

▶ MEDICAID 101: A PRIMER FOR STATE LEGISLATORS

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Medicaid is the largest health insurance program in the country, covering as many as 62 million low-income Americans over the course of a year, including one of every four children in the country. Medicaid has grown from about 10 percent of total state spending in 1987 to nearly 22 percent of total state spending in 2008, making it the top spending category for states. Medicaid, like all health care in America, is expensive—it comes with an annual price tag of more than \$300 billion in combined federal and state dollars. The program is important to not only the millions of low-income Americans who receive benefits but also to the economy of each state where Medicaid funds support thousands of health-related jobs, medical education and work force development. It is incredibly complicated and different in each state, with no two Medicaid programs alike. Policies vary from state to state and the population Medicaid serves is incredibly diverse.

The Medicaid program is loved by few, criticized by many and misunderstood by most. This primer will help you understand the basics and dispel some myths often associated with Medicaid. As a legislator, you come into contact with people who run the program in your state, service providers, those who are beneficiaries and those who are trying to become beneficiaries. This primer is designed to provide the information you need to help your constituents.

“Medicaid provides health insurance coverage to 30 million children, 16 million of their parents and 10 million people with disabilities.”



▶ THE BASICS

What is Medicaid?

Medicaid was enacted in 1965 along with Medicare with the passage of the Social Security Act. Medicare and Medicaid, however, serve very different purposes. State participation in Medicaid is voluntary and all 50 states participate. Medicaid is a publicly-funded health insurance program for low-income individuals, originally serving only those receiving assistance through Aid to Families with Dependent Children, commonly called AFDC, and states' programs for the elderly. The program has undergone many changes and has experienced rapid growth since its inception. Medicaid covered 4 million individuals at a cost of \$1 billion in its first year and grew to 62 million individuals and more than \$300 billion in 2007. In 1972, Congress enacted a federal cash assistance program for the aged, blind and disabled called Supplemental Security Income, which broadened Medicaid coverage to include this population. But the most significant expansion of Medicaid was to provide health insurance coverage not just to the welfare population but also to other low-income families, especially low-income children and pregnant women. In 1996, the official link to welfare assistance was severed with the enactment of Temporary Assistance to Needy Families or TANF. Families who receive TANF benefits do not automatically qualify for Medicaid as they did under the AFDC program. The TANF program was coupled with the State Children's Health Insurance Program or SCHIP, enacted the following year. SCHIP layered coverage for low-income children on top of the Medicaid program.

Today, Medicaid is a major source of health insurance coverage for low-income individuals. Medicaid provides health insurance coverage to 30 million children, 16 million of their parents and 10 million people with disabilities. It is also a major supplement to Medicare, providing benefits to 6 million low-income Medicare beneficiaries—roughly 20 percent of the Medicare population. It is the nation's main source of payment for long-term care, covering 1 million nursing home residents and paying for 41 percent of all long-term care expenditures in the country. Medicaid plays a large role in the national health care system, paying for 18 percent of the nation's health care bill.

▶ KEY FACTS

- ▶ Medicaid paid for services for an estimated 62 million people in 2007.
- ▶ In 2004, Medicaid spent \$288 billion in combined federal and state funds; projected total spending for 2008 is \$360 billion.
- ▶ Medicaid is the largest insurer of low-income children, pregnant women, newborns and people with disabilities and those requiring nursing home care.
- ▶ Medicaid is an important source of assistance for more than 6 million low-income Medicare beneficiaries—Medicaid pays their Medicare Part B premiums and the costs of other essential services not provided by Medicare.
- ▶ Medicaid is the nation's largest single purchaser of nursing home care, paying for about half of all nursing home care in this country.
- ▶ Although seniors and people with disabilities comprise one-quarter of Medicaid beneficiaries, they account for two-thirds of total Medicaid spending.
- ▶ Medicaid is a major source of financing for the nation's health care safety net, including community health centers, public clinics and other providers that serve low-income people.

How is Medicaid Administered?

Medicaid programs vary from state to state, and states are granted a great deal of flexibility—but not unlimited flexibility—in designing and administering their Medicaid programs. Large variations exist in terms of eligibility, covered services, provider rates and the structure of the delivery system and administrative processes.

The federal government provides matching funds to the states and offers guidance on how to use those funds, but each state shapes and administers its program to suit its needs. As a result, 56 distinctly different Medicaid programs—one for each state, territory and the District of Columbia—have emerged. And because the federal government does not cap Medicaid funds, states are able to provide a broad array of services; as long as a state can provide its match, federal funds are virtually unlimited for federally approved activities.

Although state Medicaid programs operate under broad, common federal guidelines, they are uniquely shaped by each state's decisions about who will be covered, the services they may receive, how much will be spent, and where Medicaid should rank among competing demands for limited state dollars. These state variations are one reason why Medicaid is especially complex.

Each state determines the particulars of its Medicaid program in its state plan, which specifies who will receive services, which services will be provided and how providers will be reimbursed, among other details. A state plan is the basis for a state's claim for federal matching funds known as federal financial participation. Each state's plan—and subsequent amendments to the plan—must be reviewed and approved by the federal government in order for a state to receive federal matching funds. The state plan is the funding agreement between the state Medicaid agency and the federal government.

States may also use waivers to design and operate their programs outside the common federal

guidelines. The U.S. Secretary of Health and Human Services has the legal authority to waive compliance with certain provisions of Medicaid law. In the past, states have used waivers to expand coverage, provide services that could not otherwise be offered, expand home and community services, and require beneficiaries to enroll in managed care programs. Waivers have also been approved to allow states to limit Medicaid covered services to existing Medicaid beneficiary groups in order to cut spending and to expand coverage to the uninsured.

There are three main types of waivers states may request, each named after the section in the federal Social Security statute that authorizes it.

- Home and Community-Based Services Waivers (1915c) permit a state to provide community-based long-term care services to individuals who would otherwise require and be eligible for services in a nursing facility. These waivers have been critical in state strategies to provide alternative settings for long-term care services. In 2005, states operated an estimated 300 Home and Community-Based Services Waivers that served more than 1 million beneficiaries.
- Freedom of Choice Waivers (1915b) permit a state to waive the “free choice of provider” requirement. This section also provides waivers allowing states to skip provisions requiring “comparability of services” and “statewideness”, which together require states to offer the same coverage to all categorically needy recipients statewide. Prior to the 1997 Balanced Budget Act, which allowed states to implement managed care programs under their state plans, states often used these waivers to implement managed care programs by restricting beneficiary choice of providers.

