

OKLAHOMA HEALTH CARE AUTHORITY
ANALYSIS OF FFY06 FMAP CHANGES AND
RECOMMENDATIONS TO MODIFY FORMULA

- **Issue**

In the fall of 2004 the Centers for Medicare and Medicaid Services (CMS) published the Federal Medical Assistance Percentage (FMAP). The 2006 FMAP for Oklahoma is 67.91%, a decrease of 2.27 percentage points or 3.23% from the 2005 FMAP of 70.18%.

Unless there is a change, Oklahoma will lose over \$65 million when the 2006 FMAP is fully annualized. The loss in funds could impact Medicaid providers (physicians, hospitals, nursing homes, etc.) due to decreased funds available for reimbursements. Most importantly, the loss in funds could impact Medicaid eligible recipients (e.g., the elderly and children) because the loss in funds may ultimately require a reduction in services.

- **Recommendation I (explanation can be found on Page 2)**

Limit decreases to the Federal Medical Assistance Percentage (FMAP) for Medicaid to no more than 1 percentage point per year for states which receive low disproportionate share hospital (DSH) program payments. The recommendation will limit the impact of changes to the per capita income (PCI) reports issued by the US Department of Commerce and target a benefit to states which provide a high level of care to low income persons but can not receive additional DSH payments due to statutory caps imposed on the program.

States impacted by this recommendation include: Oklahoma, Alaska, New Mexico, North Dakota, Montana, Utah and Wyoming.

- **Recommendation II (explanation can be found on Page 6)**

Recommend that the Federal Medical Assistance Percentage (FMAP) be held harmless at the 2005 FMAP rate and that a Blue Ribbon Commission be established to recommend a more accurate method of calculating FMAP for the future.

Explanation and Justification for Recommendation I

Federal law dictates the FMAP formula as follows:

$$\text{FMAP} = 1 - .45 \times \frac{\text{state PCI}^2}{\text{US PCI}^2} \quad (42 \text{ U.S.C. } 1396d, \text{ SEC. } 1905(b))$$

In addition, federal law states that:

“[T]he Federal percentage for each State (other than Puerto Rico, the Virgin Islands, and Guam) shall be promulgated by the Secretary between October 1 and November 30 of each year, on the basis of the average per capita income of each State and of the United States for the **three most recent calendar years for which satisfactory data are available from the Department of Commerce**. Such promulgation shall be conclusive for each of the four quarters in the period beginning October 1 next succeeding such promulgation... (42 U.S.C. 1301, SEC. 1101).”

There are several issues with the FMAP formula that are problematic. First, the annual PCI, as calculated by the US Department of Commerce’s Bureau of Economic Analysis (BEA), is a fluid number that changes every quarter as income data is reviewed and improved upon by BEA. BEA then issues two reports a year on PCI – one in the spring and one in the fall. The fall PCI report incorporates revisions for both the current year and prior years.

CMS uses the fall BEA report to calculate FMAP. Rather than applying the current PCI to the previous year’s FMAP calculation and bring the previously reported annual PCI numbers forward, CMS changes the historical years’ PCI pursuant to the BEA revisions and then does the FMAP calculation.

If CMS simply applied the new and current PCI for 2003 to the previously used PCI numbers for the 2006 FMAP calculation, Oklahoma’s FMAP for 2006 would be 69.18%. The following table compares the published FMAP for Oklahoma to what the FMAP would have been had CMS simply used the current PCI for each year with the previously reported PCI between 2004 and 2006:

	Published Oklahoma FMAP Using BEA Current PCI Plus Revised Historical PCI	Re-calculated Oklahoma FMAP Using BEA Current PCI Plus Original PCI for Each Year	FMAP Difference: Recalculated Less Published
2004 FMAP	70.24%	70.52%	0.28%
2005 FMAP	70.18%	70.25%	0.07%
2006 FMAP	67.91%	69.18%	1.27%

Second, every four to five years BEA does a comprehensive revision of the PCI where new definitions are applied and old definitions are perfected for statistical purposes. The comprehensive revision applies to every year PCI was calculated all the way back to 1929.

The most recent BEA comprehensive revisions of PCI occurred in 1999 and 2003. After the 2003 revisions, 29 states will lose Medicaid funds, 9 states will gain funds while the balance of the states will remain the same because they are already at the statutory minimum FMAP of 50%.

