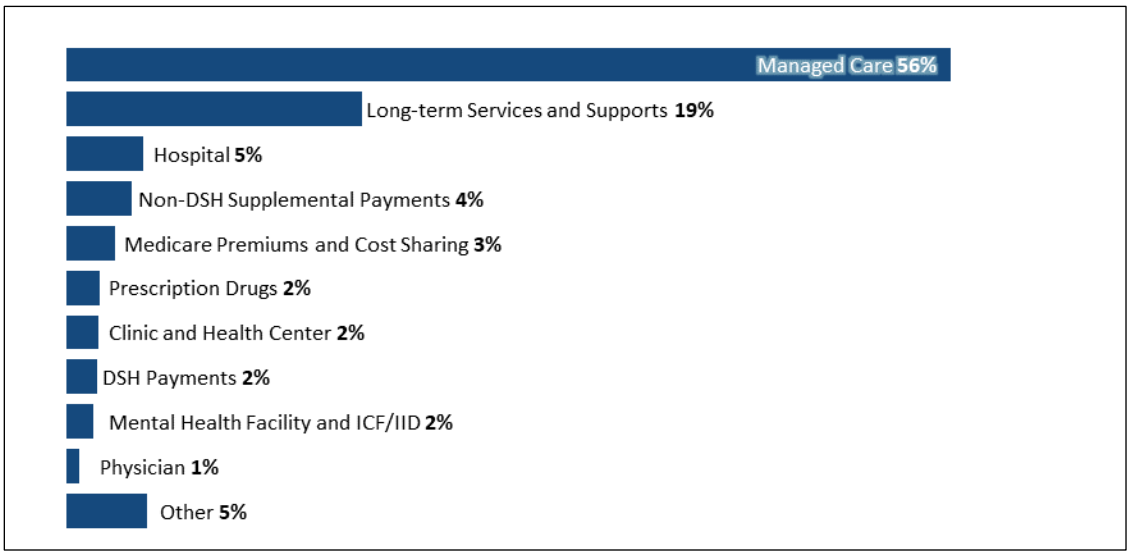
[36] States contract with health plans to provide non-comprehensive benefits (e.g., inpatient behavioral health care or dental care).

[37] Under the fee-for-service service delivery system, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee.

which include nursing facility and home- and community-based services, made up 19% of all Medicaid expenditures.[38] Hospitals received 5% of total Medicaid expenditures in return for services provided to Medicaid fee-for-service enrollees at the payment rates set by states.[39]

Figure 4. Medicaid Benefit Expenditures by Service Type

(FY2023)



Source: Congressional Research Service (CRS) analysis of CMS, Form CMS-64 Data as reported by states to the Medicaid Budget and Expenditure System, as of May 29, 2024, at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

Notes: Prescription drug expenditures are net of rebates. The other service category includes any expenditure type that amounts to less than 1% of total Medicaid expenditures, such as laboratory services, school-based services, physical therapy, etc. Long-term services and supports comprise spending for nursing facility services, home health services, home- and community-based services, personal care services, etc. Managed care is a system for delivering care in which Medicaid enrollees get most or all of their services through an organization under contract with the state, and all expenditures that are not under managed care are under fee-for-service. ICF/IID is an optional Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence. DSH and non-DSH supplemental payments are Medicaid payments made to providers that are separate from and in addition to the standard payment rates for services rendered to Medicaid enrollees.

DSH: Disproportionate Share Hospital

ICF/DD: Intermediate care facility for individuals with developmental disabilities

Per-Enrollee Medicaid Expenditures

In Medicaid, there are five main eligibility groups: children, adults, expansion adults,[40] the aged, and individuals with disabilities. Per-enrollee Medicaid expenditures across these groups averaged an estimated $8,813 in FY2022.[41] However, as shown in **Figure 5**, per-enrollee

[38] For more information about LTSS, see CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*.

[39] Hospitals also receive a significant portion of both the Medicaid DSH funding and the supplemental payments.

