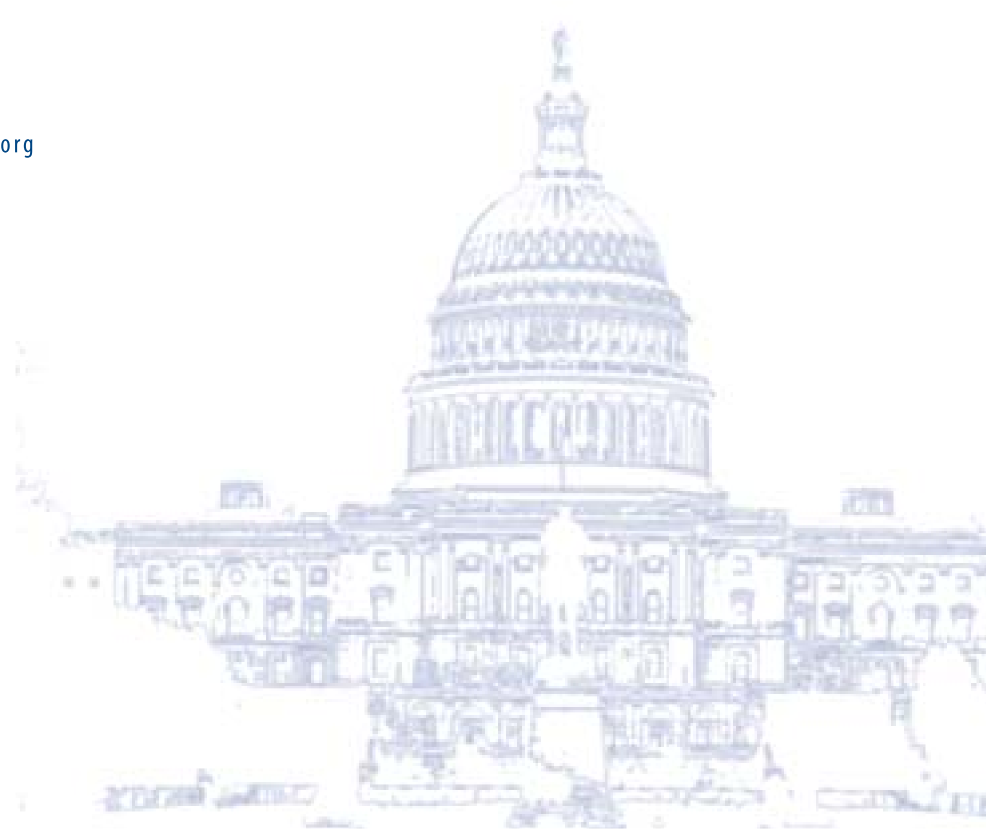

Medicaid

ACTION

- Preserve the federal guarantee of Medicaid as an entitlement program for low-income children, youth, and families. Oppose any efforts that result in reduced benefits and restricted eligibility for beneficiaries.
- Ensure that Medicaid-targeted case management and rehabilitative services remain available to children in the child welfare system.

HISTORY AND KEY FACTS

Medicaid serves as the nation's lifeblood of health care for 52 million people, including 25 million children. In addition to providing basic health care services for children, Medicaid allows many states to provide rehabilitative, therapeutic, psychiatric, and targeted case management services to children in foster care.

Medicaid is a joint federal-state partnership that allows states to create individual and unique programs specified to their needs. Federal guidelines do outline a set of mandatory beneficiaries states must provide services for:

- parents and children who meet income and asset limits for each state's welfare program as of July 16, 1996;
- pregnant women, and children 6 or younger, with family incomes up to 133% of the federal poverty line ($17,063 for a mother and child);
- all children younger than 19 with family incomes up to 100% of poverty ($12,830 for a family of two);
- all current and some former beneficiaries of Supplemental Security Income;
- all beneficiaries of Title IV-E Foster Care and Adoption Assistance; and
- certain other low-income Medicare beneficiaries.

After states meet their mandatory obligations to provide services, they have the option for additional services for individuals who may exceed the income guidelines or expand the scope and types of services offered. Any direct change for service to a state's mandatory population requires specific permission from the Center on Medicare and Medicaid Services (CMS) outlining the scope of the program. This often includes mental health services, eyeglasses, dental care, or prosthetic devices. States can receive federal reimbursement for some of these optional services if they can first meet the initial funding.

