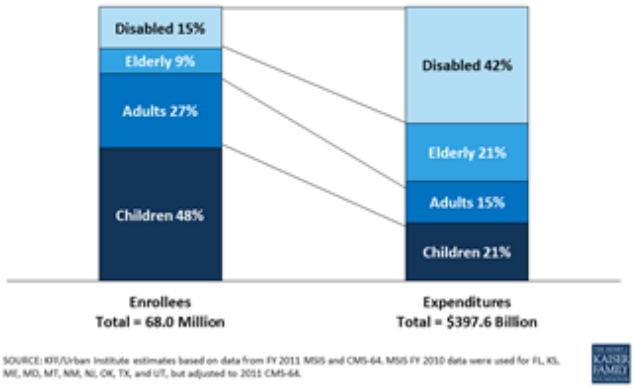
AHPA
ADVENTIST HEALTH POLICY ASSOCIATION

Report: Medicaid

Medicaid is a joint federal-state entitlement program that provides health coverage and other related services for vulnerable populations, including low-income children and their families, low-income seniors and low-income people with disabilities. Medicaid was established as part of the Social Security Amendments of 1965, the same legislation that also created Medicare. The program is the nation's single largest insurer and provides significant funding for hospitals, community health centers, physicians and other health facilities.

Medicaid currently serves approximately 70 million individuals. In FY 2011, the total national Medicaid spending per enrollee was $5,790.[1] It is important to note that this per enrollee spend varies from state to state because Medicaid is a federal-state partnership, providing states with some authority over eligibility and coverage. Nearly two-thirds of all Medicaid spending is for the elderly and persons with disabilities, while these populations only make up approximately 24 percent of the Medicaid population (see Figure 1). Medicaid also serves a large share of children with special health care needs.

Figure 1. Nearly two-thirds of all Medicaid spending is on services for the elderly and persons, FY 2011



Children's Health Insurance Program

Children represent nearly 50 percent of Medicaid enrollees nationwide, totaling 36 million children. CHIP was bipartisan legislation that was enacted in 1997 to provide coverage for children who fell above Medicaid eligibility levels. CHIP plays a critical role in the coverage landscape for children, providing health insurance coverage for 6 million children. Child-specific benefits ensure access to the medically necessary care, such as well-child visits, immunizations, medical, dental, vision and hearing services, that help children grow into thriving participants in our state's economy.

Figure 2. Work Status and Income by Race/Ethnicity for Nonelderly, 2011

Medicaid plays a significant role in reducing racial and ethnic disparities in children's coverage. A Kaiser Family Foundation report states that "even though the majority of Hispanics, Blacks and American Indians/Alaska Natives have at least one full-time worker in the family, they are more than twice as likely to be poor than whites"[2] (see figure 2). In 2011, Blacks accounted for 22 percent of Medicaid recipients, Hispanics made up 25 percent, Whites made up 41 percent and 12 percent of recipients were categorized as other.[3]

[1] http://kff.org/report-section/medicaid-per-enrollee-spending-issue-brief/
[2] http://kff.org/disparities-policy/issue-brief/health-coverage-by-race-and-ethnicity-the-potential-impact-of-the-affordable-care-act/
[3] http://kff.org/medicaid/state-indicator/medicaid-enrollment-by-raceethnicity/?currentTimeframe=0&selectedRows=percent7Bpercent22wrapupspercent22:percent7Bpercent22unite

Eligibility

The federal government defines eligibility by certain populations and financial criteria: low-income children and their parents, pregnant women, people with disabilities and low-income people aged 65 and older. States establish their own Medicaid eligibility standards, benefits and provider payment policies. However, in addition to the groups that are mandated by federal law, states have the option to consider extending coverage to other groups.

