

Medicaid Basics - Key Facts About The Program

What is Medicaid?

- Medicaid is a program financed jointly by federal and state governments, providing medical care and long-term care to many of the nation's most vulnerable lower-income people.
- Created in 1965, Medicaid pays physician and hospital bills, prescription drug costs, and other health care costs for lower-income mothers and children, frail seniors, and people with disabilities.
- Each state decides how to structure benefits, eligibility, service delivery and payment rates with guidelines established by federal law.
- State spending on Medicaid is "matched" by the federal government. The federal financing share averages 57%. The federal match varies based on per-capita income in the state.
- Medicaid finances almost 75% of all state health spending.

What is Medicaid's Impact?

- Medicaid covered 44 million people in 2000, including 22.6 million lower-income children, 12 million elderly and disabled persons, and 9.2 million lower-income adults.
- Over 25% of American children rely on the program for their health coverage.
- It pays for the care of about two-thirds of nursing home residents.
- Medicaid finances one-third of the baby deliveries in the country and covers more than half of people with AIDS.
- Medicaid spending for 2003 is expected to reach \$280 billion, with the federal government share amounting to \$159 billion.

What Does Medicaid Cover?

- States must provide all beneficiaries with a basic set of services, including doctor visits, hospital care, lab and x-ray services, family planning services and special health screening for children.
- States are also required to pay for care in nursing facilities and for home-based services. Medicaid pays for almost 50% of nursing home expenses nationally. Costly long-term institutional care is generally not covered by private insurers or Medicare.

- States may provide "optional" services, including dental care, eyeglasses, speech therapy and prescription drugs.
- Because the population served by Medicaid has little or no ability to pay for medical services, federal law limits the premiums and the amount of cost sharing permitted under the program.
- A state that chooses to provide an optional service must provide that service to all of its "categorically" eligible enrollees, e.g., physical therapy provided to elderly individuals receiving Supplemental Security Income (SSI), and must also be offered as a benefit to disabled individuals receiving SSI.

Who Gets Medicaid?

- Eligibility rules for Medicaid are complex, and vary widely from state to state. They are linked to both income and other factors like family or disability status.
- Many lower-income individuals are covered under the Temporary Assistance to Needy Families (TANF) program. The TANF program allows states to determine if a person qualifies for Medicaid under several "eligibility pathways."
- Major categories of eligible people that the states must cover (mandatory populations) include:
 - > Pregnant women and children under age 6 in families with family incomes under 133% of the federal poverty level (\$20,000 for a family of three);
 - > Children ages 6 to 18 in families with family incomes under 100% of the poverty level (\$15,000 for a family of three);
 - > Parents and 18 year olds whose incomes are below welfare standards as of July 1996; and
 - > Elderly and disabled individuals who are eligible for SSI program.
- States have substantial flexibility to cover "optional populations" who may not have health insurance. These populations include:
 - > Children and adults above the federal minimum income levels;
 - > Certain working disabled people; and
 - > People with exceptionally high medical bills also may qualify in the category of being "medically needy."
- Spending on optional groups and benefits accounts for two-thirds of all Medicaid spending.

- The extent to which states cover optional groups varies widely. Massachusetts covers 41% of their lower-income non-elderly residents through Medicaid, compared to Virginia, which covers 14% of its low-income non-elderly residents.

may receive help with Medicare premiums and cost-sharing payments through their state Medicaid program.

How Do Providers Get Paid?

- States may pay providers directly on a fee-for-service basis, or states may pay for Medicaid services through various managed care arrangements.
- States set their own payment levels for providers, and they are usually lower than those paid by other insurers. Hospitals, for example, received Medicaid payments averaging 96% of their costs in 2000, though that percentage varied widely from state to state.
- State Medicaid costs vary substantially from year to year and state to state.
- In 1998, New Hampshire spent three times the amount Mississippi spent to cover a child under Medicaid, and New York spent almost twice the national average to cover disabled individuals.
- More than half of Medicaid beneficiaries are now enrolled in some type of managed care program, ranging from traditional managed care models (HMOs) to less rigid networks with select providers.
- Many managed care plans have ended their participation in Medicaid in recent years due to low payments.

Medicaid and the State Children's Health Insurance Program (SCHIP)

- SCHIP was established in 1997 to provide funds to states to expand coverage to children who were not eligible for Medicaid under state standards in place in 1997.
- Uninsured children under 200% of poverty are the target population.
- States can use their SCHIP funds either to expand Medicaid coverage for children or create a separate SCHIP program.
- Medicaid program rules apply in SCHIP-funded Medicaid expansions. In separate SCHIP programs, states have broader authority to design their programs subject to federal standards.
- Nearly 3.5 million children are enrolled in the program as of December 2001.