According to a September 28, 2004, Bulletin from Federal Funds Information for States (FFIS), the FMAP will cause Medicaid programs nationally to lose \$527 million in federal matching funds (not including SCHIP grants which will lose \$13 million nationally).

The constant revisions to the PCI data create a moving and somewhat unreliable target for states to use when trying to estimate FMAP.

The following table illustrates the effects on PCI due to BEA revisions for Alaska, New Mexico, Wyoming, Oklahoma and the United States. The four states displayed are impacted most by the recent BEA revisions to PCI.

BEA Original PCI Release Numbers Used By CMS					
Release Date..... For Calendar Year..... FMAP.....	October-00 for 1999 FMAP 2002	December-01 for 2000 FMAP 2003	October-02 for 2001 FMAP 2004	August-03 for 2002 FMAP 2005	October-04 for 2003 FMAP 2006
Alaska	28,577	29,597	30,936	31,792	33,254
Wyoming	26,396	27,436	29,416	30,494	32,235
New Mexico	21,853	21,883	23,155	23,908	25,502
Oklahoma	22,953	23,582	25,071	25,136	26,567
United States	28,542	29,451	30,472	30,832	31,459
BEA Comprehensive Revision PCI Issued for 2003					
States	1999	2000	2001	2002	2003
Alaska	28,100	29,863	31,868	32,580	33,254
Wyoming	26,536	28,463	30,502	30,892	32,235
New Mexico	21,042	22,134	24,101	24,730	25,502
Oklahoma	22,567	24,410	26,015	25,812	26,567
United States	27,939	29,847	30,580	30,795	31,459
BEA Revised PCI Number less Original PCI Release Number					
States	1999	2000	2001	2002	2003
Alaska	-477	266	932	788	0
Wyoming	140	1,027	1,086	398	0
New Mexico	-811	251	946	822	0
Oklahoma	-386	828	944	676	0
United States	-603	396	108	-37	0

As the above table indicates, the BEA revisions and adjustments substantially increased each state's PCI beginning in 2000 while the United States' PCI did not change much and actually decreased in 1999 and 2002 through the revision process.

The PCI revisions, as illustrated above, and the method used by CMS to calculate FMAP caused the Oklahoma FMAP to decline substantially for 2006. The total annual impact of the decline will be over \$65 million and will impact providers and eligible clients alike.

To limit the impact on the federal budget from the changes proposed above we recommend that the 1 percentage point FMAP reduction limit only be applied to low disproportionate share hospital program (DSH) states which will target the benefit to states which provide a high level of care to low income persons but can not receive additional DSH payments due to statutory caps imposed on the program.

During the 1980s, the states were given broad authority to use funds provided by the DSH program. Many states were able to pass laws that exploited the program in order to address their special health care needs. In an attempt to control federal DSH expenditures during the 1990s, Congress limited the ability of states to exploit the DSH program, established state and hospital specific DSH allotments and limited future growth in the allotments.

Unfortunately, the Congressional action locked in large inequities in states' ability to utilize DSH to address the increasing cost of providing health care to low income persons. In 2003 Congress attempted to address the inequities in the DSH laws by providing low DSH states with 16% annual allotment increases to the program through 2009.

The 2003 changes to the DSH program, however, will be offset by the loss of Medicaid funds to low DSH states due to the FMAP changes. States that did not take advantage of the DSH program when it was broad and open ended during the 1980s and are currently locked into an inequitable funding stream should not continue to be adversely impacted by other administrative changes which are beyond their control.

The following table displays the 2001 Medicaid expenditures for low DSH states as presented by the National Health Policy Forum in a September 14, 2004, background paper:

Medicaid Expenditures on Low DSH State Per Enrollee and per Uninsured Person, 2001 (*)				
	2001 DSH Payment (In thousands)	Percent Total of Medicaid Payments	DSH Payment per Resident below 100% FPL	DSH Per Uninsured Person
U.S. Average	\$15,854,176	7.40%	\$482	\$385
Montana	\$244	0.10%	\$2	\$2
Utah	\$724	0.10%	\$3	\$2
Wyoming	\$241	0.10%	\$6	\$3
North Dakota	\$1,061	0.30%	\$12	\$18
New Mexico	\$15,265	1.00%	\$47	\$41
Oklahoma	\$22,702	1.10%	\$45	\$37
Alaska	\$13,975	2.40%	\$259	\$140
(*) Source: Mechanic, Robert E., "Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments." September 14, 2004, National Health Policy Forum; George Washington University.				
FPL = Federal Poverty Level (\$17,650 for a family of four in 2001)				
The "Medicare Prescription Drug, Improvement, and Modernization Act of 2003" defined extremely low DSH states as those states whose DSH payment is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year as of August 31, 2003.				

