

# Chapter 8:

## Medicaid

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**M**edicaid is an entitlement program for low-income individuals financed jointly by each state and the federal government, and state administered.

States choose to participate in Medicaid, but must accept certain federal rules if they are to receive federal Medicaid funding. They must, for example, provide certain mandatory benefits such as inpatient hospital services, laboratory and x-ray services, and physician services.<sup>1</sup> Medicaid also mandates a benefits package for children known as Early and Periodic Screening, Diagnostic and Treatment.<sup>2</sup>

Medicaid pays for nearly half of long-term care. (See chapter, "Long-Term Care," for more.) Federal law requires every state to provide nursing home care and home health care for the qualified poor.<sup>3</sup> (See chart, "Medicaid as a Percent of Health Expenditures.")

In exchange for federal funding, states must cover certain groups under Medicaid, including:

- 1) poor families that meet financial requirements for cash welfare benefits;
- 2) families for one year after tran-

sitioning from welfare to work;

- 3) pregnant women and children under age six with family incomes below 133 percent of the federal poverty level (FPL);
- 4) children ages six through 18 with family income below 100 percent of the poverty level; and
- 5) poor disabled or elderly persons who qualify for cash assistance under Supplemental Security Income (SSI).<sup>4</sup>

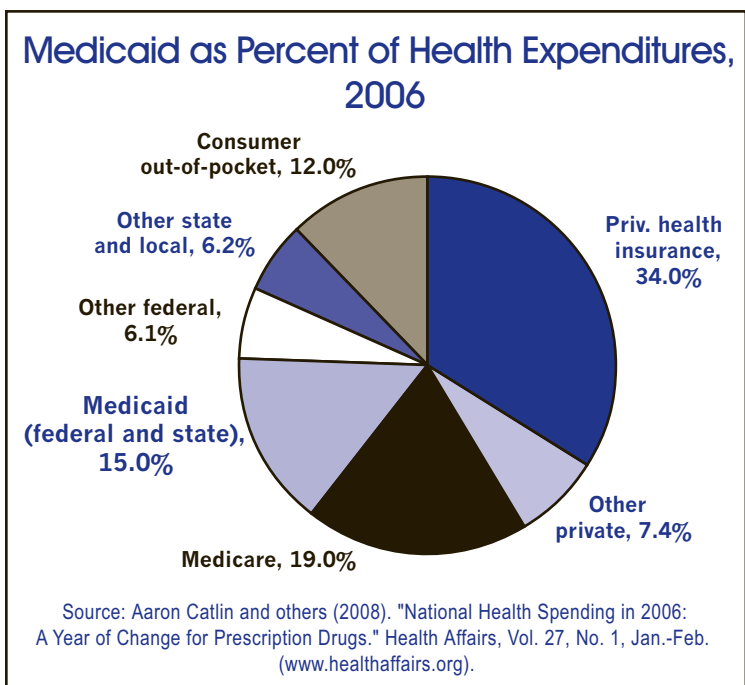
States can voluntarily choose to cover other groups, such as pregnant women and infants between 133 percent and 185 percent of FPL and certain categorically qualified individuals whose medical expenses have made them medically needy.<sup>5</sup> (See chart, "Federal Poverty Guidelines 2009.")

Nearly 30 million of Medicaid's approximately 61 million beneficiaries are children.<sup>6</sup> A little more than 16 million beneficiaries were adults in families with dependent children. There were 9.5 million individuals with disabilities and 6 million elderly people enrolled in Medicaid during FY 2007.<sup>7</sup> (See chart, "Medicaid Enrollment in 2007.")

### FAST FACTS

- Almost 61 million people were covered by Medicaid in 2007.<sup>a</sup>
- Medicaid pays for nearly half of long-term care.<sup>b</sup>
- A total of nearly 30 million of Medicaid's approximately 61 million beneficiaries are children.<sup>c</sup>
- Medicaid accounted for more than \$300 billion dollars in 2006 in combined federal and state spending.<sup>d</sup>
- There were 9.5 million individuals with disabilities and 6 million elderly people enrolled in Medicaid during FY 2007.<sup>e</sup>
- Children make up 50 percent of the Medicaid population, but they account for only 18 percent of costs.<sup>f</sup>

**For story ideas on Medicaid, see page 90. A list of experts and websites begins on page 91.**



8 Medicaid accounted for over \$300 billion dollars in 2006 in combined federal and state spending.<sup>8</sup> Medicaid accounts for 9 percent of spending on prescription drugs and 17 percent of the national spending on hospital care.<sup>9</sup>

Medicaid spending is attributable to 5 percent of the enrolled population.<sup>10</sup> Although children made up 50 percent of the Medicaid population in 2005, they accounted for only 18 percent of costs. Non-elderly adults, who made up 26 percent of Medicaid beneficiaries, accounted for just 12 percent of the costs. In contrast, the elderly made up only 10 percent of the population, but accounted for 28 percent of the program's costs. The disabled made up 14 percent of the Medicaid population but accounted for 42 percent of costs.<sup>11</sup> (See chart, "Medicaid Enrollees and Expenditures by Enrollment Group, 2005.")