▸ Section 1115 Research and Demonstration Waivers permit states to waive virtually any part of the federal Medicaid Act regarding mandatory eligibility, benefits or managed care and other delivery systems. With an 1115 waiver, states have used federal Medicaid dollars to cover groups of individuals and/or services not otherwise eligible for federal match and/or to demonstrate alternative approaches to providing or extending services to beneficiaries. The 1115 demonstration authority is relatively broad but there is an additional federal requirement that a state must show that the waiver is budget neutral. In other words, the federal

spending on services cannot be more than it would have been without the waiver.

In addition to its state plan and federal waivers, states also set some degree of Medicaid policy through state statutes and administrative rules or regulations. Most states set eligibility, benefits and cost sharing requirements such as copayments, through state statutes and/or administrative rules. Other policies, such as provider rates and methodology, are sometimes set administratively by the state Medicaid agency through manuals and instructions to providers. And still other policies are made through state budget or contracting processes. Regardless of whether policies are set in state statutes or rules, the state plan must reflect the latest policies.

▶ HOW DOES MEDICAID DIFFER FROM MEDICARE?

Medicaid

- Basics: Medicaid is designed for low-income and disabled people. By federal law, states must cover low-income pregnant women, children, elderly, disabled and parents. Childless adults are not covered, and many poor individuals earn too much to qualify.
- Administration: The states are responsible for administering the Medicaid program.
- Financing: Medicaid is financed jointly by the states and federal government. Every dollar that a state spends on Medicaid is matched by the federal government. Overall, the federal government pays for 57 percent of Medicaid costs.
- Benefits: Medicaid offers a fairly comprehensive set of benefits, including prescription drugs.

Medicare

- Basics: Medicare is a federal program that covers individuals aged 65 and over, as well as some disabled individuals.
- Administration: The federal government is responsible for administering the Medicare program.
- Financing: Medicare is financed by federal income taxes, a payroll tax shared by employers and employees, and individual enrollee premiums (for Part B and Part D).
- Benefits: Medicare Part A covers hospital services, Medicare Part B covers physician services, and Medicare Part D offers a prescription drug benefit. There are many gaps in Medicare coverage, including incomplete coverage for skilled nursing facilities, dental, hearing and vision.

▶ EXAMPLES OF THE MANDATORY ELIGIBILITY GROUPS

Some examples of the mandatory Medicaid eligibility groups are:

- ▶ Low-income families with children;
- ▶ Supplemental Security Income (SSI) recipients;
- ▶ Infants born to Medicaid-eligible pregnant women;
- ▶ Children under age 6 and pregnant women whose family income is at or below 133 percent of the federal poverty level;
- ▶ Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act;
- ▶ Certain Medicare beneficiaries; and
- ▶ Special protected groups who may keep Medicaid for a period of time, such as people who lose SSI payments due to earnings from work or increased Social Security benefits.

States also have the option to provide Medicaid coverage for other “categorically needy” groups. Examples of the optional groups that states may cover are:

- ▶ Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is below 185 percent of the federal poverty level (the percentage to be set by each state);
- ▶ Women diagnosed with breast or cervical cancer through the federal Breast and Cervical Cancer Treatment Program;
- ▶ Certain aged, blind or disabled adults who have incomes above those requiring mandatory coverage, but below the federal poverty level;
- ▶ Children under age 21 who meet income and resources requirements for Aid to Families with Dependent Children, but who otherwise are not eligible for AFDC;
- ▶ Institutionalized individuals with income and resources below specified limits;
- ▶ People receiving care under home and community-based services waivers; and
- ▶ Recipients of state supplementary payments.

Who is Eligible for Medicaid?

While the federal government grants states flexibility in setting Medicaid eligibility, it requires that certain groups be covered. In addition, the law requires states to provide benefits to all eligible people who apply for services and does not allow waiting lists. To receive Medicaid, a person must be both financially and categorically eligible. Financial eligibility is determined by income and assets, both of which must be low. Categorical eligibility is determined by the federal government—applicants must fall into one of the federally-determined population categories covered by Medicaid to qualify for the program. If an individual does not fall into one of these categories—even if his or her income and assets are low enough to meet state-established financial eligibility requirements—he or she cannot qualify for Medicaid. Most notably, an able-bodied adult under age 65 without children cannot receive Medicaid unless the state has a waiver to provide coverage.

There are more than 50 groups of individuals who may qualify for Medicaid coverage. For each eligibility group, minimum income standards apply, but states may expand beyond these minimums. For example, states are required to provide services to pregnant women up to 133 percent of the poverty level, but can choose to provide services up to 185 percent of federal poverty without a waiver. Medicaid eligible groups can be broken down into broad categories: low-income seniors and people with disabilities, low-income children and low-income adults.

▶ DUAL ELIGIBILITY

A sizeable group of Medicaid beneficiaries are enrolled in both Medicare and Medicaid. Virtually all elderly Medicaid enrollees are also enrolled in Medicare. Because Medicare does not cover long-term care, Medicaid covers a large portion of the total health care costs for low-income seniors. In addition, individuals with disabilities receiving Social Security Disability income automatically qualify for both Medicare and Medicaid.

▶ HIGHLIGHTS

Enrollment

- ▶ Medicaid enrollment increased from 41.4 million in 1999 to 62 million in 2007 and is expected to increase to 72.8 million by 2016.
- ▶ Children make up the largest portion of enrollees and accounted for almost half of all enrollees in 2007.
- ▶ Medicaid on average covers 26 percent of all children and 8 percent of all non-elderly adults.
- ▶ Medicaid covers about one-third of people whose income falls below the poverty level.

Expenditures

- ▶ The federal share of Medicaid expenditures averages about 57 percent of states' total spending.
- ▶ Some experts estimate total Medicaid spending will increase to \$690 billion in 2016 and represent 3.1 percent of GDP
- ▶ Children utilize fewer services than the other Medicaid enrollment groups and on average incur \$1,200 in expenses annually compared to \$8,600 per aged enrollee.
- ▶ The largest category of Medicaid expenditures is nursing facility costs.
- ▶ Spending on Medicaid has increased faster than any other spending category for states.
- ▶ Medicaid pays for about 40 percent of all births in the U.S.

