



Medicaid

ACTION

- Preserve the federal guarantee of Medicaid as an entitlement program for all low-income children, youth, and families. Oppose efforts to cap or block grant Medicaid funding. Oppose efforts that are labeled reform but result in reduced benefits and restricted eligibility.
- Ensure that Medicaid targeted case management and rehabilitative services can be reimbursable for child welfare services. This guarantee should be an integral component of any comprehensive child welfare financing reform Congress considers in 2005.
- Oppose any effort to include Medicaid reforms as part of a 2006 fiscal year budget reduction and reconciliation process.
- Support the Family Opportunity Act, which would permit families to purchase Medicaid on a sliding-scale basis and allow states to extend Medicaid coverage to children with potentially severe disabilities. Families of children with severe disabilities often struggle to provide their children with appropriate medical services.

HISTORY AND KEY FACTS

Medicaid is the nation's major public financing program for providing health and long-term care coverage to low-income people. It is a critical health care safety net for millions of low-income children.

In addition to providing basic health care services for children, Medicaid funding allows many states to provide rehabilitative, therapeutic, psychiatric, and targeted services to children in foster care and other parts of the child welfare system.

- In 2003, Medicaid provided health care coverage to an estimated 51 million people—including 25 million children—an increase from 47 million in 2002.
- Although children account for approximately 50% of all people covered by Medicaid, the \$45 billion spent on these children represents only 19% of the program's total cost.

Medicaid is a joint federal-state program, and each state has extensive flexibility to set its own eligibility standards, benefits package, payment rates, and program administration under broad federal guidelines. The result is 56 unique Medicaid programs—one for each state and territory, and the District of Columbia.

Under current Medicaid law, to qualify for federal matching funds, states are required to cover only the very poorest people who fit into the following “mandated” groups or categories:

- parents and children who meet the income and asset limits for each state's welfare program as of July 16, 1996;
- pregnant women, and children 6 and younger, with family incomes up to 133% of poverty (\$16,611 for a mother and child);
- all children younger than 19 with family incomes up to 100% of poverty (\$12,490 for a family of two);
- all current and some former beneficiaries of Supplemental Security Income;
- all beneficiaries of foster care and adoption assistance under Title IV-E of the Social Security Act (with a state option to cover non-IV-E eligible children); and
- certain other low-income Medicare beneficiaries.

States have the option to cover people who fit these categories but have higher incomes. Under current Medicaid law, states are only required to cover a package of core health services (mandatory services), but they must provide this package for all Medicaid beneficiaries. States have flexibility to cover an additional one or more optional services, from a list of 33 services, with federal matching dollars. These optional services usually are medically necessary.

Although states have great freedom to design their own Medicaid programs, the federal government funds a significantly high portion of total Medicaid costs in every state with federal funding ranging between 50% and 76% of the total Medicaid budget. The Federal Medical Assistance Percentage (FMAP) matching rate for each state is calculated by comparing the state average per capita income to the national average. For every dollar of state Medicaid spending, the federal government provides a match of one dollar for states that receive a 50% FMAP rate to as much as three dollars in federal funds for states that receive a 75% FMAP rate.

MEDICAID FUNDING FOR SERVICES FOR CHILDREN IN THE CHILD WELFARE SYSTEM

Medicaid covers basic health insurance coverage for many children in the child welfare system. States also use Medicaid to fund some critical medical services not always provided by the child welfare agency, its contracted providers, or other providers to children and families involved with the child welfare system. These services include targeted case management, rehabilitative services, and therapeutic and psychiatric services provided in residential facilities.

Such services to children in the child welfare system can be critical. Children in foster care may have been exposed to domestic violence, abuse, substance abuse, homelessness, and other traumas—plus, the loss of family is one more pressure added to these burdens that can harm a foster child's mental health and hinder his or her ability to obtain permanency and stability. Anywhere from 40% to 85% of children in foster care have mental health disorders. Medicaid has an important role in meeting these needs.

Targeted case management (TCM) is a service that helps beneficiaries gain and coordinate necessary medical and other services. TCM is the assessment and facilitation of service needs, not the actual services themselves. Through TCM, some states have targeted a portion of their eligible Medicaid population—such as child welfare, foster care, and adoption—to receive assistance in accessing necessary medical, social, educational, and other services. TCM may include assessing the child's needs, arranging for the delivery of needed services, tracking the child's progress, following up on services rendered, and periodically reassessing the child's needs. It may also include arranging for crisis assistance, such as making arrangements for emergency referrals and coordinating other needed emergency services.