Benefits

States are mandated to cover certain benefits and may extend coverage for additional benefits. Below are the mandatory and optional benefits:

Mandatory Benefits[4]

- Inpatient hospital services
- Outpatient hospital services
- Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing Facility Services
- Home health services
- Freestanding Birth Center services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Transportation to medical care
- Family planning services
- Physician services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Tobacco cessation counseling for pregnant women

Optional Benefits

- Prescription Drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing and language disorder services
- Respiratory care services
- Podiatry services
- Optometry services
- Personal Care
- Self-Directed Personal Assistance Services
- Services in an immediate care facility for Individuals with Intellectual Disability
- Other diagnostic, screening, preventive and rehabilitative services
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Other practitioner services
- Private duty nursing services
- Hospice
- Inpatient psychiatric services for individuals under age 21
- Case management
- Dental services
- TB related services
- Community First Choice Option
- Health Homes for Enrollees with Chronic Conditions
- Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
- State Plan Home and Community Based Services
- Other services approved by the Secretary

Payments

Medicaid payment delivery is different state be state. Some states operate under Medicaid Fee-For-Service (FFS), while other states operate under managed care plans or a mix of FFS and managed care. FFS means providers are directly paid for each covered service received by a Medicaid beneficiary.

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[4] https://www.macpac.gov/subtopic/mandatory-and-optional-benefits/

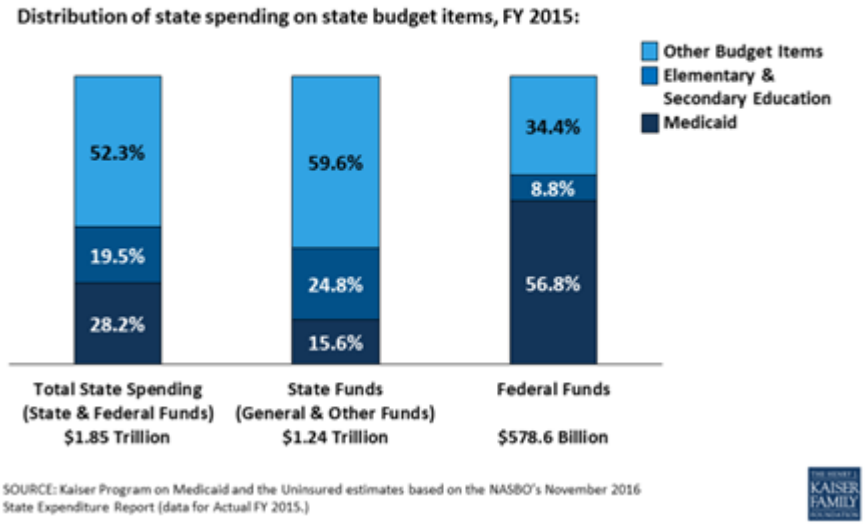
Managed care is a system of health care in which patients receive Medicaid benefits and services and agree to only visit certain doctors and hospitals. The cost of treatment is monitored through contracted arrangements between state Medicaid agencies and Managed Care Organizations (MCOs) that receive a set per capita payment.

Financing

States also differ in the way they finance Medicaid. The federal and state government have a shared responsibility of funding Medicaid. States receive federal matching dollars based on the Medicaid expenditures reported. According to statutory requirements, the federal government can only match 50 to 83 percent of the state's funding. The federal share is determined by the Federal Medical Assistance Percentage (FMAP) formula, which provides states with lower per capita incomes higher Medicaid reimbursements.

Medicaid is the third-largest domestic program in the federal budget and accounts for 9 percent of federal domestic spending in Fiscal Year (FY) 2015. In the U.S., the Medicaid program finances more than 16 percent of all personal health care spending. The federal government spent roughly $532 billion in FY 2015. In 2015, Medicaid was the second-largest item in state budgets, after elementary and secondary education (see figure 3).

Figure 3. Medicaid is both a spending item and a federal revenue source for states



Challenges Facing Medicaid

Medicaid currently faces several challenges at both the state and federal level.

American Health Care Act

In May, the House of Representatives passed the *American Health Care Act* (AHCA), a bill to repeal and replace the ACA. The bill now moves to the Senate, where it faces a long and difficult path. As the draft currently stands, Medicaid will undergo significant reform and face major cuts—nearly $834 billion.

