Medicaid Financing

Since the Medicaid program was enacted as part of the Social Security Amendments of 1965 (P.L. 89-97), Medicaid financing has been a shared responsibility of the federal government and the states, with states receiving federal matching funds toward allowable state expenditures and each state administering its own program within federal guidelines. For most Medicaid service expenditures, the federal share of costs is determined by each state's federal medical assistance percentage (FMAP), which is determined each year based on a state's per capita income relative to the national average.

This issue brief provides information on the components of Medicaid financing, including federal matching rates and exceptions, state funding sources, and the process used by states to claim federal matching funds.

Background

Medicaid is a joint federal-state program that provided health insurance coverage to an estimated 100.1 million people who were enrolled in the program at any point during fiscal year (FY) 2023 (MACPAC 2024). As a major payer in the U.S. health care system, it accounted for about 17.9 percent of national health care spending in calendar year 2023, less than either Medicare (21.2 percent) or private insurance (30.1 percent) (MACPAC 2025a, preliminary analysis).

Medicaid provides coverage for health and other related services for low-income children and their families, low-income seniors, and low-income people with disabilities. These populations often have complex health needs and may face challenges in obtaining health care services without assistance. Medicaid provides benefits not typically covered (or covered to a lesser extent) by other insurers, including long-term services and supports. It also pays for Medicare premiums and cost sharing for more than 13 million people who are enrolled in both programs (CMS 2024). It is also a major source of financing for care delivered by certain providers, particularly rural hospitals or safety net institutions that serve both low-income and uninsured individuals.

Variability in Medicaid is the rule rather than the exception. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines, effectively creating 56 different Medicaid programs—one for each state, territory, and the District of Columbia. States also differ in how they finance the non-federal share of Medicaid expenditures.

Medicaid is a source of federal financing for costs that might otherwise be borne by states and local governments solely from their own revenues, individuals paying out of pocket, and providers supplying care at free or reduced rates. In FY 2024, the federal share of Medicaid spending was approximately 64.5 percent nationally (MACPAC 2025b, preliminary estimate). This includes a temporary increase in the FMAP for the first quarter of the year as assistance under the Families First Coronavirus Response Act of 2020 (FFCRA, P.L. 116-127) phased out, as designed.

States that operate their Medicaid programs within federal guidelines receive federal reimbursement for a share of their total program costs. States incur these costs by making payments to health care providers and managed care plans and by performing administrative tasks such as making eligibility determinations, enrolling and monitoring providers, and paying claims. States receive federal matching dollars, also known as federal financial participation (FFP), based on their reports of Medicaid expenditures to the federal government. Medicaid's financing structure provides federal matching funds on all allowable state expenditures without a pre-set upper limit or cap.[1]

FMAP

The FMAP, a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa), determines the federal share for most Medicaid service costs.[2] The use of a state's relative per capita income in the FMAP formula is intended to represent the state's funding ability. The U.S. Department of Health and Human Services (HHS) calculates FMAPs one year before the fiscal year in which they are effective (e.g., FY 2026 FMAPs are calculated in calendar year 2024), using a 3-year average of the most recently available per capita income data reported by the Department of Commerce (§ 1101(a)(8)(B) of the Social Security Act (the Act)).

FMAPs have a statutory minimum of 50 percent and maximum of 83 percent. Certain exceptions apply, however, as detailed below.

Exceptions to standard match

At various points in Medicaid's history, Congress has created exceptions to the standard FMAP to reflect particular policy priorities. For example, Congress established incentives for states to provide certain benefits and encouraged states to extend eligibility for optional groups. An enhanced match has also been used to provide fiscal relief to states during economic downturns or when affected by disasters, or as special exceptions for certain populations or territories, as detailed below. A more comprehensive list of can be found on the MACPAC website.

U.S. Territories

Medicaid operates in the five U.S. territories: American Samoa, the Commonwealth of Northern Mariana Islands (CNMI), Guam, Puerto Rico, and the U.S. Virgin Islands. The territories are considered states for the purposes of Medicaid, unless otherwise indicated (§ 1101(a)(1) of the Act). However, their programs differ in many respects from those in the 50 states and the District of Columbia. The most notable difference is that rather than having an open-ended financing structure, Medicaid in the territories operates with an annual ceiling on FFP, referred to as the Section 1108 cap or Section 1108 allotment (§ 1108(g) of the Act). The federal government matches territory dollars up to the specified annual Section 1108 allotment, and beyond that, the territories generally must fund their programs with local funds.