Seniors

Medicaid provides assistance with co-pays, deductibles and long-term care services for low-income Medicare beneficiaries age 65 and older. About one in six Medicare beneficiaries are also covered by Medicaid under this dual eligibility. Although they represent only about 14 percent of the total Medicaid population, dual eligibles account for roughly 40 percent of the program's spending because health care for the elderly is so expensive. With Medicaid, dual eligibles can receive services not covered by Medicare, including long-term care services.

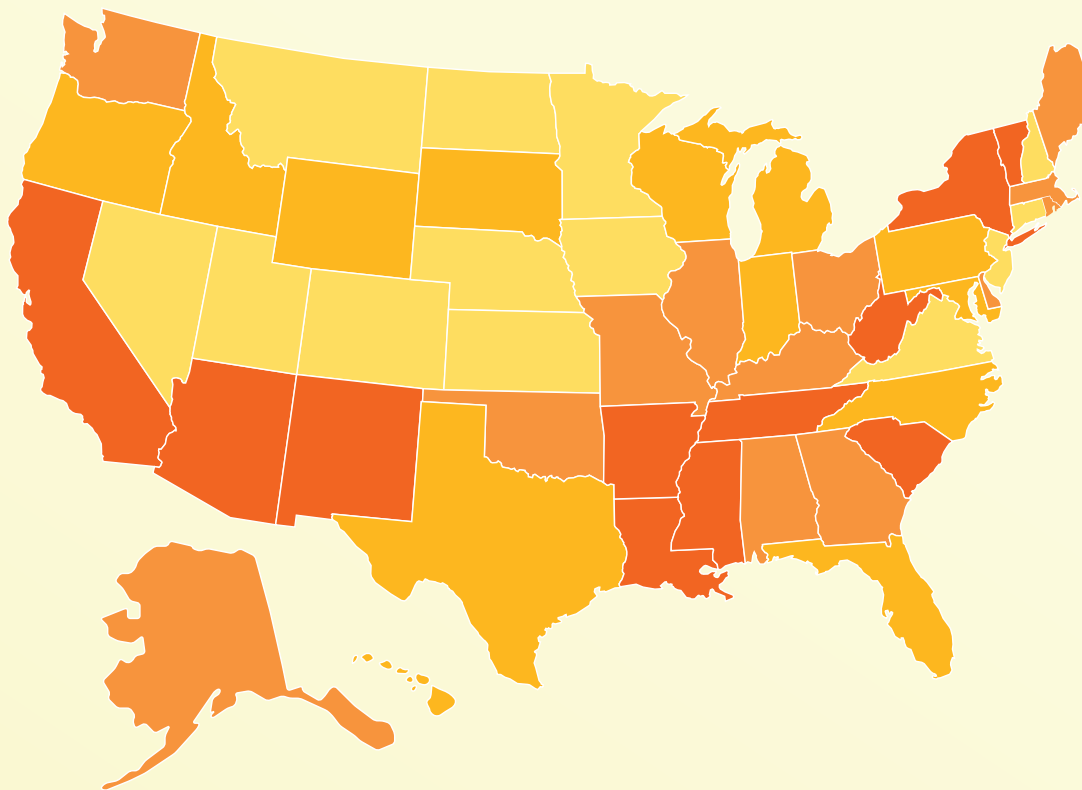
Another federal program, the Social Security program known as Supplemental Security Income, or SSI, is also a major pathway to Medicaid eligibility for both seniors and people with disabilities because, in most states, individuals who receive SSI are automatically eligible for Medicaid.

People with Disabilities

Low-income individuals of all ages with disabilities can receive medical care and long-term care through Medicaid. The standards of disability qualification are fairly strict: The disability must be severe and long-term or permanent, as decided by the Social Security Administration. There are roughly 54 million people with disabilities in the U.S., and only 10 million of those individuals are covered by Medicaid.

Because the Medicaid application process can be difficult to navigate and very time-consuming, early access to care for people with disabilities is difficult. For those with a condition that is progressive in nature, such as HIV/AIDS or multiple sclerosis, strict Medicaid eligibility standards can have major health effects. For example, an individual with HIV/AIDS doesn't qualify for Medicaid disability coverage until the condition is diagnosed as full-blown AIDS, even if the individual is financially eligible.

▶ MEDICAID ENROLLMENT AS A PERCENT OF TOTAL POPULATION, 2005



11% – 15% 15% – 18% 18% – 21% 21% – 29%

Source: Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured

▶ SCHIP: A BRIEF EXPLANATION

The State Children's Health Insurance Program (SCHIP), created in 1997, provides additional funding for states to cover low-income children who are not already eligible for Medicaid. States have the option of using federal SCHIP funds to expand their Medicaid program, create a separate stand-alone SCHIP or do a combination of both. Of the 50 states, five territories and the District of Columbia, 17 have chosen the Medicaid-expansion option, 18 have created separate stand-alone SCHIP programs, and 21 have chosen a combination.

Under SCHIP, each state is allotted a capped amount of federal funds each year. Once that capped allocation is spent, the state cannot get additional federal funds as with Medicaid. The federal SCHIP funds are made available to states at a higher federal matching rate than traditional Medicaid. SCHIP covered about 6.6 million children in 2006.



Low-income Children

Children qualify for full Medicaid benefits if their family's income falls below certain income thresholds set by each state. Those income thresholds are 150 percent of the federal poverty level for infants; 133 percent for children ages 1 to 6; and 100 percent for children ages 6 to 18. Children above these thresholds can be eligible for the State Children's Health Insurance Program. Together Medicaid and SCHIP aim to cover nearly all uninsured low-income children. Most states cover children up to 200 percent of the federal poverty level through Medicaid or SCHIP. An estimated 6.7 million children and 700,000 adults were enrolled in SCHIP at some point during 2006. State programs vary in terms of structure and characteristics, reflecting the flexibility of program design built into the SCHIP statute.