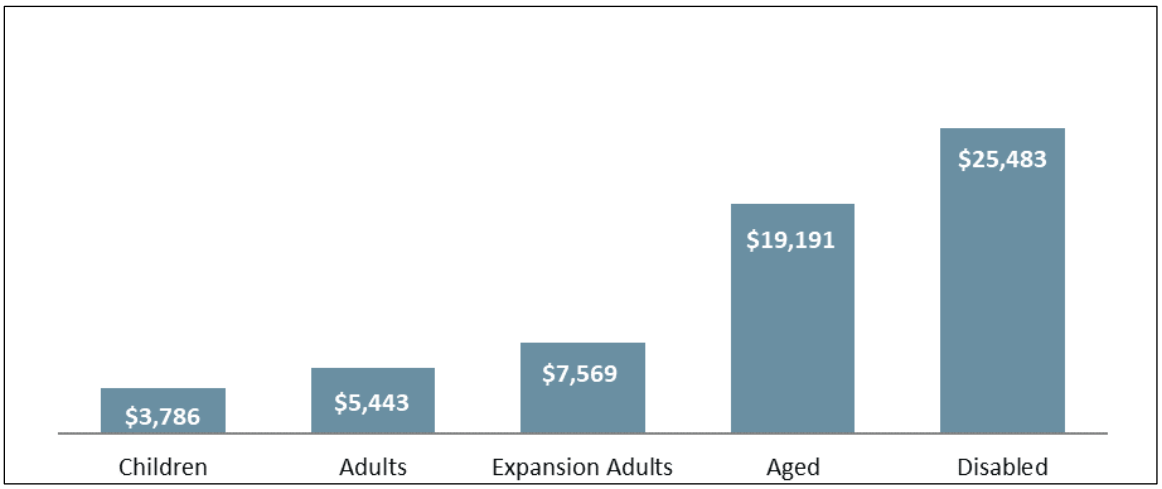
[40] Expansion adults are adults made newly eligible for Medicaid under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) beginning in 2014 pursuant to SSA §1902(a)(10)(A)(i)(VIII). For more information about the ACA Medicaid expansion, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*.

[41] The estimates of per enrollee expenditures exclude Medicaid expenditures for DSH and certain incentive and (continued...)

expenditures varied significantly by eligibility group, with the estimated per-enrollee expenditures by eligibility group ranging from $3,786 for children to $25,483 for individuals with disabilities.

Figure 5. Estimated Expenditures Per Medicaid Enrollee by Major Eligibility Groups

(FY2022)



Source: Medicaid and CHIP Payment and Access Commission, "EXHIBIT 19. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by Eligibility Group and Service Category, FY2022," *December 2024 MACStats: Medicaid and CHIP Data Book*, December 2024, at https://www.macpac.gov/publication/medicaid-benefit-spending-per-full-year-equivalent-fye-enrollee-by-eligibility-group-and-service-category/.

Notes: Enrollment is measured in full-year equivalents, which is the average enrollment over the course of the year. This chart does not include expenditures for DSH and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act.

One reason the aged and disabled populations have higher per-enrollee expenditures is because these populations consume most of the LTSS, which comprise 19% of all Medicaid expenditures (see **Figure 4**). Another reason for the difference in per-enrollee expenditures by eligibility group is that children and adults tend to be healthier and therefore tend to have lower health care costs than the aged and disabled populations, even though a significant number of nondisabled adults are pregnant women, who have higher costs on average than other nondisabled adults.

In 2020, the aged and disabled populations together accounted for about 22% of Medicaid enrollment and 54% of Medicaid expenditures. In comparison, the other populations (i.e., children, adults, and expansion adults) accounted for about 78% of Medicaid enrollment and 46% of Medicaid expenditures.[42]

Even though these differences are substantial, the estimates understate the total health expenditures for the aged and disabled populations because many aged and disabled individual

uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act. In addition, this figure is based on Medicaid enrollment measured by full-year equivalents, which is the average enrollment over the course of a year. (Medicaid and CHIP Payment and Access Commission, "EXHIBIT 19. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by Eligibility Group and Service Category, FY2022," *December 2024 MACStats: Medicaid and CHIP Data Book*, December 2024, at https://www.macpac.gov/publication/medicaid-benefit-spending-per-full-year-equivalent-fye-enrollee-by-eligibility-group-and-service-category/.)

