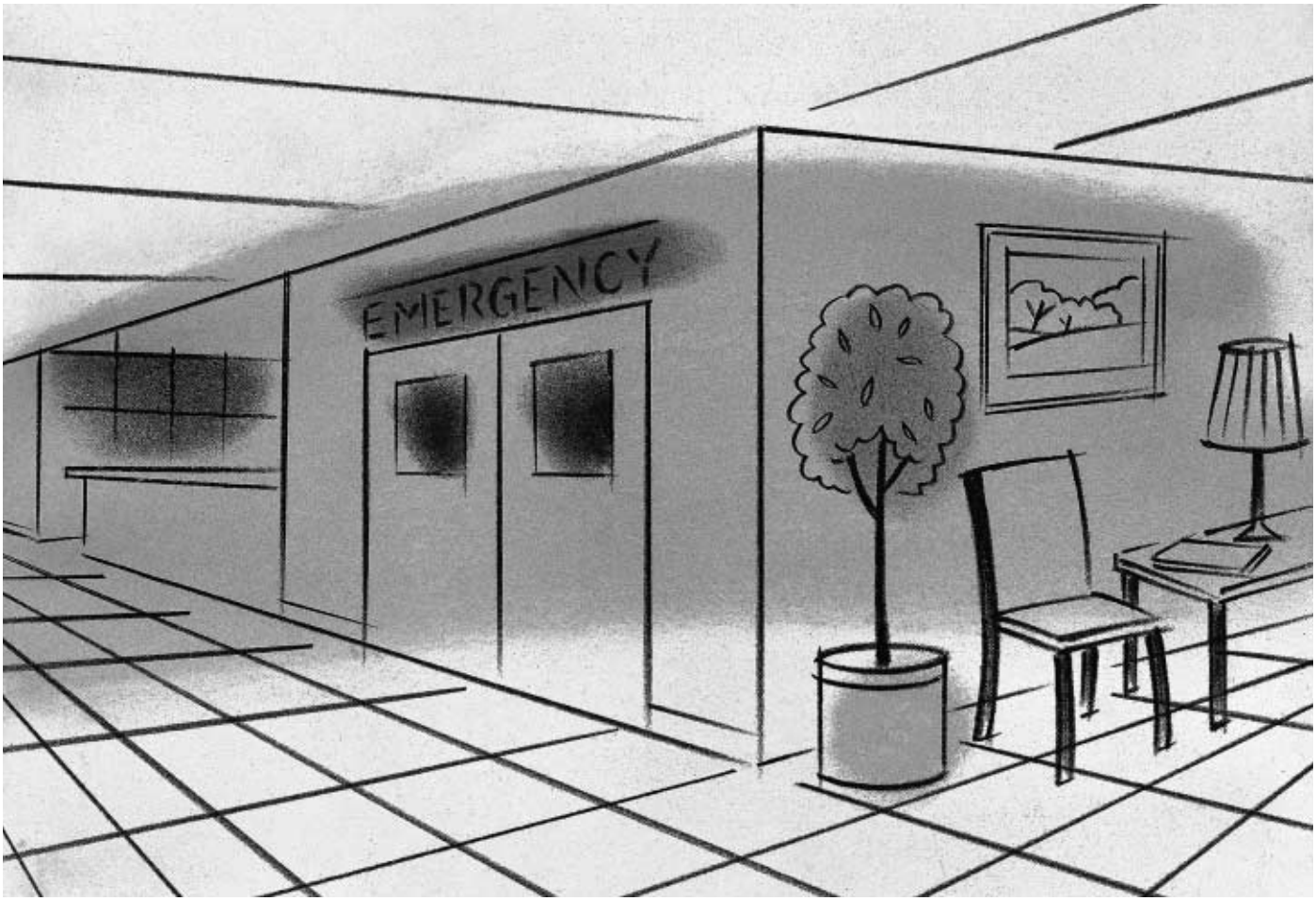
The Fiscal Impact of Medicaid on North Carolina Counties

John L. Saxon



The recent economic recession, shortfalls in state and local tax revenues, and rapidly increasing Medicaid costs have caused significant fiscal problems for North Carolina and its counties, especially counties with relatively limited property tax bases, high poverty rates, and high per capita spending for Medicaid. In state fiscal year 1999–2000 (SFY 2000), more than one-third of North Carolina's counties spent 5 to 9 percent of their budgets on Medicaid.

This article briefly explains the Medicaid program; describes the responsibilities of the federal government, the state, and the counties with respect to Medicaid funding; examines the fiscal impact of Medicaid on North Carolina's counties; and describes some options for eliminating or reducing the counties' fiscal responsibility for Medicaid.

What Is Medicaid?

Medicaid is a federal-state health insurance program for certain groups with limited incomes: children, pregnant women, people who are disabled, and senior citizens.[1] Congress established the program in 1965 when it enacted Title XIX of the Social Security Act.[2] North Carolina established its Medicaid program in 1970.