Defining a target group such as the child welfare population allows TCM to be provided to a broader population than would be covered under a specific service, yet it limits providing the service to the defined group, thus limiting the exposure of the state Medicaid program. For those states that cover TCM, the state Medicaid plan must address the target group, areas of the state in which services will be provided, comparability of services, definition of services, qualifications of providers, free choice of providers, and assurance that payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Rehabilitative services are medical or remedial services provided to reduce a physical or mental disability, helping recipients reach their optimal functioning level. These services include behavioral management services, day treatment services, family functioning interventions, and similar services.

States' reliance on Medicaid as a percentage of all federal funds used to support child welfare services varies widely, ranging from 0% in five states to 55% in one state. This variation exists because some states do not have TCM or rehabilitative services for child welfare clients as an option in their state's Medicaid plan, therefore child welfare agencies cannot claim Medicaid for these costs. Interpretation of federal policy on TCM for child welfare clients also varies by regional office of the U.S. Department of Health and Human Services (HHS).

In recent months, HHS's Centers for Medicare and Medicaid Services has attempted to stop some states from using Medicaid funding to support services for children in the child welfare system. Since states vary in their use of Medicaid to address the needs of children in the child welfare system, different federal regional offices may issue different rulings on the use of Medicaid funding for child welfare services. Whether HHS will issue a federal restrictive ruling on this issue in 2005 is unclear. Since Medicaid represents 11% of total federal funding supporting child welfare, any action to restrict its use for children in the child welfare system could have a severe effect on states' ability to care for these children.

THE 2005 DEBATE

In an effort to cut the federal deficit while increasing spending on other areas, including defense, homeland security, the war in Iraq, tax cuts, and privatizing a part of Social Security, Congress will likely scrutinize the Medicaid program in 2005 with the primary goal of reducing program costs.

In Congress, the White House, and state legislatures nationwide, concerns about mounting Medicaid costs will provide fuel for the political debate about the program's future. Although Congress may again debate the future of the Medicaid program in 2005, efforts will also continue at the state level to reduce Medicaid costs.

- The average annual growth rate in Medicaid expenditures was 13% in the last two years. Medicaid expenditures currently comprise 22% of all state spending, and the long-term growth of Medicaid is estimated to be 8%–9%.
- Despite the growth in state and federal Medicaid budgets, spending for this program still represents a critical investment in health care. At a time when the per capita costs of private health insurance rose 12.6%, and the Medicare program for seniors rose 7.1%, Medicaid rose only 4.5%.

Services to children are not the reason for the growth in Medicaid expenditures. Most Medicaid funds—69%—are spent on the elderly and disabled. Seniors and people with disabilities make up about 25% of the Medicaid population but consume nearly 70% of its resources.

- Children represent nearly half of all Medicaid enrollees but account for only 19% of total program spending. Per-capita costs for children (\$1,700) are the lowest of the groups eligible for Medicaid, compared with \$12,800 per elderly enrollee in 2003.

Currently, Medicaid is an entitlement program that ensures that the amount paid by the federal government rises automatically to keep pace with rising state costs. In 2003 and 2004, the White House proposed a cap on federal Medicaid spending offering states more flexibility in how the funds could be spent. These proposals were rejected but may be considered again in 2005.

If a cap were placed on the federal share of Medicaid funding, states would have a fixed amount of funding to support the health care costs of a wide population. For instance, states would be faced with meeting the needs of an increasing elderly population that has growing needs for long-term and nursing home care. Under a Medicaid cap, states would have to care for this growing elderly population with Medicaid funds while also supporting children and disabled people with a fixed amount of federal support.

Congress may attempt to debate Medicaid reforms early in 2005. One concern is that a reform proposal to reduce federal spending could be included as part of the FY 2006 budget resolution. This approach would not allow for a full discussion of the issue, since Congress could restrict the debate on Medicaid reform by making it part of a special piece of legislation called reconciliation. Such an omnibus reconciliation bill could include a number of different proposals such as a reauthorization of the Temporary Assistance for Needy Families program, child welfare financing reform, and perhaps other major items.

On December 22, 2004, the nation's governors, acting through the National Governors Association, sent a letter to Congress asking that any Medicaid reform proposal "not be part of a 2006 fiscal year budget reduction and reconciliation process." The debate over the future of Medicaid will continue as Congress deliberates the FY 2006 budget.

Sources for statistical information are provided in the online version of this fact sheet. See www.cwla.org/advocacy/2005legagenda.htm.

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