Total Medicaid funding for fiscal year 2005 was expected to exceed $300 billion, with the federal government assuming costs at a 2:1 ratio. The portion that states fund is determined solely on the established Federal Medical Assistance Percentage (FMAP) rate. FMAP determinations are set annually and are inversely proportional to the state's average personal income. FMAP rates range from 50% to 77% and ease the burden of cost for low-income states. For every dollar of state Medicaid spending, CMS provides a one-dollar match for states with a 50% FMAP rate. States with FMAPs of 75% receive a three-dollar match for every one-dollar spent. FY 2006 will show a decrease in the FMAP for 29 states, whereby additional stress is added to state budgets in meeting individual health care needs.

Due to increasing Medicaid enrollment, states are struggling to maintain funding for their share. Many states have already begun to cut state Medicaid expenditures.

Medicaid

These cost cutting measures have led to controlling costs of pharmaceutical drugs, reducing or freezing provider payments, reducing or restricting eligibility, loss of benefits, increased co-payments for beneficiaries, and reduction in long term care services.

IMPORTANCE OF MEDICAID FOR ABUSED AND NEGLECTED CHILDREN

Medicaid serves as a vital component to meet the needs of children in the child welfare system. States can use Medicaid funded services to address the lasting physical and mental health concerns that are not typically covered under Title IV-E Foster Care and Adoption Assistance. Some of these services include targeted case management (TCM), rehabilitative services, and therapeutic and psychiatric services that are provided in residential facilities.

Exposure to domestic violence, abuse, substance abuse, neglect, homelessness, separation from family, and other traumas are some of the pressures that children in the child welfare system face. The lack of appropriate physical and mental health services hinders the ability of a child in foster care to gain permanency and stability in their lives. Research shows that up to 80% of children in the child welfare system face emotional or behavioral disorders, developmental delays, or other issues requiring mental health intervention. This is striking when compared to the general population of youth in which a mental health diagnosis is present 20% of the time.

A 2005 Urban Institute report documented the role of Medicaid for foster children. Using available data from FY 2001, the report documents that nearly 870,000 children were enrolled in Medicaid due to their status as a foster child. The report documents that of the $3.8 billion of federal Medicaid funds, 13.1% was allocated for rehabilitative services, 11% for inpatient psychiatric services, 9.4% for inpatient hospital services, 8.7% for clinical services, and 7.7% for prescription medication. States were not able to specify how the remaining $628 million, 16.7%, of the funds were used. These funds are designated as "other" and often are used to provide services such as prosthetic devices, eyeglasses, and home and community-based waivers.

States' reliance on Medicaid as a percentage of all federal funds used to support child welfare varies from 0% in five states, up to 55% in others. This range exists due to the level of, or lack of, TCM and rehabilitative services provided for the child welfare population.

TCM is a service that helps beneficiaries gain and coordinate necessary medical services. TCM allows states to target a select population (foster care, juvenile justice, HIV/AIDS) to receive in-depth case management services. TCM for children in foster care is used to meet the health and mental health services that Title IV-E Foster Care and Adoption Assistance does not provide. TCM provides service for children who have had preexisting conditions before entering foster care.

The benefits to children in foster care receiving TCM are clear. According to the Urban Institute report, TCM represented 7.1%, or $266 million, of the total amount of Medicaid from states that reported using TCM services for children in foster care. The 144,508 youth in foster care who received TCM in FY 2001, were more likely than children in foster care not receiving TCM to receive physician services (68% compared to 44%); prescription drugs (70% compared to 47%); dental services (44% versus 24%); rehabilitative services (23% versus 11%); inpatient services (8% versus 4%) clinic services (34% compared to 20%); and inpatient psychiatric and home health care services at a rate of 3 to 1 over non-TCM recipients.

Medicaid also provides rehabilitative services for children in the child welfare system. These services aim to reduce physical or mental disabilities and help recipients reach their optimal functioning level. Some of these services include behavioral management services, day treatment services, and family functioning interventions.

THE 2005 BATTLE

Large cuts to Medicaid were initially foreshadowed in the release of the President's FY 2006 budget that called for clarification of which services may be claimed as TCM funded and by lowering the administrative matching rate for TCM to 50%. This clarification sought to severely restrict the use of Medicaid TCM services for children in child welfare.