[42] CMS, *2023 Medicaid and CHIP Beneficiary Profile: Enrollment, Expenditures, Characteristics, Health Status, and Experience*, April 2023, Page 17, at https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-profile-2023.pdf.

also are enrolled in Medicare (referred to as dual-eligible individuals). For dual-eligible individuals, Medicare is the primary payer before Medicaid. The per-enrollee expenditures shown in **Figure 5** reflect only the Medicaid expenditures, and Medicare expenditures for the dual-eligible individuals are not included.

Factors Affecting Medicaid Expenditures

Medicaid expenditures are influenced by economic, demographic, and programmatic factors. Economic factors include health care prices, unemployment rates, and individuals' wages. Demographic factors include population growth and the age distribution of the population. Programmatic factors include state decisions regarding which optional eligibility groups and services to cover and how much to pay providers. Other factors include the number of eligible individuals who enroll and their utilization of covered services.

Medicaid enrollment is affected by economic factors, which in turn impact Medicaid expenditures. Medicaid is a countercyclical program, which means Medicaid enrollment growth tends to accelerate when the economy weakens and tends to slow when the economy gains strength. People become eligible for Medicaid during economic downturns because they lose their jobs, experience reductions in income, or lose access to health benefits.[43]

State Variability in Medicaid Spending

Figure 6 shows that total Medicaid spending is highly concentrated, with the seven most populous states (California, New York, Texas, Pennsylvania, Florida, Ohio, and Illinois) accounting for almost half of Medicaid expenditures in FY2023 (see **Table A-1** for FY2023 state-by-state expenditures).[44] State variation in Medicaid per-enrollee expenditures is significant, with per-enrollee Medicaid expenditures ranging from $5,337 in South Carolina to $14,112 in the District of Columbia for FY2023.[45]

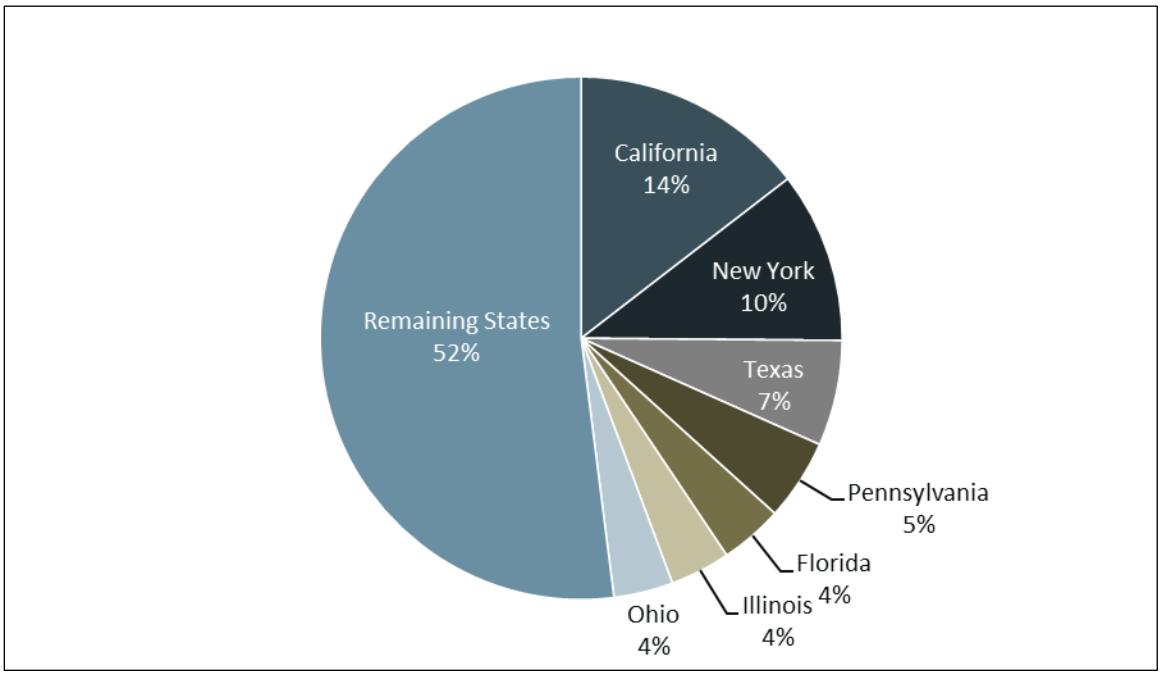
[43] For more information about the impact of recessions on the Medicaid programs, see CRS Report R46346, *Medicaid Recession-Related FMAP Increases*.