Low-income Adults

Adults can qualify for full Medicaid benefits only if they fall into certain restrictive categories, such as low-income parents or pregnant women. Medicaid covers more than 40 million low-income children and parents, and 65 percent of people who receive Medicaid are in working families. These individuals are typically employed in low-wage jobs and either they are not offered employer-sponsored health insurance or they can't afford it.

A working parent on Medicaid faces some tough choices when offered a raise or promotion. Because the income thresholds for Medicaid are strict, a few extra dollars of income may disqualify an entire family's coverage if it puts them above the established financial eligibility standards. For many Medicaid recipients, it is better to refuse a raise that is not accompanied by affordable private health insurance in order to retain Medicaid coverage for the family. As a result, some Medicaid beneficiaries choose to work part-time so they don't exceed the income limits and lose Medicaid eligibility.

In addition to covering low-income parents, Medicaid is the key source of coverage for low-income pregnant women up to 133 percent of poverty level. Medicaid provides prenatal care and neonatal intensive care for low-income pregnant women and their babies; it pays for about 40 percent of all births in the U.S.

Optional Groups

In addition to the mandatory coverage groups, states can choose to provide Medicaid coverage for other optional groups. These optional groups fall within defined categories of the mandatory groups but the eligibility criteria are somewhat more liberal. For example, many states have elected to cover pregnant women and young children at higher income levels than are required by federal law and uninsured women through the breast and cervical cancer program.

Many states have chosen to cover a group known as the medically needy. These Medicaid recipients are individuals who meet one of the

categorically needy eligibility requirements, but whose income or resources exceed the thresholds. These individuals can spend down to qualify—that is, they can deduct their medical bills from their income until they meet the income and resource requirements for Medicaid. This category of Medicaid coverage is particularly important to elderly people in nursing homes, as well as children and adults with disabilities who might incur high prescription drug, medical equipment or other health care expenses and are otherwise unable to afford medical care.

Most legal immigrants, who would otherwise be eligible for Medicaid, are not eligible except for emergency medical treatment during their first five years in the U.S. After that time, states have the option to extend them full coverage. Undocumented immigrants, on the other hand, are not eligible for Medicaid benefits, although they may be covered for emergency medical treatment and infectious disease control services.

▶ 2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES POVERTY GUIDELINES

Persons in Family or Household	Annual Income		
	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$10,400	\$13,000	\$11,960
2	14,000	17,500	16,100
3	17,600	22,000	20,240
4	21,200	26,500	24,380
5	24,800	31,000	28,520
6	28,400	35,500	32,660
7	32,000	40,000	36,800
8	35,600	44,500	40,940
For each additional person, add	3,600	4,500	4,140

Source: Federal Register, Vol. 73, No. 15, January 23, 2008, pp. 3971–3972

What Benefits Does Medicaid Cover?

Federal Medicaid rules require that certain services—the mandatory benefits—be covered, while other optional benefits can be offered at the state level.

Because federal rules mandate that Medicaid cover many of the same services usually covered in private insurance plans, Medicaid is sometimes described as having a rich benefit package. Yet as with private insurance, most of the benefits can be limited when provided to adults. For example, states can limit the number of hospital days or physician visits. However, two of the more important mandatory Medicaid benefits are not covered in most private health insurance plans: Early and Periodic Screening, Diagnostic and Treatment and long-term care services.

Early and Periodic Screening, Diagnostic and Treatment is a program within a program for individuals under age 21 covered by Medicaid. It basically requires state Medicaid programs to provide for any medically necessary service a physician determines is needed for a Medicaid-eligible child. Under this program, children

covered by Medicaid receive all the basic medical services such as well-child visits, immunizations, dental, hearing and other screening services. In addition, they are also able to access a wide array of services that states do not otherwise cover in their Medicaid programs. Outreach and education regarding such screening, diagnosis and treatment are required elements of the program as well. The open-ended nature of the program can result in extensive expenditures that states have difficulty controlling. Despite the costly requirement, however, per-child costs remain far below the costs to cover other Medicaid populations, such as low-income elderly or disabled.

All states must provide nursing home care as part of their Medicaid programs for seniors and other individuals with severe physical disabilities, though each state determines its own criteria for covering a nursing home admission. Medicaid is by far the single largest payer of nursing home care in the country, accounting for almost half of all nursing home expenditures.

▶ MEDICAID MANDATORY & OPTIONAL BENEFITS

Major mandatory benefits states must cover:

- ▶ Hospital services
- ▶ Physician services
- ▶ Laboratory & x-ray services
- ▶ EPSDT services
- ▶ Services at federally qualified health centers
- ▶ Nursing home services for people under 21
- ▶ Home health care for certain people
- ▶ Family planning services

Major optional benefits states can cover:

- ▶ Prescription drugs
- ▶ Rehabilitation services
- ▶ Physical therapy
- ▶ Dental services
- ▶ Eyeglasses & hearing aids
- ▶ Intermediate care facilities for mentally retarded
- ▶ Personal care services
- ▶ Hospice services

Although technically an optional benefit, prescription drugs are covered in all states. Medicaid expenditures for prescription drugs totaled more than \$30 billion in 2005. Beginning in 2006, Medicaid beneficiaries who are also eligible for Medicare began receiving outpatient prescription drugs through the Medicare Part D prescription drug benefit instead of through Medicaid. While the precise impact of the Part D program on Medicaid is

unclear at this time, Medicaid's drug costs for dual eligibles have been considerably reduced. Prior to the implementation of the Medicare drug benefit, drug costs for this population were roughly half of all Medicaid prescription drug costs. Medicaid does, however, cover the premium cost for Part D prescription drug benefit plans for dual eligibles, so not all drug costs for Medicare beneficiaries have been eliminated.



What Impact Did the Deficit Reduction Act Have?

The federal Deficit Reduction Act of 2005 gave states greater flexibility to modify their Medicaid programs by eliminating the requirement that states offer the same coverage to all categorically needy recipients statewide. The elimination of this requirement permitted states to vary the level and range of Medicaid coverage for the first time based on beneficiary characteristics or geographic location.

States may now amend their Medicaid state plans to replace the traditional Medicaid benefits with new benchmark plans and provides new flexibility that allows states to vary benefits across beneficiary groups and across geographic areas in the state. Generally, only low-income, relatively healthy adults and children can be enrolled in these plans. The Deficit Reduction Act maintains Early and Periodic Screening,

Diagnostic and Treatment services as a wrap-around for children.