When Congress opted to enact a budget reconciliation bill in 2006 initially designed to save $35 billion from entitlement spending, early projections were that Medicaid was to assume $15 billion of the total cost savings. Senator Gordon Smith (R-OR) led the charge in Congress to reduce Medicaid cuts and do so in a way that did not take away any services from beneficiaries. His efforts also led to the formation of a White House-convened national Medicaid Commission. That Commission issued recommendations in 2005 that would reduce Medicaid spending by $10 billion, but not alter or limit TCM services for any population.

Medicaid

However, the Deficit-Reduction Omnibus Reconciliation Act, passed in February, 2006, will have a great impact on children and families. The Act affirms the use of TCM for children in foster care including assessment, development of a specific care plan, referral to other needed services, and monitoring and other follow-up activities. The Act also specifically notes that TCM will not provide services: as part of research and completion of required foster care documentation; assessment of adoption placements; recruiting or interviewing potential foster parents; serving legal papers; conducting home investigations; providing transportation; administering foster care subsidies; or making other placement arrangements. These services should all be part of Title IV-E allowable expenditures.

This clarification assumes net federal savings of $760 million over 5 years and $2.1 billion over 10 years. Estimates also assume that the changes would shift some costs to the federal Title IV-E foster care program, increasing federal Title IV-E spending by $350 over 5 years and $940 million over 10 years. This clarification, while on its face does not prohibit the use of Medicaid for child welfare services, CMS may continue to restrict TCM claims through ongoing regulatory decisions.

The Act also includes requirements calling for low income families to pay Medicaid co-payments. For the first time, states can now charge families a co-payment of 10% if their income is at the poverty level, or up 150% of the federal poverty level ($16,000 to $24,000 for a parent and two children). Current law restricts co-payments to $3. For families whose income is 150% of poverty, states could charge a 20% co-payment and a premium.

The Act also expands Medicaid to allow middle income families to purchase Medicaid coverage on a sliding-scale basis, which permits states to extend Medicaid coverage to children with potentially severe disabilities.

The devastation of Hurricane Katrina caused a growing need for Medicaid services. Immediately following the hurricane, Senate Finance Chair Charles Grassley (R-IA) and Ranking Member Max Baucus (D-MT) introduced legislation (S. 1716) that would remove Medicaid eligibility guidelines on a good faith clause, provide a 100% FMAP rate for all individuals who received services for a limited time, and allow Alabama, Louisiana, and Mississippi to receive additional funding to assist with the increased health care costs. Expected to cost $8 billion, the White House and Congressional leadership balked at the idea of using new funds and believed that states could provide these services by applying for Medicaid waivers. A weakened version of this legislation was included in the final budget reconciliation bill that provides a temporary 100% FMAP rate for a few selected counties/parishes in Alabama, Louisiana, and Mississippi.

THE 2006 DEBATE

On the heels of the cuts made earlier this year, it is unclear if Congress will enact any significant changes to Medicaid during the remainder of this year. The more immediate decisions about Medicaid are occurring in state legislatures as more and more states are cutting back on service plans due to the increased cost of care. Additional states may apply for Medicaid waivers from CMS that would allow for new and innovative strategies to allocate Medicaid dollars. In areas where this is already enacted, scores of families are denied benefits as states enact measures that decrease benefits and result in individuals with no health care.

Even with the recent federal changes, overall Medicaid expenditures are expected to rise this year. Projections are that Medicaid enrollment is expected to increase by 5.5% in 2006, which marks the lowest growth rate since 1999. This is down from the 7.5% growth in 2005, 8.5% in 2003, and a high of 12.7% in 2001. 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.

For the past three years, the Administration has proposed increased caps or limitations on the services that Medicaid can provide. The 2005 debate may spark an increased interest in promoting a grander reform of Medicaid.

Placing a cap on Medicaid limits the amount of services that a state can provide because their funding stream is locked into a fixed, unalterable account. Currently, Medicaid serves as an entitlement program guaranteeing that the federal government increases its share of the cost to help states provide the care needed by individuals. Amending Medicaid to a fixed allocation fails to meet the demand that states face and will result in states increasingly altering their state plans and coverage.

Sources for statistical information are provided in the online version of this fact sheet. See www.cwla.org/advocacy/2006legagenda.htm.

CWLA CONTACT

Government Affairs Staff • 202/942-0336