The federal government and territorial governments jointly finance the territories' Medicaid programs. Each territory must contribute its non-federal share of Medicaid spending to access federal dollars, which are matched at the designated FMAP. The FMAP for the territories is not calculated based on per capita incomes; instead, the FMAP is a fixed match rate determined in statute. Historically, the FMAP was 55 percent, but most recently, the Consolidated Appropriations Act, 2023 (P.L. 117-328) set the FMAP for American Samoa, CNMI, Guam, and the U.S. Virgin Islands permanently at 83 percent and set the FMAP for Puerto Rico at 76 percent through FY 2027.

Medicaid expansion population

For individuals who meet the definition of newly eligible through the Medicaid expansion for non-elderly adults under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), there is an increased FMAP (100 percent for 2014–2016, phasing down to 90 percent in 2020 and subsequent years) (§ 1905(y) of the Act). This matching rate covers those who would not have been eligible for Medicaid in the state as of December 1, 2009, or who were eligible under a waiver but not enrolled because of limits or caps on waiver enrollment. In states that expanded eligibility to low-income parents and adults without children prior to the ACA, the traditional matching rate was increased gradually until it equaled the newly eligible matching rate in 2020 (§ 1905(y) of the Act).

The American Rescue Plan Act (P.L. 117-2) offered a 5 percent FMAP increase for eight quarters to any state newly adopting the ACA Medicaid expansion, beginning in March 2021 (§ 1905(ii) of the Act). Under Public Law

119-21, an Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, states that adopt the Medicaid expansion after January 1, 2026 will not be eligible for this temporary FMAP increase (§ 1905(ii)(3)(B) of the Act).

Certain services

Certain services receive a higher FMAP established in statute. For example, services provided at an Indian Health Service facility receive a 100 percent FMAP (§ 1905(b) of the Act) and family planning services receive a 90 percent FMAP (§ 1903(a)(5) of the Act).

FMAP increases may be used as an incentive for states to cover optional services. For example, expenditures made for home- and community-based attendant services and related supports under the Community First Choice option receive a 6-percentage point increase on the state's FMAP (§ 1915(k)(2) of the Act). In some cases, the FMAP increase is time limited. For example, states that establish a health home to coordinate care for individuals with chronic conditions receive a 90 percent FMAP for specific health home services for the first eight quarters the health home option is in effect.

Economic downturns

Medicaid is a countercyclical program: enrollment and spending increase when a downturn in the economic cycle leads to rising unemployment and growth in both the low-income population and the number of people losing employer-sponsored insurance. During economic downturns, enrollment in Medicaid grows resulting in increasing costs to states while tax revenues decline. However, although Medicaid spending can increase in response to changes in economic activity, the FMAP, which determines how much states must contribute toward Medicaid benefit expenditures, is calculated one year prior to the effective date using data that are as much as five years old. This formula, which normally helps provide budget stability by minimizing year-to-year changes, also constrains how quickly and the amount the federal share can increase in response to declining state economic conditions.

In response to recent economic downturns, Congress has passed legislation to provide a temporary, enhanced FMAP to support the costs of increased Medicaid enrollment and to offer additional fiscal relief to states. For example, the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) provided a temporary increase in each state's FMAP from October 2008 through December 2010 in response to the economic recession. More recently, the FFCRA increased each state's FMAP by 6.2 percentage points during the public health emergency period associated with the COVID-19 pandemic.[3]

Medicaid-expansion State Children's Health Insurance Program (CHIP)

CHIP is a joint federal-state program that provides coverage to uninsured children in families whose incomes are too high to qualify for Medicaid. CHIP gives states flexibility to create their programs as an expansion of Medicaid, as a program entirely separate from Medicaid, or as a combination of both approaches.

Unlike Medicaid, federal CHIP funding is capped. Federal CHIP allotments are provided to states annually, with amounts based on each state's recent CHIP spending increased by a growth factor. An enhanced FMAP (E-FMAP) is provided for both services and administration under CHIP, subject to the availability of funds from a state's federal allotment. The E-FMAP is calculated by reducing the state share under the regular FMAP by 30 percent. When a state expands its Medicaid program using CHIP funds (rather than Medicaid funds), the enhanced FMAP applies and is paid out of the state's federal CHIP allotment.