States have used the Deficit Reduction Act to comprehensively restructure benefits by setting more limited coverage standards for people who appear to be in relatively good health, while allowing more generous benefits for adults who have certain chronic physical or mental conditions and disabilities. The act eliminated much of the uniformity of the program and added a new layer of complexity to an already complicated program. The effects of these changes on states' Medicaid programs are unknown. As of October 2008, only eight states—Idaho, Kansas, Kentucky, South Carolina, Virginia, Washington, West Virginia and Wisconsin—had approved state plan amendments that implement this section of the Deficit Reduction Act.

Who Pays for Medicaid?

States and the federal government share the cost of Medicaid. For every dollar a state spends on Medicaid, the federal government contributes between \$1 and \$3.25, but the actual amount a state receives is based on its matching rate, known as the Federal Medical Assistance Program. The match rate is calculated each year by comparing a state's per capita income to the national average income. The higher a state's per capita income relative to the national average, the lower its match rate. And the higher the match rate, the more federal dollars flow into the state.

The lowest match rate, which occurs in 18 states and territories in 2009, is 50 percent. In other words, the federal government pays 50 cents of every dollar spent on Medicaid. The highest contribution, in Mississippi, is almost 76 percent in 2009. Thus, for every dollar spent on Medicaid in Mississippi in 2009, the federal government will pay 76 cents. Across all states, the average federal contribution is 57 percent. A slightly higher

percentage is used toward the costs of the State Children's Health Insurance Program. States must provide matching dollars from their own public funds or a combination of state funds and local tax dollars. Because Medicaid is an entitlement program, the amount of total federal matching funds for Medicaid has no statutory limit. Federal spending is only limited by states' abilities to provide matching funds.

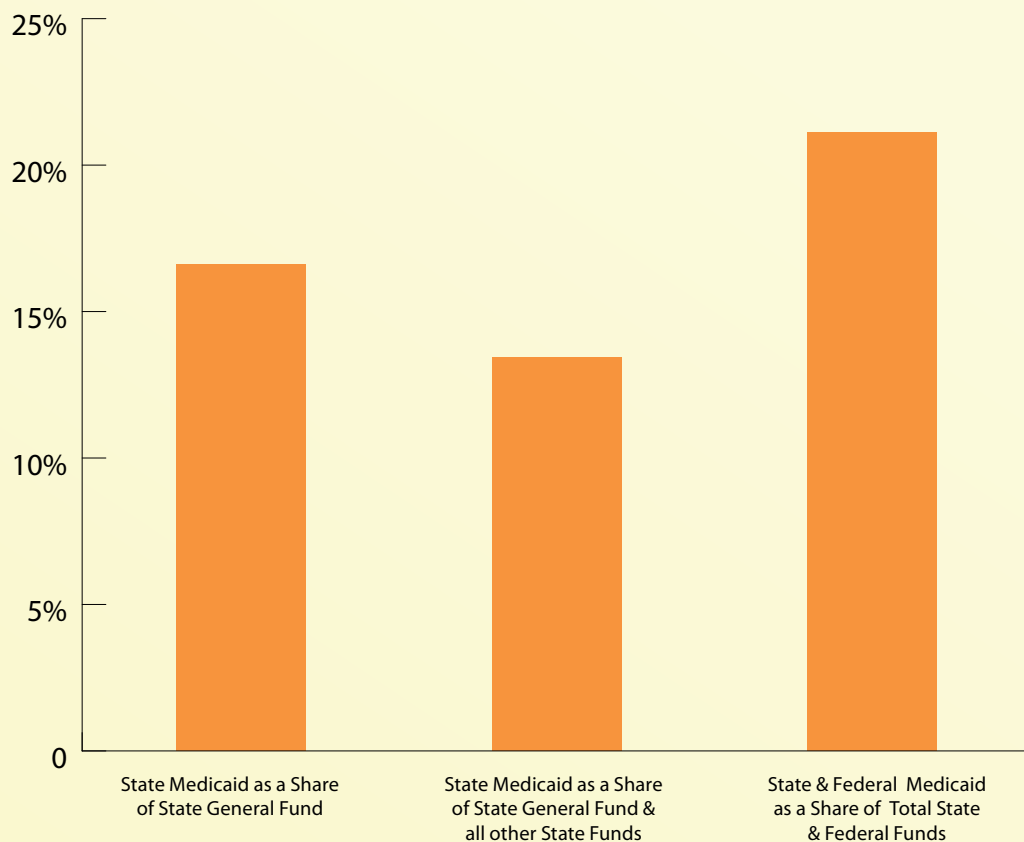
To trigger federal Medicaid matching funds, a state must spend some combination of state or local funds on Medicaid. For example, when a Medicaid recipient receives a health care service, the provider incurs the costs and requests to be paid by the state Medicaid agency, at which point the state pays the provider based on the Medicaid rate for that service. The state is then reimbursed by the federal government at an amount equal to that state's match rate.

In addition to the costs of providing medical services, states also receive federal funds for the

costs of administering the Medicaid program. This includes such functions as claims processing and eligibility determination. Generally, the match rate for all states for administrative activities is 50 percent; however, certain activities including nursing home survey and certification, operation

of information systems, and some activities to stop fraud and abuse qualify for a higher match rate. Overall, states' administrative costs represent about 5 percent of total Medicaid spending in a given year, so the bulk of the federal matching funds pay for medical services.

▶ MEDICAID SPENDING AS A SHARE OF STATES BUDGETS, 2006



State Medicaid spending can be analyzed in a number of ways. This chart generally shows Medicaid expenditures as a share of states' budgets, but each bar represents a different calculation. The first bar is state Medicaid expenditures as a share of state general fund budgets. The middle bar is state Medicaid expenditures as a share of all state funds, including the general fund and any other state revenues. The third bar is state and federal Medicaid expenditures as a share of total state and federal expenditures in state budgets. In this chart, the bars represent the calculation for all states combined or an average for the states. Each calculation tells a slightly different budget story within an individual state; comparisons between states are difficult due to differences in states' budgeting.

Data Source: Center for Children and Families analysis of National Association of State Budget Officers, "Fiscal Year 2006 State Expenditure Report," (Fall 2007).

