AREA OF FOCUS
Achieving Universal Coverage →

EXPLAINER / MARCH 14, 2025

How Do We Pay for Medicaid?

Medina Healthcare System Chief Financial Officer Kevin Frosch explains revenue data in a conference room of the medical complex in Hondo, Texas, on February 26, 2025. States primarily pay their share of the Medicaid program through general revenue, including taxes and other monies collected by the state. Photo: Kaylee Greenlee for the Washington Post via Getty Images

AUTHORS

Akeiisa Coleman

RELATED CONTENT

What Is Medicaid's Value?

How New Rules Can Improve Access, Quality, and Transparency in Medicaid and CHIP

New Medicaid Payment Rules Aim to Expand Access to Care

How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost

How States Would Fare Under Medicaid Block Grants or Per Capita Caps: Lessons from Puerto Rico

Medicaid, the public health insurance program covering more than 72 million people with low income, is jointly funded by states and the federal government. Medicaid spending totaled around $890 billion in the 2023 federal fiscal year, with the federal government paying 69 percent and states paying 31 percent.

States administer their own Medicaid programs within broad parameters set by the federal government. In the same way that each state's program has significant variation in who is covered, what is covered, and how much is paid for care, there is variation in how the program is funded at the state level. The federal government's contribution also differs from state to state.

How is the federal share of Medicaid funding determined?

The federal share of Medicaid funding — typically called the federal match or the federal medical assistance percentage (FMAP) — is expressed as the percentage of state spending matched by the federal government. The base federal match, FMAP for health services for the traditional Medicaid population, varies by state, ranging from 50 percent to 77 percent in the 2023 federal fiscal year. The exact rate is determined by a formula set in law that uses state per capita income relative to national per capita income; states with lower per capita income receive a higher share of federal funding. By law, this base FMAP cannot exceed 83 percent or fall below 50 percent.

Specific services and eligibility groups have their own FMAP rates set in statute. Administrative costs, including day-to-day operations and oversight of managed care contracts are matched at 50 percent, while technology updates to eligibility and enrollment systems are 75 percent or 90 percent. Federal funding for Medicaid has grown over time as new groups and types of services were authorized by Congress, for example optional and then mandatory coverage of pregnant women up to the federal poverty level in the 1980s.

Most recently, in states that expanded Medicaid eligibility as authorized by the Affordable Care Act, the newly covered population has an enhanced FMAP of 90 percent.

How do states finance their Medicaid programs?

States primarily pay their share of the Medicaid program through general revenue, including taxes and other monies collected by the state. Medicaid is typically the second-largest state expense behind K–12 education, and the largest source of federal funding. Counties and local governments may also contribute, but states must pay at least 40 percent of the nonfederal share of Medicaid expenditures. Local government funding can involve intergovernmental transfers or direct spending on Medicaid services or program administration, known as certified public expenditures.

States have multiple methods for financing their share of Medicaid funding. Provider assessments, commonly in the form of taxes on hospitals, nursing homes, or managed care organizations are a major source of funding. Every state except Alaska has at least one provider assessment, and this funding mechanism has been allowed since the inception of the Medicaid program in 1965. Other state funding sources may include cigarette taxes; settlement funds, such as the tobacco master settlement agreement; pharmaceutical rebates; insurance premium taxes, including funds formerly used to support state high-risk pools; and sales taxes, such as in Utah, which increased sales tax 0.15 percentage points to fund its Medicaid expansion.

How does federal funding flow to states?

State Medicaid agencies report how much they have spent on covered services to the Centers for Medicare and Medicaid (CMS), which then matches these funds at the regular or enhanced FMAP based on the enrollment group of the beneficiary or type of service. Expenditures are confirmed by claims data after payments to providers are made, and they're often adjusted to correct coding or billing errors, among other reasons. Following a reconciliation process, states may return overpayments, receive funds to offset underpayments, or be asked to provide additional information to verify provider or enrollee eligibility.

The federal match for administration works similarly. States report to CMS how much they have spent over a specified period, and CMS then matches this based on the FMAP for the types of administrative services claimed.

What determines the Medicaid budget?