Limiting and targeting the FMAP reductions is a fair and equitable way to treat the changes and vagaries of the BEA revisions to PCI and the method used by CMS to calculate FMAP each year. The following table illustrates the estimated cost of the proposal:

Oklahoma Health Care Authority Estimated Federal Cost Impact to Cap FMAP Reduction at 1 Percentage Point (for Certain States) Projected FFY 2006					
State	2006 FMAP Reduction	Medicaid Expenditures	Total Cost to State w/Full FMAP Reduction	Federal Amount to States w/ Cap on FMAP Reduction	Reduction to States w/ 1 Percentage Point Cap on Reduction
Alaska	7.42%	927,820,408	68,844,274	59,566,070	9,278,204
Wyoming	3.67%	411,742,028	15,110,932	10,993,512	4,117,420
N. Mexico	3.15%	2,507,212,586	78,977,196	53,905,071	25,072,126
Oklahoma	2.27%	2,924,733,647	66,391,454	37,144,117	29,247,336
N. Dakota	1.64%	565,830,511	9,279,620	3,621,315	5,658,305
Utah	1.38%	1,445,925,839	19,953,777	5,494,518	14,459,258
Montana	1.36%	726,849,009	9,885,147	2,616,656	7,268,490
Total		9,510,114,027	268,442,400	173,341,260	95,101,140
Note: Included are states that are: a) projected to experience an FMAP reduction in excess of 1 percentage point; and b) Defined as a low disproportionate share state (Low-DSH) state in accordance with criteria specified in the Federal MMA.					
Estimated costs provided in this chart are based on state MAP expenditures published on CMS 64 Reports (2004 trended by 9% for 2 years). The costs do not reflect official estimates from any of the States, but should provide a fair representation of the impact for each state.					

Explanation and Justification for Recommendation II

The Medicaid FMAP formula was created in federal statute in 1965. The formula does not apply to the territories. While the formula has not been changed since 1965 there have been two exceptions made to it for the District of Columbia and Alaska. No state can receive a match rate of less than 50% or more than 83%.

By federal law the FMAP formula is based on the relationship between a state's 3-year average of its personal per capita income to the 3-year average of the national personal per capita income (PCI). The formula squares the PCI to reflect its dual purpose as a proxy for a state's economic condition and financial capacity to fund the Medicaid program and as a reflection of the state's level of poverty.

In 1965 per capita income was considered the best measure of a state's economic wealth and ability to support the federal Medicaid program. As such, PCI is the only variable in the formula.

As discussed above in Recommendation I, the annual PCI, as calculated by BEA, is a fluid number that changes every quarter as income data is reviewed and improved upon by BEA. BEA then issues two reports a year on PCI – one in the spring and one in the fall. The fall PCI report incorporates revisions for both the current year and prior years. Finally, every three to four years BEA does a comprehensive revision of PCI definitions and methods and revises the PCI numbers all the way back to 1929.

CMS uses the fall BEA report to calculate FMAP. Rather than applying the current PCI to the previous year's FMAP calculation and bring the previously reported annual PCI numbers forward CMS changes the historical years' PCI pursuant to the BEA revisions and then does the FMAP calculation.

The BEA revisions to the PCI can dramatically change a state's PCI and the relationship a state PCI has to the national average. The revisions can have serious consequences for state FMAPs.

There is an inherent problem with the entire process involving PCI, which was noted in a July 2003 GAO report and a report issued by AARP in September 2004.¹ Under federal law, FMAP percentages for the next federal fiscal year are reported at the beginning of the current federal fiscal year. Due to statistical limitations and methods used by BEA, and the CMS reporting requirements, the annual FMAP percentages are based on a 3-year average of 3-year old PCI

¹ Miller, Vic. Federal Funds Information for States (FFIS). "The Medicaid Matching Formula: Policy Considerations and Options for Modification." # 2004-09, AARP Public Policy Institute. September 2004.