Pregnant women, children, people who are disabled, and senior citizens generally are eligible for Medicaid if their incomes are low enough to receive public assistance (Supplemental Security

The author is a School of Government faculty member who specializes in social welfare law and policy, elder law, and child support enforcement. Contact him at saxon@iogmail.iog.unc.edu.

Medicaid Eligibility and Services

Who Is Eligible for Medicaid?

Federal law generally requires states to provide Medicaid to pregnant women and children under the age of six whose family incomes do not exceed 133 percent of the federal poverty level, children between the ages of six and nineteen whose family incomes do not exceed the federal poverty level, children who receive foster care or adoption assistance payments under Title IV-E of the Social Security Act, people who are elderly or disabled who receive Supplemental Security Income payments, people with low income who are covered by Medicare, families that meet the state's 1996 requirements for Aid to Families with Dependent Children, and other "mandatory eligibles."

States have the option of extending Medicaid eligibility to people who are elderly or disabled and meet a state's "medically needy" income limits, pregnant women and infants with family incomes up to 185 percent of the federal poverty level, nursing home patients with incomes up to 300 percent of the federal poverty level, and people who are elderly or disabled whose family income does not exceed the federal poverty level. These people are "optional eligibles."

What Services Are Provided to Medicaid Recipients?

Federal law requires states to provide certain medical services (including inpatient and outpatient hospital services, rural health clinic services, laboratory and X-ray services, nursing home and home health care services for people more than twenty years old, physician services, and family planning services) to eligible Medicaid recipients other than Medicare beneficiaries who have low income. However, it gives states some flexibility in defining the amount, the scope, and the duration of covered services.

States may choose to provide up to thirty-three optional Medicaid services, including optometrist services, chiropractor services, dental services, prescription drugs, eyeglasses, dentures, emergency hospital services, hospice services, and medical transportation services.

What Are the Optional Eligibility Groups and Services in North Carolina?

North Carolina has chosen to provide Medicaid coverage to several optional groups, including people who are elderly or disabled and have incomes up to the federal poverty level. It also provides a number of optional Medicaid services, including intermediate-care facilities for people who are mentally retarded, personal care services, prescription drugs, dental care, eye care, chiropractic care, and hospice care. The state Division of Medical Assistance estimates that almost half of all Medicaid payments are for optional services provided to mandatory eligibles and for services provided to optional eligibles.

Source: Information in this sidebar is based on Medicaid in North Carolina: Annual Report, State Fiscal Year 2000 (Raleigh: Div. of Medical Assistance, N.C. Dep't of Health and Human Servs., no date), available at www.dhhs.state.nc.us/dma/2000report/annualreport.pdf, and A Profile of Medicaid: Chart Book 2000 (Washington, D.C.: Health Care Financing Admin., U.S. Dep't of Health and Human Servs. no date), available at www.hcfa.gov/stats/2Tchartbk.pdf.

Income or Temporary Assistance for Needy Families) or are below the federal poverty level. More than 1.2 million North Carolinians were covered by Medicaid during SFY 2000.[3]

North Carolina's Medicaid program pays for hospital care, nursing home care, physicians' services, dental care, prescription drugs, and other medical services. The total cost (federal, state, and county funding) of North Carolina's Medicaid program for SFY 2000 was approximately $5.8 billion, including $4.8 billion in payments for medical services to eligible Medicaid recipients and $228 million in state and local administrative costs—a 17 percent increase from SFY 1999.[4]