Federal Match for Administrative Costs

The federal match for Medicaid administrative activities does not vary by state and is generally 50 percent, although certain administrative functions have a higher federal match (§ 1903(a) of the Act). These exceptions include administrative activities that require medically trained personnel, the operation of information systems for eligibility and claims processing, fraud control activities, and administration of services that have higher medical

assistance match rates. For example, expenditures related to the design, development, and implementation of a Medicaid management information system or eligibility determination system receive a 90 percent federal match, while expenditures related ongoing operations of these systems receive a 75 percent federal match. A more comprehensive list of federal matching rates for administrative activities can be found on the MACPAC website.

In many cases, higher administrative match rates are provided only for expenditures that meet certain conditions; for example, external quality review activities conducted by a qualified organization that meets specific requirements can be matched at 75 percent, while the same activities conducted by other types of organizations can only be matched at 50 percent (§ 1903(a)(3)(C)(ii) of the Act).

If a state contracts with managed care plans under a risk contract, amounts paid to the managed care plan to cover administrative functions are matched as a medical assistance cost at the applicable FMAP, not as an administrative cost (42 CFR 438.812).

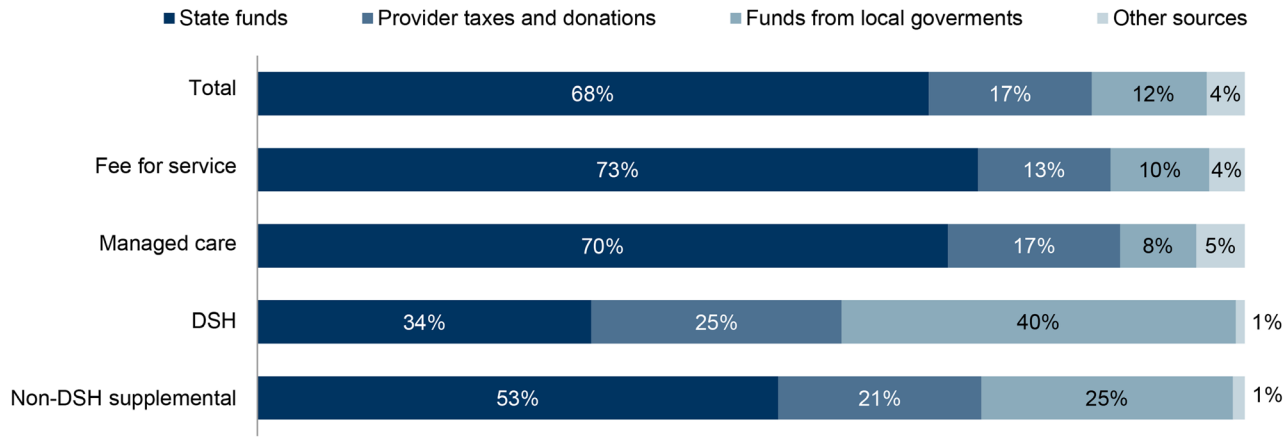
State Funding Sources

The Medicaid statute permits states to raise their share of Medicaid expenditures through multiple sources, including state general revenue, contributions from local governments (including providers operated by local governments), and specialized revenue sources such as permissible health care-related taxes. At least 40 percent must be financed by the state, and up to 60 percent may come from local governments (§ 1902(a)(2) of the Act).

The extent to which states rely on funding sources other than state general revenue varies considerably and may be influenced by how states have historically split financing with localities for functions such as education, social services, indigent care, and corrections. Counties, municipalities, and other units of local government contribute to the non-federal share of Medicaid spending in many states. These units of local government, which may also be Medicaid providers (e.g., a county hospital or school district), either transfer local government funds in the amount of the non-federal share of Medicaid payments to the state Medicaid agency through an intergovernmental transfer (IGT), or certify the total expenditure incurred to provide Medicaid services or Medicaid program administration, known as a certified public expenditure (CPE).

As shown in Figure 1, in state fiscal year (SFY) 2018, 68 percent of funds came from state general revenues, 12 percent from local governments (including intergovernmental transfers and certified public expenditures), 17 percent from health care related taxes, and 4 percent from other sources (GAO 2020).

Figure 1: Share of Non-Federal Funds for Medicaid Payments from Different Sources, SFY 2018



Notes: SFY is state fiscal year. DSH is disproportionate share hospital. State funds include state general funds and interagency transfers. Funds from local governments include intergovernmental transfers and certified public expenditures. Other sources include funds, such as tobacco settlement funds, that are used to fund the state's non-federal share of Medicaid expenditures and are not considered to fit in the other categories listed. Numbers do not sum to 100 due to rounding.