United States General Accounting Office (GAO) # 03-620. "Medicaid Formula: Differences in Funding Ability among States Often are Widened." July 2003.

data. As such, the 2006 FMAP was established using an average PCI for the years 2001 through 2003.

In addressing the PCI as a proxy for state's financial capacity and economic condition and as a reflection of a state's poverty level the GAO report concluded that:

- PCI is not a comprehensive measure of either a state's resources and or as a proxy measure of the size of and cost to serve a state's population in poverty;
- the current Medicaid formula does not adequately address wide differences among states in their ability to fund program services and the formula's reliance on PCI is the primary cause; and
- under the current Medicaid system, two states devoting roughly the same proportion of their resources to Medicaid spend very different amounts per person in poverty.

In addition, the September 2004 AARP report prepared by FFIS states that the FMAP formula:

- does not adequately reflect the different fiscal capacities of states;
- does not adequately respond to changes in individual state economic circumstances; and
- does not take into account the fiscal circumstances of states with high concentrations of poor citizens.

In 1983 Oklahoma was a victim of this flawed data process. The state economy was devastated by an economic failure in the energy industry, high unemployment and an increasing demand on public services. Yet the Medicaid FMAP percentage for the state dropped from 63.69% in 1982 to 59.91% in 1983. The reason for the drop was the PCI data used to calculate the 1983 FMAP involved the years 1979 through 1980, which were the peak years for oil prices, production and the state's growing energy based economy.

Given the problems and limitations associated with using PCI as the sole indicator of a state's economic and financial condition as well as its level of poverty we recommend that the current 2005 FMAP rates be held harmless and a Blue Ribbon Commission be formed to recommend a new formula to calculate the state and federal match for Medicaid.

The estimated cost to implement this recommendation may be \$860 million in 2006 as detailed in the chart below:

Oklahoma Health Care Authority			
Estimated Cost Impact for Hold Harmless FMAP Provision			
Projected FFY 2006			
State	2006 FMAP Reduction	Medicaid Expenditures	Federal Amount to States w/ Hold Harmless on FMAP
Alaska	7.42%	927,820,408	68,844,274
Wyoming	3.67%	411,742,028	15,110,932
New Mexico	3.15%	2,507,212,586	78,977,196
Oklahoma	2.27%	2,924,733,647	66,391,454
Maine	1.99%	2,344,739,613	46,660,318
West Virginia	1.66%	2,362,642,867	39,219,872
North Dakota	1.64%	565,830,511	9,279,620
Vermont	1.62%	899,658,464	14,574,467
Utah	1.38%	1,445,925,839	19,953,777
Montana	1.36%	726,849,009	9,885,147
Alabama	1.32%	4,174,809,256	55,107,482
Louisiana	1.25%	5,735,530,756	71,694,134
Nevada	1.14%	1,202,661,716	13,710,344
Mississippi	1.08%	3,752,796,588	40,530,203
Arkansas	0.98%	2,974,366,673	29,148,793
South Dakota	0.96%	622,166,738	5,972,801
Rhode Island	0.93%	1,900,919,404	17,678,550
Tennessee	0.82%	8,319,862,112	68,222,869
Idaho	0.71%	1,069,486,215	7,593,352
Wisconsin	0.67%	5,292,600,883	35,460,426
Kansas	0.60%	2,055,601,420	12,333,609
South Carolina	0.57%	4,449,546,832	25,362,417
Arizona	0.47%	5,316,086,422	24,985,606
Kentucky	0.34%	4,696,572,355	15,968,346
Delaware	0.29%	889,778,823	2,580,359
Texas	0.21%	18,493,311,745	38,835,955
North Carolina	0.14%	9,123,532,486	12,772,945
Michigan	0.12%	9,759,225,767	11,711,071
Florida	0.01%	14,776,788,951	1,477,679
Total		119,722,800,114	860,043,998
<p>Note: Included are states that are projected to experience an FMAP reduction in FFY06. Estimated costs provided in this chart are based on state MAP expenditures published on CMS 64 reports (2004 trended by 9% for 2 years). The costs do not reflect official estimates from any of the states, but should provide a fair representation of the impact for each state.</p>			