The Federal-State Relationship

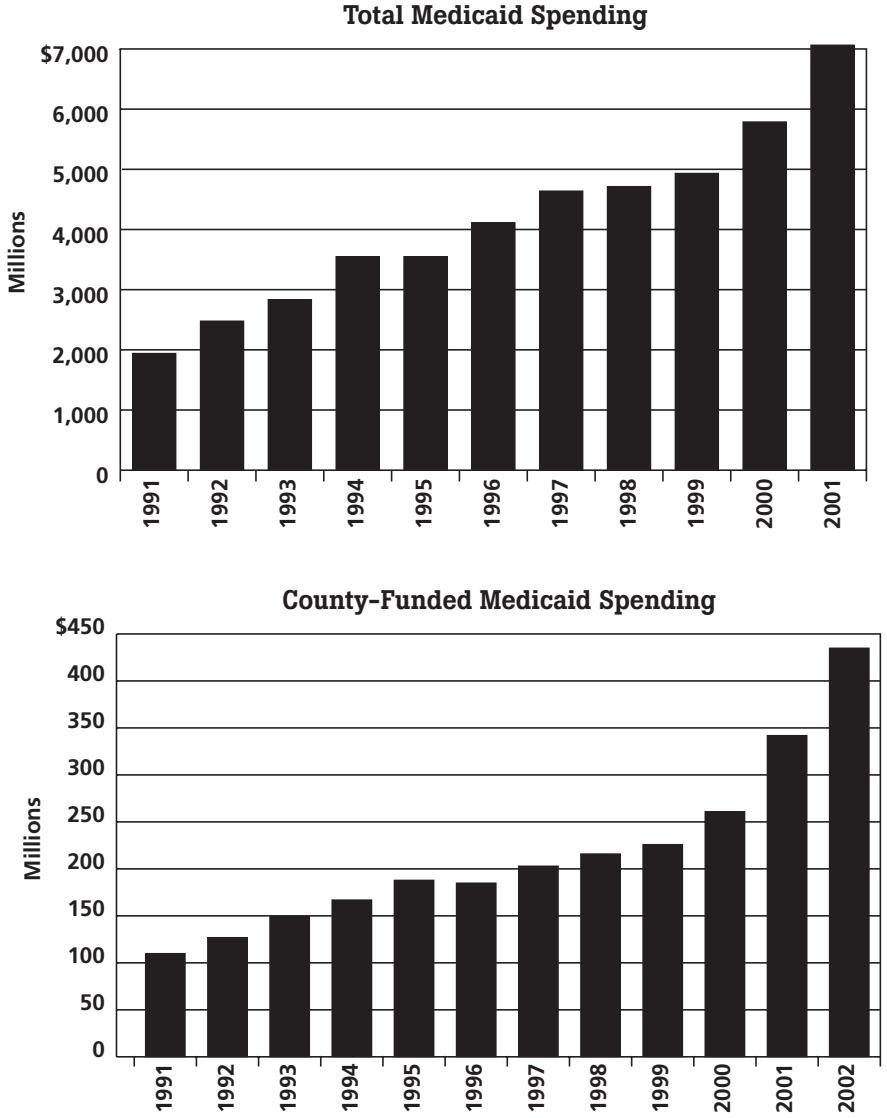
Federal law does not require states to establish Medicaid programs. The federal government, however, provides significant funding for state Medicaid programs—about $125 billion in federal fiscal year 2000–2001 (FFY 2001), or 7 percent of the total federal budget.[5] The total cost nationwide (federal, state, and local funding) of the Medicaid program in FFY 2001 was approximately $219 billion.[6]

The federal government pays at least 50 percent of the amount that state Medicaid programs pay to health care providers for covered Medicaid services delivered to Medicaid recipients, plus at least 50 percent of the cost of administering each state's Medicaid program. The federal government's share of the cost of Medicaid services in a state is called the "federal medical assistance percentage" (FMAP); the nonfederal share is called the state "match."[7] Each state's FMAP is based on its per capita income relative to the national per capita income.[8] As a state's per capita income rises relative to the national per capita income, its FMAP declines, requiring the state to pay an increased share of Medicaid costs. A state's FMAP, however, may not be less than 50 percent or more than 83 percent. In FFY 2000, ten states had an FMAP of 50 percent, and ten had an FMAP greater than 70 percent—Mississippi having the largest, at 76.8 percent.[9]

North Carolina's FMAP for FFY 2002 is 61.46 percent. This means that the federal government pays about $.61 of each dollar that North Carolina's Medicaid program pays for medical services for Medicaid recipients. The remainder ($.39 of each dollar) must be paid from state (or state and county) revenues. North Carolina's FMAP has decreased more or less steadily over the past seventeen years—from 69.5 percent in FFY 1985, to 67.5 percent in FFY 1990, to 64.7 percent in FFY 1995, to 62.49 percent in FFY 2000, and, as noted, to 61.46 percent in FFY 2002—but will increase to 62.56 percent in FFY 2003.[10]

Federal Medicaid funding comes with strings attached. When a state accepts the funding, federal law requires the state to administer its Medicaid program on a uniform statewide basis, to provide Medicaid to certain groups of people with low income, to provide certain medical services to Medicaid recipients, and to comply with other federal requirements regarding Medicaid eligibility, services, and administration (for more detail, see the sidebar on this page).

Figure 1. **Medicaid Spending in North Carolina, SFY 1991 through SFY 2002**



County-Funded Spending as a Percentage of Total Spending

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
County-Funded Medicaid Spending (millions)	$110	$127	$149	$167	$188	$185	$203	$216	$226	$261	$342	$435
Percentage Increase	—	15.5	17.3	12.1	12.6	– 1.6	9.7	6.4	4.6	15.5	31.0	27.2
Percentage of Total Medicaid Spending	5.7	5.1	5.2	4.7	5.3	4.5	4.4	4.6	4.6	4.5	4.8	NA

Source: Information for SFY 1991 through SFY 2001 is based primarily on data from North Carolina Division of Medical Assistance (DMA) annual reports. It reflects actual spending for Medicaid services and administration. Information for SFY 2002 is based on DMA spending estimates and projections. NA = not available.

The Role of State and Local Governments

Although states must comply with federal Medicaid requirements, they may cover nonmandatory groups, cover nonmandated services, and establish (within certain limits) their own payment rates for covered services. As a result, there are essentially fifty-six Medicaid programs—one for each state, territory, and the District of Columbia.[11]

Because the federal Medicaid law requires that state Medicaid programs be administered uniformly statewide, Medicaid policies regarding coverage for optional groups, provision of optional services, scope and duration of covered services, payment levels for providers, and other issues that are not mandated by federal law are established on a statewide basis by state legislatures or state health or social services agencies.[12] In North Carolina, nonfederal Medicaid policy decisions are made primarily by the General Assembly through its enactment of the state budget. County officials exercise little, if any, policy-making authority with respect to Medicaid.