Cost-Sharing in Medicaid

Medicaid has historically limited patient cost-sharing because it serves a much poorer and sicker population than private health insurance. Over the past few years, however, most states have introduced or increased cost-sharing requirements for their Medicaid beneficiaries. (Forty-four states and the District of Columbia have co-payments and five states have co-payments only on prescription drugs). Only six states—Connecticut, Hawaii, New Jersey, Nevada, Texas and Washington—have no co-payments.

Several reasons are given for this change, including the beliefs that: even those with very low incomes should bear some portion of their health care costs; co-pays will make Medicaid recipients less likely to make unneeded visits to the doctor or to seek out unnecessary treatment; cost-sharing encourages personal responsibility; and co-pays for prescription drugs will encourage Medicaid beneficiaries to use generic drugs in an effort to control costs.

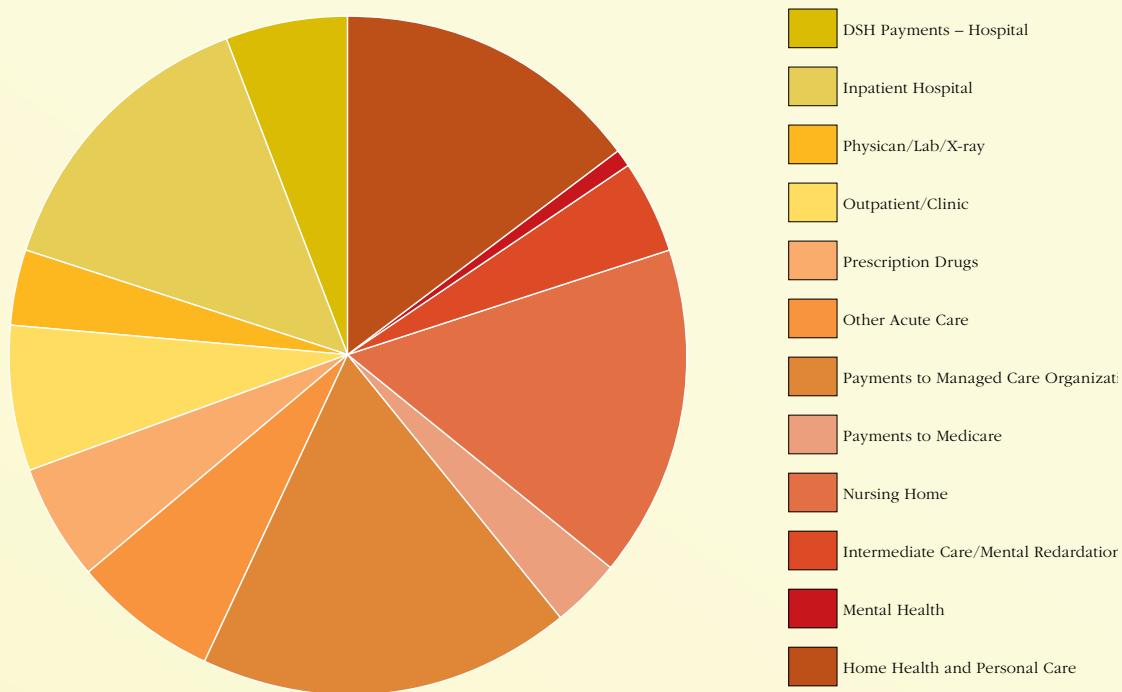
A few states have decided against cost-sharing because they found that the collection of co-payments from Medicaid recipients adds to both the cost and complexity of administering the Medicaid program. Furthermore, the money a state collects from recipient co-pays is not eligible for federal Medicaid matching funds, so substituting beneficiary co-pays for state dollars in the Medicaid budget will not make up for federal matching funds that will be lost. Some also fear that cost-sharing may force people to forgo needed health care, causing them to become sicker and need more expensive care later on, increasing costs in the long run.

Cost-sharing requirements for Medicaid recipients are determined by states but are subject to federal guidelines. Before passage of the Deficit Reduction Act, states could only require some beneficiaries to pay nominal

co-payments on services, and states were very limited in their ability to charge premiums. Co-payments were limited to \$3 for most services and providers were prohibited from denying services to individuals who did not pay. But starting in 2005, the Deficit Reduction Act gave states the option to increase the level of cost-sharing for Medicaid recipients and to require premium payments by many Medicaid beneficiaries whose family income is at or above the federal poverty level. (Exceptions include children, pregnant women and individuals living in institutions). States may require individuals with family income between 100 percent and 150 percent of poverty to pay up to 10 percent of the costs of their services; individuals with higher incomes may be charged 20 percent coinsurance. However, total cost-sharing and premiums for all family members may not exceed 5 percent of the family's income. Under the Deficit Reduction Act, states may allow providers to deny services for lack of payment, require payment of premiums prior to enrollment, and impose cost sharing on non-preferred prescription drugs and inappropriate emergency room use—two very costly items for states. States may also increase nominal co-payments over time at the rate of medical inflation for individuals with incomes below the poverty level.

By the 2008 fiscal year, four states were using the Deficit Reduction Act to make at least some copayments enforceable, and Wisconsin was using the act's authority to extend nominal co-payment requirements to certain parents and children in managed care. Beginning in the 2009 fiscal year, Nevada plans to use the act to implement new co-payment requirements for adults and to make these co-payments enforceable. Two states—Oregon and Pennsylvania—also used the act's authority to eliminate copayments.

▶ MEDICAID EXPENDITURES BY SERVICE, 2006



Source: Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured

Note: Although these statistics vary somewhat from year to year and state to state, the spending patterns generally hold true.



How are Providers Paid?

Medicaid providers are usually paid for each service they provide to a beneficiary on a fee-for-service basis. States typically establish their own payment rates, and federal rules require that these rates be sufficient to enlist enough providers so that medical care and services are available to Medicaid beneficiaries at least to the same degree they are available to the general population in a given geographic location. In general, providers cannot charge Medicaid more than they charge other payers for the same service. Except for allowable co-payments, Medicaid payment is considered payment in full and providers may not charge beneficiaries an additional amount.



“In general, providers cannot charge Medicaid more than they charge other payers for the same service.”

Where Does the Medicaid Dollar Go?