[44] U.S. Census Bureau, " Annual Estimates of the Resident Population for the United States, Regions, States, District of Columbia, and Puerto Rico: April 1, 2020 to July 1, 2023 (NST-EST2023-POP)", December 2023.

[45] Medicaid and CHIP Payment and Access Commission, "EXHIBIT 23. Medicaid Benefit Spending Per Full-Year Equivalent Enrollee for Newly Eligible Adult and All Enrollees by State, FY 2023," *December 2024 MACStats: Medicaid and CHIP Data Book*, December 2024, at https://www.macpac.gov/publication/medicaid-benefit-spending-per-full-year-equivalent-enrollee-for-newly-eligible-adult-and-all-enrollees-by-state/.

Figure 6. States' Share of Total Medicaid Expenditures

(FY2023)



Source: CMS, Form CMS-64 Data as reported by states to the Medicaid Budget and Expenditure System, as of May 29, 2024, at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

Notes: The expenditures shown in this figure include all Medicaid expenditures, which include both administrative and benefit spending. These expenditures exclude state Medicaid Fraud Control Units, Medicaid survey and certification of nursing and intermediate care facilities, and the Vaccines for Children program.

Some of the state variation in Medicaid per-enrollee expenditures is due to demographic differences across states. For instance, states with lower-than-average proportions of elderly and disabled Medicaid enrollees and higher-than-average proportions of Medicaid enrollees who are children and adults would be expected to have lower-than-average per-enrollee Medicaid expenditures. However, state policy choices regarding optional populations and services cause variation in Medicaid spending. Other reasons for state variation in Medicaid per-enrollee expenditures include variation in utilization and provider payment rates.

Conclusion

Medicaid continues to be a significant and growing component of national health expenditures. In FY2023, Medicaid expenditures totaled $894 billion, with the federal government paying $614 billion, or about 69% of the total. States paid the remaining $280 billion, or 31%, of Medicaid expenditures.

In recent years, Medicaid expenditures have increased significantly due to the temporary FFCRA FMAP increase and the associated continuous coverage requirement. As a result, both Medicaid enrollment and expenditures rose sharply from FY2020 through FY2023. With the end of the FFCRA FMAP increase on December 31, 2023, Medicaid enrollment is estimated to have fallen from 96 million in FY2023 to 83 million in FY2024, almost a 14% decrease. This reduction in Medicaid enrollment is expected to result in slower growth in total Medicaid expenditures.