Federal law requires that state Medicaid programs be administered by a single state agency or by local agencies under the supervision of a single state agency.[13] Most states have opted for administration by a single state health or social services agency. North Carolina's Medicaid program is administered jointly by state and county agencies.[14] County departments of social services administer Medicaid at the local level, processing applications and determining whether individuals are eligible, under federal and state rules, for Medicaid coverage. The state Department of Health and Human Services' Division of Medical Assistance (DMA) administers Medicaid at the state level, supervises local Medicaid administration by the counties, and ensures that administration of the entire state Medicaid program is consistent with federal and state requirements. DMA also is responsible, through a private contractor, for processing Medicaid claims and making Medicaid payments to health care providers for services provided to Medicaid recipients.

Table 1. **Estimated County Spending for Medicaid as a Percentage of County Budgets, SFY 2001–02**

Counties like Hertford and Robeson, with high poverty rates and other contributing factors, spend a significant percentage of their budgets on Medicaid.

County	Percentage of County Budget	County	Percentage of County Budget	County	Percentage of County Budget
Hertford	14.1	Avery	7.8	Polk	5.4
Robeson	14.0	Pamlico	7.7	Cumberland	5.4
Swain	13.9	Montgomery	7.6	Stokes	5.4
Bertie	13.8	Burke	7.6	Camden	5.2
Bladen	12.9	Warren	7.2	Davidson	5.2
Richmond	11.2	Chowan	7.2	Macon	5.1
Columbus	11.0	Perquimans	7.2	Moore	5.1
Northampton	10.2	Caldwell	7.2	Pitt	5.0
Yancey	9.9	Stanly	7.2	Alexander	5.0
Madison	9.8	Granville	7.2	Johnston	4.9
Hoke	9.6	Surry	7.1	Lincoln	4.9
Anson	9.5	Wayne	7.1	Clay	4.6
Duplin	9.5	Wilson	7.1	Transylvania	4.6
Lenoir	9.4	Caswell	7.1	Carteret	4.5
Cherokee	9.3	Craven	6.7	Davie	4.3
Vance	9.3	Cleveland	6.7	Watauga	4.2
Ashe	9.2	Wilkes	6.7	Iredell	4.2
Washington	9.1	Nash	6.7	Brunswick	4.2
Greene	9.1	Yadkin	6.6	Forsyth	4.1
Graham	9.0	Rockingham	6.6	Onslow	4.1
Pasquotank	8.9	Gaston	6.4	Chatham	4.1
Sampson	8.6	Alamance	6.4	New Hanover	4.0
Martin	8.5	Alleghany	6.4	Guilford	3.9
Rutherford	8.5	Rowan	6.3	Cabarrus	3.9
Jones	8.4	Franklin	6.1	Union	3.6
McDowell	8.4	Gates	6.1	Catawba	3.5
Edgecombe	8.3	Haywood	6.1	Orange	2.9
Halifax	8.1	Lee	6.1	Wake	2.9
Tyrrell	8.1	Randolph	6.0	Mecklenburg	2.4
Beaufort	7.9	Jackson	5.7	Currituck	2.3
Scotland	7.9	Henderson	5.6	Durham	2.2
Mitchell	7.8	Buncombe	5.6	Dare	1.6
Harnett	7.8	Person	5.6	All Counties	5.0
Pender	7.8	Hyde	5.5		

Source: For Tables 1–3, estimated county spending for Medicaid is based on the North Carolina Division of Medical Assistance's projected ***budget estimates*** (not ***actual spending***) for each county's share of the total cost of Medicaid services for county residents during SFY 2001–02 ($377.8 million for all counties, not including local administrative costs). The amounts of county budgets and adjusted property values are based on data from the North Carolina Association of County Commissioners Budget and Tax Survey 2001–02 (available at www.ncacc.org/budtax.htm) ($7.6 billion combined budget for all counties).

Table 2. **Estimated County Spending for Medicaid Per $100 of Adjusted Assessed Property-Tax Base, SFY 2001–02**

Counties with limited property-tax bases and high rates of poverty, Medicaid eligibility, and Medicaid spending feel the fiscal effects the most. Robeson, for example, spends 25.8 cents on Medicaid for every $100 of its property-tax base. Dare, by contrast, spends only 1.4 cents.