Medicaid insures a very diverse population and provides the broadest array of acute and long-term medical care and related services in the country. Medicaid program costs are determined by numerous factors, including the number of eligible participants, the extent of recipient health care needs, the scope of benefits, and the reimbursement rate providers are paid. In 2007, Medicaid spending totaled more than \$300 billion. Nearly 60 percent was spent on acute care, 35 percent on long-term care and 6 percent on hospitals that serve a disproportionate share of low-income and uninsured patients.

Medicaid spending per capita varies significantly by eligibility group, with the average annual costs per child at roughly \$1,400, compared to \$1,800 per adult, \$12,000 per enrollee with disabilities and \$10,000 per elderly enrollee. While children and their parents make up 75 percent of the Medicaid population, most of the spending (70 percent) goes to services for the elderly and people with disabilities. Approximately half of Medicaid spending is attributable to 4 percent of Medicaid enrollees who, due to their health care needs and utilization of services, incur very high costs exceeding \$25,000 per enrollee.

A large portion of the Medicaid dollar is spent on services for dual eligibles, low-income seniors and people with disabilities who are enrolled in both Medicare and Medicaid. While dual eligibles account for only about 15 percent of the Medicaid population, their costs account for roughly 40 percent of Medicaid spending, particularly for long-term care services and prescription drugs. The institution of Medicare Part D prescription benefit should reduce drug costs for this population, although it is too soon for data to confirm this assumption.



“Many states rely on the hospitals themselves to finance the payments, either through provider taxes or through intergovernmental transfers from local governments and public hospitals.”

▶ BEYOND THE BASICS

Disproportionate Share Hospital Program

Congress created the Medicaid Disproportionate Share Hospital requirement in 1981 to ensure that state Medicaid programs provide adequate payments to hospitals whose patient populations are disproportionately composed of low-income and uninsured patients. These safety net providers are often unable to generate enough revenue to cover their uncompensated care costs because they typically incur higher costs than other health care facilities, have fewer private paying patients than most hospitals, and therefore rely heavily on Medicaid payments that are often significantly lower than actual incurred costs. Medicaid payments have become one of the most important sources of financing for these providers. Federal funding for such payments is capped at both the federal and state levels. In other words, not only is the amount of total federal funds fixed each year, so are each state's allocation of funds.

States have substantial flexibility in distributing Disproportionate Share Hospital funds. Many states provide different payment levels for different types of hospital providers; some add these payments on to hospital payment rates; and others provide lump sum payments on a periodic basis throughout the year. Methods of financing the state share of these payments also vary from state to state. Many states rely on the hospitals themselves to finance the payments, either through provider taxes or through intergovernmental transfers from local governments and public hospitals.

Financing Arrangements

The major financing arrangements used by states to maximize federal dollars include intergovernmental transfers, certified public expenditures and provider taxes. The widespread use of these financing arrangements, many of which are completely legitimate ways to draw down federal funds and maximize state dollars, has become controversial and increased tensions between the states and the federal government over costs and control of the Medicaid program.

Intergovernmental Transfers

Intergovernmental transfers are transfers of public funds between or within levels of government. The transfer of funds may take place from one level of government to another (i.e., county to state) or within the same level of government (i.e., from a state university hospital to the state Medicaid agency). States can use county or state funds as the match for federal funds. As many as 34 states have used intergovernmental transfers to support funding in their Medicaid programs.

The use of these transfers is clearly authorized in federal statute and is both legal and useful. They only become problematic when states draw down federal funds without contributing to the cost of the program. This happens if:

- States raise the federal share of total Medicaid funding beyond the required match rate. States have required public providers—hospitals and nursing homes—to transfer back to the state some or all the federal Medicaid funds originally paid to those providers that exceeded the usual Medicaid payment rate, resulting in the payment to the provider being made up of a larger portion of federal funds than the required match rate.

- The federal funds are used for purposes other than providing services to Medicaid beneficiaries, i.e., road projects, other non-health care services, etc. Intergovernmental transfers have been used by states to fill budget gaps for other programs and to draw down additional federal dollars to maintain Medicaid services.
- Medicaid spending growth rates are raised without a corresponding increase in state spending for services for Medicaid enrollees. Since Medicaid spending growth rates reflect both the federal and state share of expenditures, when the state's share is paid with intergovernmental transfers that are returned to local governments to use as they please, in reality, Medicaid expenditures have only increased by the amount of federal outlay.
- States reduce their own funding for public facilities and replace these funds with federal dollars. In other words, state dollars are no longer used to support public facilities.

As a consequence, for the past several years there has been heightened tension between states and the federal government over the Medicaid program. This tension has resulted in several pieces of federal legislation and regulation aimed at addressing these perceived abuses. In June 2008 President Bush signed into law a Congressional moratorium on these regulations that delays their implementation until April 2009.

Certified Public Expenditures

A financing arrangement that is similar to intergovernmental transfers, but more restrictive, is certified public expenditures. These expenditures are certifications by state or

local government entities that they have spent funds on items and services that are eligible for federal matching Medicaid funds. The spent funds may not include public funds that had originated as state Medicaid payment revenues. Federal matching funds are then provided for the federal share of the certified expenditure. Unlike intergovernmental transfers, certified public expenditures do not involve an actual transfer of funds to the Medicaid agency. Instead, the federal government recognizes the expenditure by the state or local government entity as eligible for federal match and provides the federal share to the Medicaid agency. Like intergovernmental transfers, certified public expenditures are legal under the federal Medicaid statutes.

Provider Taxes

State Medicaid revenue comes from several sources, including income, property, sales and estate taxes and other sources that generally make up states' and counties' general funds. But states can also raise Medicaid revenue by imposing fees, assessments and other taxes on health care providers. Health care provider taxes and donations were common practices to raise Medicaid matching funds until 1991, when strict rules were placed on provider taxes, greatly limiting a state's ability to use provider taxes as the source of Medicaid matching funds. However, because of increased revenue pressures on states due to the current widespread economic downturn, several states have turned to or are considering the use of provider taxes from hospitals, nursing homes and managed care organizations to help finance their Medicaid programs. In 2008, 44 states were taxing at least one provider category and 30 of these states were taxing more than one provider category.

Medicaid and the Economy

Because every dollar a state spends on Medicaid brings new federal matching dollars into the state, Medicaid is a particularly important funding source that not only provides crucial health care to the most vulnerable residents, but also yields significant economic benefits for states.

