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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. Medicaid is a federal and state partnership that is jointly financed by both the federal government and the states.

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Congressional Research Service Summary

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The Medicaid program is jointly funded by the

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federal government and states. The federal government pays states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP) . States must ensure they can fund their share of Medicaid expenditures for the care and services available under their state plan.

Financial Management | Medicaid

State Spending: Despite an increase in the state share of financing for the Affordable Care Act's (ACA's) Medicaid expansion (from 6% in 2018 to 7% in 2019 and 10% in FY 2020 –

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New Delhi, Nov 18 (PTI) N K Singh, Chairman of the 15th Finance Commission, on Wednesday suggested increasing public spending on the health sector to 2.5 per cent of the GDP in four years from 0 ...

Increase public spending on health sector to 2.5% of GDP ...

Health New England announced today a new diabetes program, taking effect January 1, 2021, that is aimed at improving health outcomes and lowering costs for its commercial members with diabetes. According

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to the CDC, over 10% of the U.S. population has diabetes, and having it can lead to increased medical costs, lost work and wages.

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. 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

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federal medical assistance percentage (FMAP) rate. 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 a good deal of flexibility in determining the composition of the state share (also referred to as the non-federal share) of Medicaid expenditures. As a result, there is significant variation from state to

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state in the funding sources used to finance the state share of Medicaid expenditures. In state fiscal year 2010, states reported that on average state general funds (i.e., revenues from personal income, sales, and corporate income taxes) made up 76% of the state share of Medicaid expenditures and the remaining 24% was financed by “other state funds” (i.e., provider taxes, local government funds, and tobacco settlement funds). In FY2011, Medicaid expenditures totaled \$428 billion, with the federal government paying \$271 billion, about 63% of the total. While Medicaid expenditures (like

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all health expenditures) generally grow at a rate faster than the economy, as measured by the gross domestic product (GDP), spending per enrollee under Medicaid tends to be lower than the per person spending for other forms of health insurance. One of the major factors impacting Medicaid spending is the economy. Also, state-specific factors, such as programmatic decisions and demographics, affect Medicaid expenditures and cause Medicaid spending to vary widely from state to state. Starting in FY2014, Medicaid expenditures are expected to increase significantly as a result of the reforms

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enacted in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended). The most noteworthy ACA change to Medicaid begins in 2014, or sooner at state option, when some states expand Medicaid eligibility to adults under age 65 with income up to 133% of the federal poverty level (FPL) (effectively 138% FPL with the Modified Adjusted Gross Income 5% FPL income disregard). Following the June 28, 2012, Supreme Court decision in *National Federation of Independent Business v. Sebelius*, it is uncertain how many states will refuse to expand their Medicaid program to cover this

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new group. The Congressional Budget Office and the Joint Committee on Taxation updated their estimate of the ACA Medicaid expansion to account for the Supreme Court decision, and they project the expansion will cost \$642 billion from FY2014 to FY2022, which is \$288 billion less than the estimate prior to the Supreme Court decision. This report provides an overview of Medicaid's financing structure, including both federal and state financing issues. The Medicaid expenditures section of the report discusses economic factors affecting Medicaid, state variability in spending, and projected program spending.

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Other issues that are examined include congressional proposals to turn Medicaid into a block grant program, federal deficit reduction proposals affecting Medicaid, and state fiscal conditions affecting Medicaid financing and services.

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The financing of the \$299 billion Medicaid

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program is shared between the fed. gov't. and states. States pay qualified providers for covered Medicaid services and receive fed. matching funds for expenditures authorized in their state Medicaid plans. In addition to these standard Medicaid payments, most states make supplemental payments to certain providers, which are also matched by fed. funds. This report provides info. about Medicaid supplemental payments and examines: (1) what info. states report about supplemental payments on Medicaid expenditure reports; and (2) in selected states, how much was distributed as supplemental payments, to

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what types of providers, and for what purposes. Includes recommendations. Illustrations.

This article provides an overview of financing for long-term services and supports (LTSS) in the United States, paying special attention to how it has changed and not

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changed over the last 30 years. Although LTSS expenditures have increased greatly (like the rest of health care), the broad outline of the financing system has remained remarkably constant. Medicaid—a means-tested program—continues to dominate LTSS financing, while private long-term care insurance plays a minor role. High out-of-pocket costs and spend-down to Medicaid because of those high costs continue to be hallmarks of the system. Although many major LTSS financing reform proposals were introduced over this period, none was enacted—except the Community Living Assistance Services and Supports Act, which

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was repealed before implementation because of concerns about adverse selection. The one major change during this time period has been the very large increase in Medicare spending for post-acute services, such as short-term skilled nursing facility and home health care. With the aging of the population, demand for LTSS is likely to increase, placing strain on the existing system.

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