County	Cents Per $100 of Property	County	Cents Per $100 of Property	County	Cents Per $100 of Property
Robeson	25.8	Caldwell	9.5	Haywood	6.4
Hertford	20.2	Rockingham	9.4	Johnston	6.3
Bladen	20.2	Stanly	9.4	Pender	6.2
Bertie	19.2	Beaufort	9.3	Clay	6.1
Northampton	17.9	Pitt	9.1	Alamance	6.0
Edgecombe	17.4	Wilkes	8.9	Lincoln	5.8
Columbus	17.0	Mitchell	8.9	Alleghany	5.8
Washington	17.0	Burke	8.8	Polk	5.7
Richmond	16.6	Cumberland	8.8	Davie	5.2
Halifax	15.9	Gaston	8.7	Durham	5.2
Scotland	15.7	Surry	8.7	Henderson	5.1
Hoke	15.7	Nash	8.7	Avery	5.1
Vance	14.2	Pamlico	8.6	Forsyth	4.9
Greene	14.0	Hyde	8.6	Moore	4.8
Martin	13.9	Yadkin	8.6	Cabarrus	4.6
Sampson	13.7	Rutherford	8.4	New Hanover	4.5
Jones	13.6	Franklin	8.4	Chatham	4.5
Chowan	13.3	Yancey	8.2	Transylvania	4.5
Lenoir	13.2	Montgomery	8.0	Union	4.4
Swain	12.7	Ashe	8.0	Jackson	4.3
Duplin	12.5	Onslow	7.9	Guilford	4.3
Pasquotank	12.5	Craven	7.7	Catawba	4.3
Anson	12.5	Stokes	7.6	Orange	3.6
Graham	12.3	McDowell	7.5	Iredell	3.6
Warren	12.1	Madison	7.5	Macon	3.6
Gates	11.9	Lee	7.4	Carteret	3.4
Harnett	11.7	Person	7.4	Brunswick	3.3
Caswell	11.6	Granville	7.2	Mecklenburg	3.1
Wayne	11.0	Rowan	7.2	Watauga	2.6
Cleveland	10.7	Alexander	6.8	Wake	2.4
Cherokee	10.6	Randolph	6.7	Currituck	2.3
Tyrrell	10.3	Camden	6.6	Dare	1.4
Perquimans	10.0	Buncombe	6.5	All Counties	6.1
Wilson	9.9	Davidson	6.4		

Source: See Table 1, page 17.

Under Medicaid, dental care is an optional service for low-income adults, a mandatory service for low-income children.

In most states the state pays the entire nonfederal share of Medicaid costs from state revenues. Federal law, however, allows states to require counties to pay part of the nonfederal share.[15] North Carolina is one of about ten states that have chosen to require counties to do so.[16]

In North Carolina, state law currently requires counties to pay 15 percent of the nonfederal share of the cost of Medicaid services provided to county residents (about 5.6 percent of the total cost of Medicaid payments on behalf of county residents) and almost all the nonfederal share of local administrative costs.[17] State revenues pay the remaining 85 percent of the nonfederal share for Medicaid services, 100 percent of the nonfederal share for state administration, and some of the nonfederal share of local administrative costs—a total of about $2 billion in SFY 2002, or 14 percent of the state's General Fund budget.

State law also requires county commissioners to levy property taxes in an amount sufficient to pay the county's part of the nonfederal share of Medicaid costs. The state may withhold payment of county sales tax revenues collected by the state Department of Revenue on behalf of a county if the county fails to pay its share of mandated public assistance costs to the state.[18]

The Fiscal Impact of Medicaid on North Carolina's Counties

A number of factors that counties cannot control drive their spending for Medicaid: federal and state policies expanding Medicaid eligibility and services; increases in the number of county residents covered by Medicaid; county poverty rates; increased health care costs; increased use of health care; and decreases in North Carolina's FMAP.

During the 1990s, county-funded spending for Medicaid in North Carolina rose from about $86 million in SFY 1990 to $226 million in SFY 1999—a 163 percent increase without adjusting for inflation (see Figure 1). By contrast, during the same period, total county spending increased by 115 percent. Despite these increases, county spending for Medicaid in SFY 1999 remained less than 3 percent of the $7.9 billion combined budgets of North Carolina's 100 counties, representing about $.05 per $100 of the counties' combined property tax bases. Since then, however, a skyrocketing increase in the total cost (federal, state, and county funding) of Medicaid—about 50 percent between SFY 1999 and 2002—has put even greater pressure on state and county budgets.

From 1988 through 1991, increased Medicaid caseloads (due to policy changes, the economic recession during that period, and increased outreach) accounted for about one-third of the national increase in Medicaid spending. Inflation accounted for another third, and increased use of services and higher reimbursement rates for the remaining third.[19] Federal officials now project that caseload growth will account for about one-sixth of future increases in Medicaid spending, that inflation will account for about one-third, and that the balance will be due to spending per Medicaid recipient in excess of inflation.[20]

The Impact in Particular Counties

Although rising Medicaid costs and falling or stagnant tax revenues have dealt state and county budgets a "one-two punch," fiscal responsibility for

Table 3. **Additional State Spending Using a Per Capita Income Formula for County Medicaid Costs, SFY 2001–02**

One option for reducing counties' fiscal responsibility for Medicaid costs would be to base each county's share on its per capita income. What the counties would save, the state would pay.