State and federal dollars spent on health care services help employ health care workers and purchase medical goods and equipment from businesses in the state. Because of this increased employment and steady business in the health sector, other state economic sectors such as grocery stores, retail businesses, automotive services, etc. are also bolstered. Economists call this the

multiplier effect. Medicaid spending at the state level injects more money into the state economy than would otherwise be there because of federal matching. In this way, Medicaid spending, more than other state spending, has uniquely powerful economic impacts on states. The magnitude of the Medicaid multiplier effect varies from state to state, depending on the size of the state's federal matching rate, how the initial dollars are spent and the economic conditions in the state. But clearly, the positive impact of Medicaid spending on a state's economy outweighs the value of services purchased directly by the state Medicaid program.



Medicaid and Managed Care

Since 1990 managed care has grown into the primary health care delivery system in Medicaid as states tried to control cost without negatively impacting the quality of services. Managed care is designed to improve access and reduce costs by eliminating inappropriate and unnecessary services through coordination of patient care. States began their managed care programs in the 1990s by enrolling healthier populations of children and adults and are now moving their disabled populations into these programs.

The Balanced Budget Act of 1997 gave states the authority to require Medicaid beneficiaries to enroll in managed care without getting a waiver. The proportion of all Medicaid beneficiaries in any form of managed care was 64 percent in 2007. Only Alaska and Wyoming have no form of Medicaid managed care.

There are two major types of managed care models: risk and primary care case management. In a risk model, a Medicaid agency contracts with a health care organization to provide or arrange for the provision of services for each enrolled person for a monthly set fee. The prepaid fee does not vary from month-to-month based on the amount of services used by the individual enrollee. In this kind of arrangement, the contractor assumes some level of financial risk for providing care to the participant. If the health care costs exceed the monthly payment, the contractors must absorb the excess cost. This model is closest to health maintenance organization models operated in the private sector.

In a primary care case management model, Medicaid enrollees are assigned to a primary care provider who manages their care, and in some states, acts as a gatekeeper to specialty services. The provider receives payment on a fee-for-service basis and a small additional monthly fee for each enrollee. Primary care case management providers usually do not assume any financial risk for providing care to enrollees. Cost-savings from this model can come from increased use of preventive services and decreased use of emergency room services. As of 2007, 30 states use primary care case management in their Medicaid programs, either alone or in conjunction with HMOs.

Glossary

Acute Care Services: Inpatient and outpatient hospital services, clinic services, federally qualified health centers services, physician, lab and X-ray services and pharmacy services.

Categorically Needy: Under Medicaid, categorically needy are aged, blind or disabled individuals or families and children who meet financial eligibility requirements for Temporary Assistance for Needy Families, Supplemental Security Income or an optional state supplement.

Certified Public Expenditure: An expenditure certified by a public agency to represent its contribution in providing care to Medicaid recipients or uninsured persons.

Chronic Disability: A disabling condition or impairment that has already lasted one year or is expected to last for at least one year.

Copayment: A fixed amount that a beneficiary must pay at the point of service when he or she receives the service.

Deductible: An amount that an insured person must pay before covered benefits begin.

Disproportionate Share Hospital: A hospital that provides inpatient and outpatient services to a disproportionate share of low-income and uninsured individuals.

Dual eligible: An individual who is eligible for both Medicaid and Medicare.

Early and Periodic Screening, Diagnosis and Treatment: A federally mandated program under Medicaid that provides a comprehensive set of health benefits for children and adolescents.

Federal Financial Participation: The portion paid by the federal government to states for their share of expenditures for providing Medicaid services and administering the Medicaid program.

Federal Medical Assistance Percentage: The federal government's share of Medicaid based on the relationship between each state's per capita personal income and the national average per capita personal income over three years; it is recalculated every year.

Federal Poverty Level: The measure of poverty as determined by the federal Department of Health and Human Services.

Federally Qualified Health Center: A health center in a medically underserved area that is eligible to receive cost-based Medicare and Medicaid reimbursement.

Fee for Service: A payment method in which physicians and other health care providers receive a fee for services performed.

Freedom of Choice: With certain exceptions, a state's Medicaid program must allow recipients freedom of choice among health care providers participating in Medicaid.

Institutional bias: The provision in Medicaid law that requires states to provide institutional services to all eligible individuals as a mandatory benefit, and permits (does not require) states to make services available in the community.

Intergovernmental transfer: A transfer of funds among or between different levels of government.

Long-term Care Services: Nursing facilities, intermediate care facilities for the mentally retarded, inpatient care at state mental health facilities, home health services, personal care, targeted case management, hospice, and home and community-based waiver services.

Managed Care: A delivery system that manages health care with the goal of controlling costs. Managed care systems typically rely on a primary care physician who acts as a gatekeeper for patients to obtain other health services such as specialty medical care, surgery or physical therapy.

Medicaid Match: The match of federal Medicaid funds to state Medicaid dollars, which is roughly designed to even out federal Medicaid spending per Medicaid recipient. The match rate varies by state, with poorer states receiving more generous matching than richer states.

Medically Needy: Individuals with incomes greater than income limits to qualify under the mandatory or optional groups who are able to qualify for Medicaid by spending down, i.e., incurring expenses for medical care to offset their excess income, thereby reducing income to a level below the level allowed by that state's Medicaid program.

Premium: Money paid for an insurance policy/coverage.

Primary Care Case Management: A health care delivery system under which a primary care provider coordinates the health care of consumers.

Primary Care Provider: The primary care practitioner in managed care organizations who determines whether a patient needs to see a specialist or receive other non-routine care.

State Children's Health Insurance Program: A federal/state partnership created as part of the Balanced Budget Act of 1997 to expand health insurance coverage to children whose families earned too much to be eligible for Medicaid but not enough to afford private insurance.

Spend-Down: The process of reducing the assets an individual possesses in order to qualify for Medicaid, i.e., spending one's money until the appropriate asset limit is reached.

Temporary Assistance to Needy Families: A block grant created in 1996 as part of a federal effort to change the nation's welfare system. The TANF block grant replaced the Aid to Families with Dependent Children program, which had provided cash welfare to poor families with children since 1935.



Sharing capitol ideas.

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