The federal government reimburses states for a part of their Medicaid program expenses. The federal share, known as the federal medical assistance percentage (FMAP), differs from state to state. In FY 2008, states received a share as low as 50 percent of total spending or as high as 76 percent.<sup>12</sup> The FMAP will temporarily increase, however, by 6.2 percentage points for each state under the American Recovery and Reinvestment Act passed by Congress and signed into law in early 2009. Some states with substantial increases in unemployment will qualify

for additional FMAP increases.<sup>13</sup> The increase will be in effect through the "recession adjustment period" which ends December 31, 2010.

FMAP payments vary based on state per capita income.<sup>14</sup> (For a list of states and their FMAP percentages before the stimulus bill, go to <http://aspe.hhs.gov/health/fmap.htm>.)

Medicaid is considered a counter-cyclical program. This means that the program's enrollment grows just as state and federal tax revenues that fund it decline. As a result, states often struggle to maintain Medicaid obligations and balance their budgets, as nearly all are constitutionally required to do, during economic downturns.<sup>15</sup>

In FY 2008, the trend among states was toward expansion and enhancement of Medicaid benefits, such as targeted benefit improvements. However, in light of the recession, states may have to cut their Medicaid budgets as they did during the last economic downturn.<sup>16</sup>

As of November 2008, 22 states had reduced their overall budgets.<sup>17</sup> On average, states spend about 17 percent of their general funds on Medicaid, which in most states is second only to education.<sup>18</sup> If the economy continues to falter, experts believe the number of people covered by Medicaid and benefit levels could well be in jeopardy.<sup>19</sup> This could also put at risk efforts by the states to cover uninsured residents using the program as a vehicle.<sup>20</sup>

The 2009 economic stimulus act shows one way to ease this counter-cyclical predicament for states. The FMAP increase in that act may forestall states having to make Medicaid cuts, but as of early 2009, it is too early to tell.

There is some precedent for this sort of help to the states: in 2003, in response to another economic slowdown, Congress temporarily increased FMAP rates by 2.95 percentage points. As a condition of the increased rate, states agreed not to cut eligibility during the 18-month duration of the FMAP increase.<sup>21</sup> A November 2008 proposal by Senate Finance Committee Chairman Max Baucus would make relief to the states automatic by increasing FMAP rates whenever certain indicators of an

economic downturn occur.

Much of Medicaid spending provides coverage for so-called "dual eligibles,"<sup>22</sup> individuals entitled to both Medicare and Medicaid. Medicaid provides coverage that wraps around Medicare to individuals who are eligible for full Medicaid coverage. Medicare is the primary payer for benefits that both programs cover, with Medicaid paying the difference up to the state's payment limit for a given service.

There are other benefits for Medicare beneficiaries entitled to some - but not full - Medicaid benefits. These benefits, collectively called the Medicare Savings Program, provide help with a variety of out-of-pocket costs. The Qualified Medicare Beneficiary program (QMB or "Quimby"), one part of the Medicare Savings Program, pays for Medicare premiums, deductibles and coinsurance for people with incomes below 100 percent of the federal poverty level (FPL) and with resources two times the standard allowed under the Supplemental Security Income program.

Specified Low Income Medicare Beneficiaries (SLMB or "Slimby") have their Medicare Part B premiums paid if they are between 100 and 200 percent of the FPL and have resources at or below twice that allowed under SSI. (Part B pays for doctors.) Qualifying individuals can get help with their Part B premiums if they are between 120 and 135 percent of the FPL. However, this benefit is not an entitlement; states receive a limited amount of money from the federal government.

Qualified Disabled and Working Individual (QDWI) benefits are for individuals with disabilities who are entitled to Medicare but because they return to work, consequently lose the right to get their Medicare Part A premium paid. (Part A pays for hospital care.) Medicare covers some individuals who have been disabled for at least two years. Under QDWI the individual must have an income less than 200 percent of the FPL.<sup>23</sup>

## LIKELY POLICY DEBATES

The debate around Medicaid in Congress will likely focus on the following: Medicaid as an economic stimulus mechanism, Medicaid as a vehicle for health coverage expansion and Medicaid as part of the problem of exploding entitlement costs. For the

## Medicaid Enrollment in 2007

Population	Number enrolled (in millions)	Percent of total Medicaid enrollment
Children	29.2	48.0
Adults	16.2	26.6
Blind/Disabled	9.5	15.6
Elderly	6.0	9.9
<b>Total</b>	<b>60.9</b>	<b>100</b>

Source: Senator Max Baucus, Chairman, Senate Finance Committee (2008). "Call to Action: Health Reform 2009." November 12, page 23. (<http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf>).

near term, the economy and the states' efforts to cut their budgets in the face of declining revenues and expanded numbers of uninsured will probably dominate Medicaid policy debate.