County	Adjusted Percentage of Nonfederal Share	County Savings
Alamance	14.9	$ 20,624
Alexander	10.8	407,886
Alleghany	13.8	56,510
Anson	9.9	659,589
Ashe	9.8	602,909
Avery	12.1	229,955
Beaufort	9.9	1,083,246
Bertie	8.2	907,369
Bladen	9.4	1,177,216
Brunswick	9.2	1,479,328
Buncombe	15.0	0
Burke	10.4	1,399,381
Cabarrus	15.0	0
Caldwell	11.5	933,424
Camden	9.7	105,836
Carteret	12.6	415,844
Caswell	8.0	597,951
Catawba	15.0	0
Chatham	15.0	0
Cherokee	7.2	960,362
Chowan	10.4	323,671
Clay	8.8	228,590
Cleveland	10.4	1,754,039
Columbus	9.4	1,990,351
Craven	12.9	606,932
Cumberland	13.7	1,066,392
Currituck	11.6	144,023
Dare	12.8	134,053
Davidson	12.8	850,803
Davie	15.0	0
Duplin	10.0	1,081,415
Durham	100.0	0
Edgecombe	8.3	1,927,803
Forsyth	15.0	0
Franklin	11.1	683,011
Gaston	12.9	1,474,329
Gates	7.8	263,709
Graham	6.9	427,371
Granville	10.7	625,582
Greene	8.2	518,975
Guilford	15.0	0
Halifax	8.1	2,104,303
Harnett	8.6	2,014,448
Haywood	11.1	766,728
Henderson	15.0	0
Hertford	7.4	1,110,240
Hoke	5.0	1,345,437
Hyde	8.4	182,114
Iredell	13.9	304,988
Jackson	10.1	550,276
Johnston	12.7	826,762
Jones	8.7	$ 297,572
Lee	14.3	122,724
Lenoir	10.8	1,174,726
Lincoln	10.6	788,552
Macon	9.1	612,109
Madison	10.9	350,217
Martin	8.3	965,211
McDowell	8.1	1,065,093
Mecklenburg	15.0	0
Mitchell	9.0	427,579
Montgomery	9.6	554,281
Moore	15.0	0
Nash	13.1	571,063
New Hanover	15.0	0
Northampton	8.4	887,234
Onslow	11.6	1,006,197
Orange	15.0	0
Pamlico	10.6	262,993
Pasquotank	9.3	790,304
Pender	7.7	1,107,990
Perquimans	7.8	332,186
Person	10.5	639,119
Pitt	12.4	1,185,365
Polk	15.0	0
Randolph	12.1	1,047,832
Richmond	8.5	1,555,074
Robeson	6.9	5,989,514
Rockingham	10.2	1,687,582
Rowan	11.2	1,475,830
Rutherford	9.5	1,298,832
Sampson	9.9	1,413,601
Scotland	8.8	1,247,044
Stanly	11.0	846,977
Stokes	9.8	602,543
Surry	11.9	831,721
Swain	6.2	546,663
Transylvania	13.1	179,353
Tyrrell	6.6	175,988
Union	12.0	828,620
Vance	8.8	1,382,009
Wake	15.0	0
Warren	6.4	846,039
Washington	8.1	481,181
Watauga	10.4	414,259
Wayne	9.0	2,321,315
Wilkes	11.6	893,263
Wilson	13.1	550,173
Yadkin	10.9	525,588
Yancey	7.9	512,717
All Counties		$75,138,008

Source: See Table 1, page 17.

Medicaid has affected some counties more than others because of differences between counties in poverty rates, percentage of residents covered by Medicaid, average Medicaid spending per recipient, value of the property tax base, and other demographic, political, and economic factors.

In Martin, Halifax, Hertford, Robeson, Bertie, Northampton, and twelve other counties, between one-quarter and one-third of all residents were covered by Medicaid in 2000, compared with less than one-eighth of the population in Wake and ten other counties.[21] Furthermore, total federal, state, and county Medicaid spending per capita and per recipient varies significantly from county to county, from a high of $1,420 per capita in Martin County to a low of $300 in Wake County and from a high of $5,695 per recipient in Avery County to a low of $2,955 in Cumberland County.[22]

In Martin, Halifax, Hertford, Robeson, Bertie, Northampton, and twelve other counties, between one-quarter and one-third of all residents were covered by Medicaid in 2000, compared with less than one-eighth of the population in Wake and ten other counties.

Counties that have relatively limited property-tax bases combined with relatively high rates of poverty, Medicaid eligibility, and Medicaid spending feel the fiscal effects the most. In SFY 2000, more than one-third of North Carolina's counties were required to spend 5 to 9 percent of their budgets for Medicaid. In twenty-five counties, county-funded spending for Medicaid services that year represented between $.08 and $.18 per $100 of adjusted property-tax value. Meanwhile, county-funded spending for Medicaid services accounted for less than 3 percent of the total county budgets of twenty counties in SFY 2000, and county-funded spending for Medicaid represented less than $.04 per $100 of adjusted property-tax value in twenty-eight counties (for estimates of comparable data for SFY 2001–02, see Tables 1 and 2, pages 17–18).