Source: U.S. Government Accountability Office (GAO). 2020. *CMS needs more information on states' financing and payment arrangements to improve oversight*. Report no. GAO-21-98. Washington, DC: GAO. https://www.gao.gov/products/GAO-21-98.

Health care-related taxes

Health care-related taxes (often referred to as provider taxes, fees, or assessments) are defined by federal statute as taxes of which at least 85 percent of the tax burden falls on health care providers or services (§1903(w)(3)(A) of the Act). Federal regulations also consider a tax that is not limited to health care items or services to be health care related if it treats health care providers differently than other individuals or entities. Such taxes are typically approved by state legislatures and are mandatory for providers.

Federal statute and regulations place limits on states' ability to use such tax revenue as the non-federal share of Medicaid payments. In general, taxes must be broadly applied to all nongovernmental providers throughout the jurisdiction of the taxing authority, and the tax amount must be uniformly applied. However, states can apply for waivers of these federal requirements if the tax meets certain statistical tests that are intended to ensure that the net costs and benefits of the tax are generally redistributive and the amount of the tax is not an undue burden on Medicaid providers.

In addition, providers cannot be held harmless through a direct or indirect guarantee that they will be repaid for all or a portion of the taxes that they pay. However, the indirect guarantee test does not apply if the tax rate falls within a safe harbor established under statute. Public Law 119-21 restricts these safe harbor provisions, setting the threshold at zero percent for new provider taxes. The safe harbor for existing provider tax arrangements will be set at current tax rate; however, expansion states will be subject to a phase down of the safe harbor threshold beginning in 2028.[4]

Public Law 119-21 also establishes new standards for waivers of the uniform tax requirement for Medicaid provider taxes. A provider tax will not be considered generally redistributive if the arrangement taxes Medicaid units (e.g., hospital days) or high-volume Medicaid providers more than non-Medicaid units or low-volume Medicaid providers (§ 1903(w)(3)(E)(iii) of the Act).[5] These new standards for waivers of the uniform tax requirement are effective upon the date of enactment (July 4, 2025), and the Secretary has discretion to apply a transition period not to exceed three fiscal years (§71117(c) of Public Law 119-21).

Intergovernmental Transfers (IGTs)

An IGT is a transfer of funds from another governmental entity (e.g., a county or other state agency) to the Medicaid agency before a Medicaid payment is made. When these funds are used as the non-federal share of a Medicaid expenditure, they are eligible for FFP (§1903(w)(6) of the Act; 42 CFR 433.51). IGTs are commonly used by counties to contribute the non-federal share for certain governmental providers (e.g., community mental health centers, hospitals) located in those counties. IGTs may also be contributed directly by governmental providers themselves, such as hospitals operated by state or local government.

Public providers, such as public hospitals, can derive the funds that they use for IGTs from any public funds, including local tax revenue or patient revenue. If local governments impose health care-related taxes, the federal rules that apply to statewide taxes also apply.

Certified Public Expenditures (CPEs)

A CPE is a financing approach by which a governmental entity, including a governmental provider (e.g., county hospital, local education agency), incurs an expenditure eligible for FFP under the state's approved Medicaid state plan (§1903(w)(6) of the Act; 42 CFR 433.51). The governmental entity certifies that the funds expended are public funds used to support the full cost of providing the Medicaid-covered service or the Medicaid program administrative activity. Based on this certification, the state then claims FFP. Under a CPE arrangement, the non-federal share amount is not transferred to the state. States are not required to pay the federal share associated with CPEs to providers. Any CPE from a public provider can be used only to finance payments to the provider certifying the allowable Medicaid service.

CPE-based financing must recognize actual costs incurred. As a result, CMS requires cost reimbursement methodologies for providers using CPEs to document the actual cost of providing the services, typically determined through a statistically valid time study, periodic cost reporting, and reconciliation of any interim payments.

Provider donations

Provider donations are voluntary contributions made directly or indirectly to a state or a local government by or on behalf of a health care provider or entity related to a health care provider. Provider-related donations are permissible if they are bona fide donations, which means there is no direct or indirect relationship to the payments made to the provider under a hold harmless provision. Donations of up to $5,000 per year for individual providers and up to $50,000 per year for health care organizations are presumed to be bona fide donations so long as there is no hold harmless provision.

Federal rules on provider donations also apply to local units of government. As a result, public agencies that provide IGTs for payments to a non-governmental provider cannot receive impermissible donations from these providers.