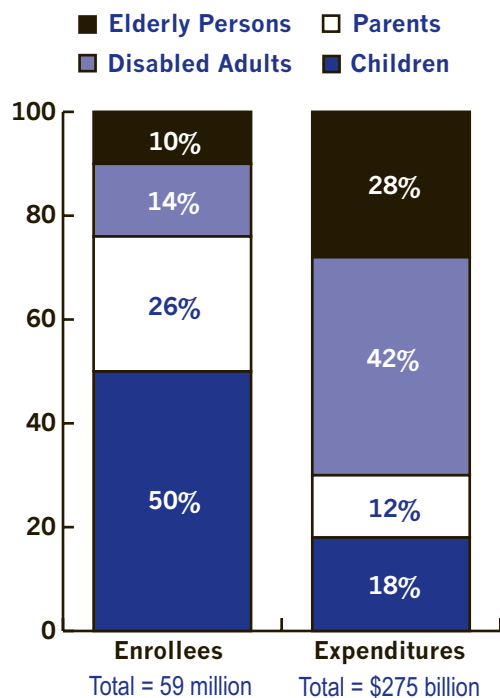
But look for parallel debates on the suitability of Medicaid expansion when comprehensive health reform is considered. Medicaid expansion is a feature of the health plan President Obama offered during the campaign and of leading congressional proposals such as that offered by Senator Max Baucus.<sup>24</sup>

The Obama campaign plan did not specify how eligibility would be expanded.<sup>25</sup> The Baucus plan would eliminate mandatory Medicaid eligibility for certain categories of people, instead requiring eligibility for everyone at or below 100 percent of the federal poverty level. States would be obliged to maintain coverage for anyone currently covered optionally even if they are above 100 percent FPL.<sup>26</sup> Subsidiary issues include low current Medicaid payment rates to providers and their impact on access and quality.

## TIPS FOR REPORTERS

- Make sure you understand the difference between Medicaid and Medicare, especially with regard to long-term care. Even some lawmakers get them confused. Read the Medicare and long-term care chapters in this sourcebook for details.

## Medicaid Enrollees and Expenditures by Enrollment Group, 2005



SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on 2005 MSIS data (2009). "Medicaid: A Primer 2009." [www.kff.org/medicaid/upload/7334-03.pdf](http://www.kff.org/medicaid/upload/7334-03.pdf).

- Listening to, or reading about, state financing for Medicaid can make your head spin. There are many different ways to look at the same thing. When discussing this with your state Medicaid officials or legislators, just make sure you understand what they're talking about. For example, financing of Medicaid can refer to: 1) Medicaid spending for your state including state and federal Medicaid funds, or 2) Medicaid spending using state-only funds (not including federal matching funds).
- Most states contract with managed care organizations to provide coverage to beneficiaries. What contractual obligations between the state and the insurer exist to ensure quality of care? How are these obligations enforced?
- Dual eligibles are a constant point of contention between federal and state governments. Be sure to sort out what state and federal obligations are toward these individuals and whether the respec-

tive obligations are being met. Look for proposals that may reduce state obligations to the federal government in exchange for federal funding or vice versa.

- Be mindful of which groups and services are mandated to be covered by Medicaid and which groups and services are covered at your state's option. Coverage for voluntary groups varies significantly from state to state, while mandatory coverage is the same across states. The same is true for benefits.

### STORY IDEAS

- How is the declining economy affecting state efforts to maintain existing Medicaid eligibility and cover the uninsured? Is the temporary increase in the federal matching rate making a difference?
- How will your state use the increased Medicaid money that it is receiving as a result of The American Recovery and Reinvestment Act of 2009? What kinds of plans are being developed by your state to sustain these programs after the Medicaid money runs out?
- How are access to care and quality affected by the relatively low payment levels that Medicaid sets for hospitals, physicians and other providers? What percentage of physicians in your state accept Medicaid patients? Do these physicians have practices made up largely of Medicaid patients?
- What strategies is your state pursuing to streamline Medicaid costs, improve efficiency, and improve quality?
- What impact are Medicaid budgetary problems having on safety net providers such as community health clinics and public hospitals?
- The American Recovery and Reinvestment Act of 2009 includes financial incentives toward the adoption of electronic health records (EHRs) by several types of Medicaid providers (physicians, nurse midwives, nurse practitioners, dentists, certain physician assistants, children's hospitals and general acute care hospitals) that serve a high volume of Medicaid patients.<sup>27</sup> Is this

incentive causing providers in your area to get on board with EHRs? If not, why not? What hurdles to providers face?