Proposals to Eliminate or Reduce Counties' Responsibility for Medicaid

Several bills to eliminate or reduce counties' fiscal responsibility for Medicaid were introduced during the General Assembly's 2001 legislative session. House Bill 1082 and Senate Bill 923 would have required the state to pay 100 percent of the nonfederal share of the cost of Medicaid services (calling for $365–$378 million in additional state funding in SFY 2002). House Bill 65 would have reduced the fiscal responsibility of Tier 1, 2, 3, and 4 counties from 15 percent across the board to 3, 6, 9, and 12 percent, respectively.[23] (North Carolina counties are classified as Tier 1, 2, 3, 4, or 5 under the William S. Lee Economic Development Act; Tier 1 counties are the most economically distressed, Tier 5 the least.)[24]

Although none of these bills were enacted last year, the North Carolina Association of County Commissioners is continuing to study ways to eliminate or reduce counties' fiscal responsibility for Medicaid.[25] Options include the following:

- Seeking emergency federal funding to offset (partially) rising Medicaid costs and shortfalls in state and local revenues[26]
- Requiring the state to pay the entire nonfederal share of the cost of Medicaid services provided to county residents
- Swapping the counties' fiscal responsibility for Medicaid, for fiscal responsibility for programs or services currently funded by state revenues
- Capping each county's fiscal responsibility for Medicaid on the basis of past or current Medicaid spending for county residents
- Requiring the state to pay the entire nonfederal share of increased Medicaid costs resulting from changes in federal or state policy
- Basing each county's share of Medicaid costs on its relative per capita income (using a formula similar to the one used to determine each state's FMAP)[27] (see Table 3, page 20)
- Basing each county's share of Medicaid costs on its per capita adjusted property-tax base relative to the statewide average or median per capita adjusted property-tax base[28]
- Basing each county's share of Medicaid costs on its tier designation
- Basing each county's share of Medicaid costs on its poverty rate, percentage of residents receiving Medicaid, or other factors

Each of these proposals has significant economic consequences for both the counties and the state. Clearly, however, given the continued forecast for rapidly rising Medicaid costs and limited state and local revenues, fiscal responsibility for North Carolina's Medicaid program will remain a major issue in the coming years.

Notes

1. The public sometimes confuses Medicaid with Medicare. Medicare is a separate federal program providing health insurance to people who are elderly or disabled. The federal government administers it, and federal payroll taxes primarily finance it. Unlike eligibility for Medicaid, eligibility for Medicare is not limited to people with low income. A person with a low income who is elderly or disabled may be eligible for both Medicare and Medicaid.

2. 42 U.S.C. §§ 1396–1396v.

3. The average monthly number of Medicaid recipients doubled between SFY 1990 and SFY 1999. Effective January 1, 1999, North Carolina's Medicaid eligibility rules were expanded to include about 35,000 people who were elderly or disabled and had incomes under the federal poverty guideline. MEDICAID IN NORTH CAROLINA: ANNUAL REPORT, STATE FISCAL YEAR 2000 (Raleigh: Div. of Medical Assistance, N.C. Dep't of Health and Human Servs., no date), available at www.dhhs.state.nc.us/dma/2000report/annualreport.pdf (hereinafter N.C. MEDICAID ANNUAL REPORT 2000).

4. *Id.* Expenditures for nursing home care ($808.9 million), prescription drugs ($754.5 million), and inpatient hospital care ($736.1 million) accounted for somewhat less than

half of Medicaid payments in SFY 2000. Although Medicaid recipients who are elderly or disabled make up less than one-third of all Medicaid recipients, they account for approximately 75 percent of total Medicaid spending.

5. BACKGROUND MATERIALS AND DATA ON PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS 912–13 (Washington, D.C.: Gov't Printing Office, 2000), available at www.utdallas.edu/~jargo/green2000/contents.html.

6. *Id.*

7. The FMAP applies only with respect to payments for covered services provided to eligible Medicaid recipients. An enhanced FMAP applies with respect to family planning services. The FMAP does not apply to administrative costs. Instead, the federal share of Medicaid administrative costs is set at 50 percent for all states (or an enhanced rate, 75 percent, for specified administrative costs).

8. 42 U.S.C. §§ 1396b(1), 1396d(b); 45 C.F.R. § 433.10. A state's FMAP generally is equal to 0.45 times the square of its average per capita income divided by the average national per capita income. Federal law currently sets the FMAP for U.S. territories at 50 percent, for Alaska and the District of Columbia at 70 percent.

9. A PROFILE OF MEDICAID: CHART BOOK 2000, at 36–37 (Washington, D.C.: Health Care Financing Admin., U.S. Dep't of Health and Human Servs., no date), available at www.hcfa.gov/stats/2Tchartbk.pdf (hereinafter MEDICAID CHART BOOK 2000).

10. *Id.* at 37; 66 Fed. Reg. 59,792 (Nov. 30, 2001).

11. MEDICAID CHART BOOK 2000, at 6.

12. 42 U.S.C. § 1396a(1); 42 C.F.R. § 431.50.

13. 42 U.S.C. § 1396a(5).