Block Grants

Under a block grant, the federal government would give states annual fixed amounts to manage their Medicaid program. That amount would grow only per a preset formula, no matter how large the Medicaid population of a state becomes or how much a state spends on health care. However, under a block grant system, population growth is not properly accounted for, which will put certain states at a severe disadvantage. A block grant system does not properly account for the size of each Medicaid eligibility group. Each eligibility group—elderly, blind and disabled,

children, adult "expansion" enrollees and other enrollees—has widely varying spend rates. For states with larger elderly and disabled populations, a block grant system will provide inadequate funding for the needs of the population.

Per Capita Allotments

Under Per Capita Allotments (PCA), the federal government would establish limits on per capita spending per Medicaid enrollee. The states' Medicaid population for Fiscal Year 2016 would serve as the "baseline" for calculating the PCA amounts. The amount of the per-capita caps would be calculated based on average state spending on each of the five subpopulations. That amount would then be used to calculate the federal FMAP for individuals in each subpopulation. As the composition of a state's Medicaid beneficiaries' changes from year-to-year, the number of individuals in each enrollment category will change and the average cost against which matching funds are provided would change correspondingly.

The per-capita allotments would grow at the rate of the "medical care component of the consumer price index for all urban consumers" (CPI-M) plus 1 percent. CMS predicts that CPI-M will grow at 4.2 percent per year from 2017 to 2025. To the extent that such inflation adjustments are greater or lesser than the actual changes in Medicaid program costs, states would incur an increased or decreased financing burden.

President's Budget

President Trump released a budget for Fiscal Year (FY) 2018 that would cut Medicaid funding by nearly half over the next decade. It includes the $834 billion cuts in the AHCA bill, as well as an additional $610 billion cut. The budget also includes the largest proposed cuts to social programs in decades. The budget proposes a $72.5 billion cut over 10 years to programs for disabled people. This includes cutting Social Security Disability Insurance and Supplemental Security Income, which provide support for impoverished disabled and elderly people. The Supplemental Nutrition Assistance Program (SNAP), America's safety-net food assistance voucher is given a $191 billion cut over 10 years for food stamps. The Children's Health Insurance Program (CHIP) federal match funding would receive a 23 percent reduction. This would reduce the portion of the program's costs that is paid for with federal funding, leaving states to contribute a larger share. While it is unlikely that this budget will pass Congress, it sends a strong message to lawmakers that these programs are acceptable areas for large budget cuts.

Future of Medicaid and Analysis

With multiple challenges facing Medicaid, the future of Medicaid remains uncertain. Federal reforms to transition to PCA or block grants may lead to already vulnerable populations being negatively impacted. Current federal proposals to reform Medicaid do not keep up with the cost of growth. New treatments and drugs, economic downturns, disease outbreaks and other unforeseen circumstances mean it is nearly impossible to pick a steady rate of growth that will meet the needs of the Medicaid program. Setting fixed Medicaid budgets would mean states would be unable to accommodate the availability of treatments, or weather downturns in the economy that necessitate increased enrollment.

Proposals at the state level are equally concerning. While it is difficult to predict what reforms will take place, we can anticipate that social reform will be a part of the Medicaid debate. We can see that in the trend to include work requirements and co-payments in Medicaid programs. Additionally, consider Vice President Pence's move as republican governor of Indiana to expand Medicaid under a waiver. Or Seema Verma, who served as Vice President's top health care consultant, to develop the Medicaid program.

Children with access to Medicaid and CHIP are more likely to achieve positive educational outcomes and become healthier adults who will earn higher wages and pay more in taxes than children who do not have appropriate health care coverage. Medicaid also ensures that working families are not devastated financially by a child's medical condition. Current proposals to reduce federal funding for CHIP, in combination with state and federal proposals to reform Medicaid at large may have devastating impacts on children.