Process for State Claiming of Federal Medicaid Funds

State Medicaid withdrawals of federal funds are authorized under Section 1903(a)(1) of the Act, which requires HHS to make quarterly grant awards matching state costs for medical assistance and administrative activities based on the relevant FMAP.

Before each quarter, a state submits the Medicaid Program Budget Report (Form CMS-37) that provides the state's funding requirements for the current and next fiscal year to regional administrators of the CMS Center for Medicaid and CHIP Services, which prepares a decision report recommending initial state grant allotments. Once the grant awards are finalized, HHS's fiscal intermediary makes funds available to the states through the HHS Payment Management System (PMS), which the agency uses to account for and track state withdrawals for Medicaid and CHIP and other HHS-funded activities in the state (OIG 2016).

Throughout the quarter, states can withdraw federal Medicaid funds from their PMS accounts for qualified Medicaid expenditures. Thirty days after the end of the fiscal quarter, states must submit the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) to CMS, reporting actual spending and any spending adjustments from prior periods. CMS staff compare the Form CMS-64 to the corresponding Form CMS-37, account for any supplemental grant funding, and adjust the grant award to the extent that the state spent more or less than estimated.

Endnotes

[1] State Medicaid programs are statutorily required to make disproportionate share hospital (DSH) payments to hospitals that serve a high proportion of Medicaid beneficiaries and other low-income patients (§ 1923 of the Act). The total amount of such payments is limited by annual federal DSH allotments, which vary widely by state. In addition, federal statute and regulations have established upper payment limits on certain services (e.g., hospitals, nursing facilities, durable medical equipment) above which federal matching funds are not available.

[2] Section 1905(b) of the Social Security Act specifies the formula for calculating FMAP as follows: FMAP = 1 – [(state per capita income squared ÷ U.S. per capita income squared) × 0.45].

[3] The increased FMAP under the FFCRA was retroactive to January 1, 2020, and as a provision of receiving it, states were required to provide continuous coverage for beneficiaries (i.e., no disenrollment). In 2023, the Consolidated Appropriations Act of 2023 (CAA, P.L. 117-328) decoupled the end of the continuous coverage requirement from the public health emergency. The CAA established an end date of March 31, 2023, for the requirement and a phase-down of the enhanced matching rate over the remainder of 2023 for states that met certain renewal processing and data reporting requirements.

[4] Currently, the hold harmless threshold is 6 percent of the provider's net patient revenue. Under Public Law 119-21, the safe harbor threshold will change for fiscal years beginning on or after October 1, 2026 (§ 1903(w)(4)(C)(ii) of the Act). After October 1, 2026 the hold harmless threshold is 0 percent for any new provider tax that was not in effect as of July 4, 2025, the date of enactment of Public Law 119-21 (§ 1903(w)(4)(D)(i)(I)(bb), (II)(bb) of the Act). For provider taxes that were in effect as of July 4, 2025, the safe harbor differs between expansion and non-expansion states. For states that have not adopted the Medicaid expansion, the hold harmless threshold for a particular class of providers is set at applicable percent of net patient revenue that was in effect as of July 4, 2025, so long as the tax amount was within the prior safe harbor (§ 1903(w)(4)(D)(i)(I)(aa) of the Act). For states that have adopted the Medicaid expansion, the hold harmless threshold for a particular class of providers is set at applicable percent of net patient revenue that was in effect as of July 4, 2025; however, these existing tax arrangements will be subject to an upper limit starting in FY 2028 (§ 1903(w)(4)(D)(i)(II)(aa) of the Act). In FY 2028, the hold harmless threshold will be the lower of the existing percent of net patient revenue or 5.5 percent; this upper limit phases down by 0.5 percent annually until reaching 3.5 percent in FY2032 (§ 1903(w)(4)(D)(ii) of the Act). In expansion states, taxes on nursing facility or intermediate care facility provider classes are exempt from the upper limit (§ 1903(w)(4)(D)(iv) of the Act).

[5] A provider tax arrangement will not be considered generally redistributive if it implements a higher tax rate on Medicaid taxable units than on non-Medicaid taxable units or implements a lower tax rate on low-volume Medicaid providers than on high-volume Medicaid providers. A tax arrangement that has a similar effect as either of the above arrangements would also not be considered generally redistributive for purposes of waiving the uniform tax requirement (§ 1903(w)(3)(E)(iii) of the Act).

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