Currently, Congress is discussing policy options for reducing federal Medicaid expenditures. The House of Representatives adopted the House FY2025 budget resolution (H.Con.Res. 14) on April 10, 2025. H.Con.Res. 14 includes reconciliation instructions directing the Committee on Energy and Commerce to reduce the deficit by not less than $880 billion for FY2025 through FY2034.[46] Some press reports suggest that much of the $880 billion in reductions could come from reductions to federal Medicaid expenditures.[47]

Detail has not been provided regarding how the $880 billion in reductions to federal Medicaid expenditures would be achieved. However, the following policy options have been discussed in the media as possibly being included in the budget reconciliation package: structural reforms to Medicaid financing, such as implementing Medicaid per capita caps (i.e., limiting federal Medicaid funding to states on per enrollee basis), as well as limiting or eliminating states' use of Medicaid provider taxes; amending the FMAP; limiting or eliminating state Medicaid directed payments; and implementing work requirements.

Some of these policy options would have implications for state budgets, and states would need to make decisions about how to respond to the reductions in federal Medicaid funding. States could choose to backfill the loss of federal funding with state funding, or states could choose to make cuts to their Medicaid programs in terms of Medicaid payment rates, income eligibility levels, or benefits. As policymakers consider potential reforms, the structure and variability of Medicaid expenditures, which are shaped by demographic, economic, and policy choices, highlight the tradeoffs involved in balancing fiscal sustainability with Medicaid's role in supporting health coverage for low-income populations.

[46] The Senate also adopted an FY2025 budget resolution (S.Con.Res. 7) on February 21, 2025. The Senate Finance Committee has jurisdiction of Medicaid, and it is instructed to reduce the deficit by $1 billion, but the Senate Finance Committee has broader jurisdiction than the House Energy and Commerce Committee. As a result, it is unclear how the Senate budget resolution might impact Medicaid expenditures.

[47] Margot Sanger-Katz and Alicia Parlapiano, "What Can House Republicans Cut Instead of Medicaid? Not Much.," *New York Times*, February 25, 2025, https://www.nytimes.com/2025/02/25/upshot/republicans-medicaid-house-budget.html; Joe Light, "Medicaid Cuts Appear Inevitable. States May Pick Up the Bill," *Barron's*, February 26, 2025, https://www.barrons.com/articles/medicaid-cuts-taxes-states-312ebfd5.

Appendix. Medicaid Expenditures by State

Table A-1 provides the most recent Medicaid expenditures for each state, the District of Columbia, and the territories, including both the federal and state shares of spending on benefits, administrative services, and total Medicaid expenditures. These Medicaid expenditures exclude spending for State Medicaid Fraud Control Units, Medicaid survey and certification of nursing and intermediate care facilities, and the Vaccines for Children program.

Table A-1. Medicaid Expenditures for Benefits and Administration for the States, the District of Columbia, and the Territories, FY2023

($ in millions)

	Benefits			State Program Administration			Total Medicaid		
	Federal	State	Total	Federal	State	Total	Federal	State	Total
Alabama	$6,079	$1,751	$7,830	$153	$106	$259	$6,232	$1,857	$8,089
Alaska	1,975	555	2,530	105	71	176	2,080	626	2,706
American Samoa	53	7	60	1	1	2	54	8	62
Arizona	17,906	4,278	22,184	197	119	316	18,102	4,397	22,500
Arkansas	6,954	1,651	8,605	352	176	528	7,306	1,827	9,133
California	80,518	42,216	122,734	4,438	2,962	7,400	84,956	45,178	130,134
Colorado	8,148	4,656	12,804	484	358	843	8,633	5,014	13,647
Connecticut	6,555	3,771	10,326	257	155	412	6,812	3,926	10,738
Delaware	2,404	936	3,340	81	47	127	2,485	982	3,467
District Of Columbia	3,230	898	4,129	116	73	189	3,346	971	4,317
Florida	22,297	11,897	34,194	400	248	648	22,697	12,145	34,842
Georgia	11,356	4,580	15,937	427	245	672	11,783	4,825	16,609
Guam	160	20	180	4	2	6	163	23	186
Hawaii	2,195	803	2,998	70	38	108	2,265	841	3,107
Idaho	2,830	709	3,539	91	50	141	2,921	760	3,681
Illinois	21,002	11,189	32,191	688	428	1,116	21,690	11,617	33,307
Indiana	13,035	4,243	17,278	327	214	541	13,363	4,457	17,820
Iowa	4,922	1,855	6,777	95	56	151	5,017	1,911	6,928
Kansas	3,368	1,825	5,193	153	90	243	3,521	1,915	5,437
Kentucky	13,315	2,984	16,299	222	121	343	13,537	3,105	16,642
Louisiana	12,883	3,323	16,207	273	149	422	13,156	3,473	16,629
Maine	2,963	1,138	4,101	123	62	186	3,086	1,201	4,287
Maryland	10,745	6,172	16,917	403	232	635	11,148	6,404	17,552
Massachusetts	14,118	9,110	23,228	733	526	1,260	14,851	9,637	24,488
Michigan	17,486	5,506	22,991	473	277	750	17,959	5,783	23,742