## EXPERTS AND WEBSITES

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## 2009 Federal Poverty Guidelines

Persons in Family or Household	Poverty Line - 48 Contiguous States and D.C.
1	\$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010
For each additional person, add	3,740

Source: Federal Register, Vol. 74, No. 14, January 23, 2009, pp. 4199-4201. (<http://aspe.hhs.gov/poverty/09fedreg.pdf>). Poverty line in Alaska and Hawaii is higher

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**Websites**

AARP

[www.aarp.org](http://www.aarp.org)

Alliance of Community Health Plans

[www.achp.org](http://www.achp.org)

American Enterprise Institute

[www.aei.org](http://www.aei.org)

American Hospital Association

[www.aha.org](http://www.aha.org)

American Medical Association

[www.ama-assn.org](http://www.ama-assn.org)Center for Health Services Research and Policy,  
George Washington University[www.gwumc.edu/sphhs/healthpolicy/chsrp/](http://www.gwumc.edu/sphhs/healthpolicy/chsrp/)

Center for Medicare Advocacy

[www.medicareadvocacy.org](http://www.medicareadvocacy.org)

Center on Budget and Policy Priorities

[www.cbpp.org](http://www.cbpp.org)

Centers for Medicare and Medicaid Services

[www.cms.hhs.gov](http://www.cms.hhs.gov)

Children's Defense Fund

[www.childrensdefense.org](http://www.childrensdefense.org)

Commonwealth Fund, The

[www.commonwealthfund.org](http://www.commonwealthfund.org)

Congressional Budget Office

[www.cbo.gov](http://www.cbo.gov)

Consumers Union

[www.consumersunion.org](http://www.consumersunion.org)

Denver Health

[www.denverhealth.org](http://www.denverhealth.org)

Families USA

[www.familiesusa.org](http://www.familiesusa.org)George Washington University Department of  
Health Policy[www.gwhealthpolicy.org](http://www.gwhealthpolicy.org)Georgetown University Center for Children and  
Families<http://ccf.georgetown.edu>

Georgetown University Health Policy Institute

<http://ihcrp.georgetown.edu/>

Government Accountability Office

[www.gao.gov](http://www.gao.gov)

Health Policy R &amp; D

[www.hprd.net](http://www.hprd.net)

Hilltop Institute, UMBC

[www.chpdm.org](http://www.chpdm.org)Kaiser Commission on Medicaid and the  
Uninsured[www.kff.org/about/kcmu.cfm](http://www.kff.org/about/kcmu.cfm)

Kaiser Family Foundation

[www.kff.org](http://www.kff.org)

Lewin Group

[www.lewin.com](http://www.lewin.com)Maine Governor's Office of Health Policy and  
Finance[http://maine.gov/governor/baldacci/cabinet/health\\_policy.html](http://maine.gov/governor/baldacci/cabinet/health_policy.html)

Mathematica Policy Research

[www.mathematica-mpr.com](http://www.mathematica-mpr.com)

Medicaid Health Plans of America

[www.mhpa.org](http://www.mhpa.org)

Medicare Rights Center

[www.medicarerights.org](http://www.medicarerights.org)

National Academy for State Health Policy

[www.nashp.org](http://www.nashp.org)

National Association of Children's Hospitals

[www.childrenshospitals.net](http://www.childrenshospitals.net)National Association of Community Health  
Centers[www.nachc.com](http://www.nachc.com)

National Association of Public Hospitals

[www.naph.org](http://www.naph.org)

National Association of State Budget Officers

[www.nasbo.org](http://www.nasbo.org)

National Association of State Medicaid Directors

[www.nasmd.org](http://www.nasmd.org)

National Center for Policy Analysis

[www.ncpa.org](http://www.ncpa.org)

National Coalition on Health Care

[www.nhc.org](http://www.nhc.org)

National Conference of State Legislatures

[www.ncsl.org](http://www.ncsl.org)

National Governors Association

[www.nga.org](http://www.nga.org)

National Health Law Program  
www.healthlaw.org

National Health Policy Forum  
www.nhpf.org

National Partnership for Women and Families  
www.nationalpartnership.org

National Women's Law Center  
www.nwlc.org

State Coverage Initiatives  
www.statecoverage.net

United Hospital Fund  
www.uhfnyc.org

Urban Institute  
www.urban.org

## ENDNOTES

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