Since the inception of the program, federal funding for Medicaid is open-ended, meaning there is no cap or preset amount. There is an exception for the territories, which historically receive fixed federal funding amounts. This funding arrangement means each territory must cover all costs when it reaches the federal limit and that the Medicaid program operates differently in the territories than in states. For example, Puerto Rico has significantly lower eligibility levels than those in the states, owing to capped federal funding. The federal government sometimes increases funding when states face increased financial pressures. For example, during the COVID-19 pandemic, the Families First Coronavirus Response Act increased the base FMAP as an incentive for states to maintain coverage until the end of the public health emergency.

States must balance their budgets and estimate how much they will spend on Medicaid each budget cycle. In the event of projected overspending, states may allocate additional funding or reduce it by cutting optional Medicaid benefits or provider reimbursement

rates. Medicaid is considered a countercyclical program, so more people rely on it when there are economic downturns. This means Medicaid spending may increase in periods when state revenues decline, requiring difficult budget decisions to either maintain or shrink Medicaid programs.

How does Medicaid spending compare to other types of coverage?

In 2021, state Medicaid spending for each full-benefit enrollee ranged from $3,750 to $12,425, with a national average of $7,593. This wide variation is driven by differences in how states design and administer their programs as well as variations in the health and characteristics of the covered population, like age, disability, and access to food and stable housing.

Medicaid is often noted for paying providers less than Medicare or commercial insurance, which in turn may impact providers' willingness to accept Medicaid and enrollees' ability to access care. In 2019, Medicaid fee-for-service (FFS) physician reimbursement rates were 72 percent of Medicare rates. Commercial hospital reimbursement rates are up to 200 percent of Medicare rates. In comparison, Medicaid FFS hospital payments vary significantly between 49 percent and 169 percent of Medicare rates. There is little transparency, however, in the rates Medicaid managed care plans pay providers, which covers around 75 percent of the Medicaid population. If a Biden administration Medicaid managed care rule is fully implemented, managed care plans will start reporting how their total Medicaid payments for certain services compare to Medicare FFS starting in 2026.

There are other payment mechanisms in the Medicaid program intended to improve access for Medicaid patients. Hospitals serving a higher proportion of low-income patients — both Medicaid enrollees and uninsured — receive supplemental payments called disproportionate share hospital payments. Additionally, states can make upper payment limit supplemental payments to bring FFS provider reimbursements in line with Medicare or average commercial rates. States also can direct Medicaid managed care plans to make payments to providers — called state-directed payments — to bring reimbursements in line with, or closer to, the average commercial rate and to facilitate value-based purchasing arrangements.

Factoring in these supplemental payments, Medicaid hospital reimbursement rates can be comparable to or even higher than Medicare rates.

How do administrative costs in Medicaid compare to other types of coverage?

One key area of health insurance spending is administrative costs, which account for an estimated 15 percent to 30 percent of total health spending. The Affordable Care Act's "medical loss ratio" requires most insurance plans to spend 80 percent to 85 percent of premiums collected on medical services and quality improvement activities or pay a rebate. This leaves 15 percent to 20 percent for administrative costs and profits. Medicaid managed care plans are expected to achieve a minimum medical loss ratio of 85 percent; states can request reimbursement from plans that do not meet state-specified rates.

Total administrative costs for FFS Medicaid in federal fiscal year 2023 were 4 percent of expenditures. By comparison, traditional Medicare FFS administrative spending was estimated to be 1.35 percent of expenditures in 2018, while in Medicare Advantage plans it ranged from 10.9 percent to 14.8 percent. For Medicaid managed care plans, administrative costs, which are included in their capitated rates, may be more in line with Medicare Advantage rates.

ACKNOWLEDGMENT

The author thanks Carson Richards of the Commonwealth Fund for help in developing this explainer.

PUBLICATION DETAILS

DATE

March 14, 2025

CONTACT

Akeiisa Coleman, Senior Program Officer, Medicaid, The Commonwealth Fund

ac@cmwf.org

CITATION

Akeiisa Coleman, "How Do We Pay for Medicaid?" (explainer), Commonwealth Fund, Mar. 14, 2025. https://doi.org/10.26099/t28v-s666

AREA OF FOCUS

Achieving Universal Coverage

TOPICS

Medicaid,
Medicaid Expansion,
Medicaid Managed Care,
Government Programs & Policies,
State Health Policy and Medicaid,
Coverage and Access,
Costs and Spending