	Benefits			State Program Administration			Total Medicaid		
Minnesota	11,670	6,646	18,315	452	345	798	12,122	6,991	19,113
Mississippi	5,220	1,104	6,324	151	72	223	5,371	1,176	6,548
Missouri	12,456	3,409	15,865	303	190	493	12,759	3,599	16,358
Montana	1,870	469	2,339	74	32	106	1,944	502	2,445
CNMI	76	10	86	2	1	3	79	10	89
Nebraska	2,612	1,137	3,749	117	65	182	2,729	1,202	3,931
Nevada	4,297	1,275	5,572	124	75	198	4,421	1,350	5,770
New Hampshire	1,497	948	2,444	102	46	149	1,599	994	2,593
New Jersey	14,301	8,009	22,310	624	398	1,023	14,926	8,407	23,332
New Mexico	6,716	1,390	8,106	243	124	367	6,959	1,514	8,473
New York	58,919	33,526	92,445	1,226	931	2,157	60,145	34,456	94,602
North Carolina	14,082	5,243	19,326	697	429	1,126	14,779	5,673	20,452
North Dakota	1,001	514	1,515	67	31	98	1,069	545	1,613
Ohio	23,437	8,229	31,666	723	463	1,186	24,160	8,691	32,852
Oklahoma	7,046	1,559	8,605	149	100	249	7,195	1,659	8,854
Oregon	11,084	3,584	14,668	382	278	660	11,466	3,862	15,328
Pennsylvania	27,824	15,943	43,767	729	476	1,204	28,553	16,419	44,971
Puerto Rico	3,343	526	3,869	104	43	147	3,446	569	4,015
Rhode Island	2,285	1,164	3,449	150	87	237	2,435	1,250	3,685
South Carolina	6,370	2,081	8,451	269	151	420	6,639	2,233	8,872
South Dakota	802	371	1,173	59	31	90	861	403	1,264
Tennessee	8,847	3,623	12,470	686	278	964	9,533	3,901	13,434
Texas	36,907	19,608	56,514	1,169	740	1,909	38,075	20,348	58,423
Utah	3,421	1,111	4,531	128	69	197	3,548	1,180	4,728
Vermont	1,311	686	1,997	113	64	178	1,425	750	2,175
Virgin Islands	146	18	164	11	4	15	158	22	180
Virginia	14,067	7,054	21,122	313	164	478	14,381	7,218	21,599
Washington	12,219	6,122	18,341	629	528	1,157	12,848	6,651	19,499
West Virginia	4,443	984	5,427	199	64	263	4,642	1,048	5,690
Wisconsin	7,810	4,174	11,984	348	201	549	8,157	4,375	12,533
Wyoming	420	296	716	44	18	62	464	313	778
Total	$592,995	$266,887	$859,882	$21,056	$13,307	$34,363	$614,051	$280,193	$894,244

Source: CMS, Form CMS-64 Data as reported by states to the Medicaid Budget and Expenditure System, as of May 29, 2024, at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

Notes: May not sum to totals due to rounding.

CNMI: Commonwealth of the Northern Mariana Islands.

a. Figures presented in this table may change if states revise their expenditure data after this date.

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