14. In North Carolina, California, Minnesota, Montana, New York, North Dakota, Ohio, and Wisconsin, Medicaid is administered locally by county health or social services agencies rather than by the state Medicaid agency. PUBLIC HUMAN SERVICES DIRECTORY (Washington, D.C.: American Public Human Servs. Ass'n, 2000).

15. If a state requires counties to pay part of the nonfederal share of Medicaid costs, federal law requires the state to pay at least 40 percent of the nonfederal share of Medicaid costs from state revenues and to ensure that a lack of adequate funds from local sources will not result in lowering the amount, the duration, the scope, or the quality of care and services available under the state's Medicaid program. 42 U.S.C. § 1396a(2).

16. There is no current, accurate, and complete list of states that require counties to pay part of the nonfederal share of Medicaid costs for administration or services. North Carolina, Arizona, Florida, Iowa, Nevada, New Mexico, and New York require counties to pay part of the nonfederal share of medical services provided. New York requires counties to pay 20 percent of the nonfederal share (about 10 percent of the total cost) for Medicaid long-term-care services for county residents and 50 percent of the nonfederal share (about 25 percent of the total cost) for other Medicaid services. Arizona requires counties to pay about 10 percent of the total cost of Medicaid services. Iowa counties must pay about 4 percent of the cost of Iowa's Medicaid program. North Carolina, Colorado, Minnesota, and Nevada require counties to pay all or part of the nonfederal share of local administrative costs for Medicaid.

17. North Carolina law requires the state to pay *at least* 50 percent of the nonfederal share of Medicaid costs. N.C. GEN. STAT. § 108A-54 (hereinafter G.S.). Before the state's Medicaid program was established, counties and the state shared fiscal responsibility for three programs that provided medical services and hospital care for public assistance recipients and indigent people. *See* G.S. ch. 108, art. 8, pts. 4, 4A, and 4B (repealed by 1965 N.C. Sess. Laws ch. 1173). When the state Medicaid program was first established, state law required counties to pay 50 percent of the nonfederal share of the cost of Medicaid services provided to county residents. 1969 N.C. Sess. Laws ch. 807, § 8(f). In 1971 the General Assembly reduced the counties' fiscal responsibility for Medicaid payments to 10 percent of the nonfederal share. 1971 N.C. Sess. Laws ch. 708, § 7. Since 1973 the General Assembly has required counties to pay 15 percent of the nonfederal share of most Medicaid services provided to county residents. 1973 N.C. Sess. Laws ch. 533, § 7; SL 2001-424, § 21.19(b).

18. G.S. 108A-90, -93. In the early 1990s, several North Carolina counties attempted (unsuccessfully) to withhold payments for their share of Medicaid costs. *See* John L. Saxon, *Mandates, Money, and Welfare: Financing Social Services Programs*, POPULAR GOVERNMENT, Summer 1994, at 2.

19. JOHN HOLAHAN, EXPLAINING THE RECENT GROWTH IN MEDICAID EXPENDITURES (Washington, D.C.: Urban Inst., 1993).

20. MEDICAID CHART BOOK 2000, at 26.

21. N.C. MEDICAID ANNUAL REPORT 2000, tbl. 10 (last visited Apr. 18, 2002), available at www.dhhs.state.nc.us/dma/2000report/table10.pdf.

22. *Id.* The data are based on total federal, state, and county spending for Medicaid services provided to county residents in SFY 2000.

23. House Bill 317 (and Senate Bills 580, 691, and 844) also would have reduced the fiscal responsibility of counties for Medicaid based on their classification as Tier 1, 2, 3, 4, or 5 counties. None of the bills considered during the 2001 legislative session would have eliminated or reduced the counties' fiscal responsibility for the nonfederal share of local Medicaid administrative costs (approximately $54 million in county funding in SFY 1999).

24. *See* G.S. 105-129.3.

25. Section 10.4 of the Studies Act of 2001, SL 2001-491, also authorized the Joint Legislative Health Care Oversight Committee to study issues related to the counties' share of Medicaid costs.

26. Provisions authorizing additional temporary federal Medicaid funding for states were stripped from the Economic Recovery and Security Act of 2001, H.R. 3090 (107th Congress, 2001–02) before it passed the Senate and the House and was signed into law by President George W. Bush on March 9, 2002. Congress has considered but not enacted other legislation that would have provided up to $260 million in additional temporary Medicaid funding to North Carolina. *See* State Budget Relief Act of 2001, H.R. 3414 (107th Congress, 2001–02), § 2; Economic Recovery Act of 2001, H.R. 3501 (107th Congress, 2001–02), § 404; Economic Recovery and Assistance for American Workers Act, S. 1732 (107th Congress, 2001–02), § 204.

27. A per capita income formula to determine each county's portion of the nonfederal share of Medicaid costs would be similar to the federal formula for determining the federal and state shares of Medicaid costs. A county's relative per capita income, however, is not necessarily an accurate indicator of its fiscal ability since county tax revenues are derived primarily from property and sales taxes, not income taxes.

28. The North Carolina Association of County Commissioners calculates the "adjusted" value of each county's property tax base by multiplying the reported value of taxable property in the county by a ratio of assessed value to sales.