The Medicaid-Medicare Relationship

- Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid program.
- Services that are available include nursing facility care, prescription drugs, eyeglasses and hearing aids.
- Certain other lower-income Medicare beneficiaries

State Budgets and Medicaid

- Medicaid consumes a high proportion of spending by state governments, an estimated 15% of general revenue spending in 2001. It is estimated to grow to 20% in some states over the next two years.
- The economic slowdown of 2001, coupled with the fallout from the events of September 11, has resulted in lower tax revenues flowing into state treasuries.
- States estimated that their revenues would grow a modest 2.4% for fiscal 2002, but Medicaid increased by 9.0% due to rapidly rising health care costs.
- A major component in the renewed momentum in Medicaid spending is the rise in prescription drug costs within the program. Drug costs rose 15% to 20% for states in 2002.
- As unemployment increases, more families can be expected to turn to Medicaid for health insurance coverage, placing even greater pressure on already depleting state budgets.

Current Policy Proposals — Coping with Budget Deficits but Trying to Expand Coverage

A prominent policy issue in 2003 is how policymakers are coping with growing Medicaid spending in times of slow or no revenue growth. State policymakers are considering or implementing the following strategies:

- Restraining payments to providers.
- Many states made cuts in payments to nursing homes, hospitals, and physicians in 2002 and will continue to make additional cuts in 2003.
- A majority of states are either reducing or freezing some of their provider payment rates in FY 2003. Twenty-two states reported provider rate cuts or freezes for FY 2002.
- States are pursuing different strategies to control rising prescription drug costs such as:
 - 1) making more use of generic drugs;
 - 2) using pharmacy benefit managers;
 - 3) setting up "preferred drug" lists;
 - 4) instituting fail-first policies; and
 - 5) cutting payments to pharmacies.
- Forty-five states are planning to implement prescription drug cost controls in FY 2003, an increase of over 32 states in FY 2002.
- Substantial cuts in provider payments could affect beneficiaries' access to services if providers drop out of the program.
- Restricting eligibility or services.
- States have substantial discretion in deciding who qualifies for Medicaid, what services they may receive,

and how many of those services are available.

- For 2003, many states are considering cutting back on categories of people eligible for Medicaid, reducing income limits, or postponing planned expansions.
- Fifteen (15) states are reducing Medicaid benefits in FY 2003. Nine states reduced benefits in FY 2002.
- Eighteen states are reducing or restricting eligibility.
- Use of federal waivers to expand coverage.
- Under section 1115 of the Social Security Act, the federal government may permit states to establish comprehensive demonstration projects that waive Medicaid requirements related to benefits, cost-sharing, and eligible populations.
- The Centers for Medicare and Medicaid Services (CMS) reviews and approves waiver requests.

Summary

Since its enactment in 1965, Medicaid has improved access to health care for the poor, pioneered health care delivery and community-based service innovations, and stood alone as the primary source of financial assistance for long-term care services. Medicaid struggles to meet multiple responsibilities and expand health insurance coverage to lower-income groups, while under continued fiscal pressure. Despite these pressures, Medicaid continues to play a critical role in providing acute and long-term care services to millions of our nation's most vulnerable people.

References and Reports on Medicaid

The Commonwealth Fund. The Fund is a public policy think tank that publishes reports and surveys on the Medicaid and Medicare programs. (For copies of their reports, visit their web site at www.cmwf.org or call 1-888-777-2744 to request publications.)

Families USA. Families produces regular reports and fact sheets on Medicaid. (For copies of their reports, visit their web site at www.familiesusa.org or call 202-628-3030 to request information.)

Kaiser Commission on Medicaid and the Uninsured. The Kaiser Family Foundation through the Commission issues periodic reports and surveys on the Medicaid program. (For copies of their reports, visit the Kaiser Family Foundation web site at www.kff.org or call 1-800-656-4533 to request publications.)

The Urban Institute. The Institute is a public policy organization that produces detailed articles on the Medicaid and Medicare programs. (For more information, visit their web site at www.urban.org or call 202-261-5815 to request articles.)

Notes

Medicaid and Mental Health Care

Background

- Medicaid is a program financed jointly by federal and state governments, providing medical care and long-term care to many of the nation's most vulnerable lower-income people.
- Medicaid is the primary payer of *public* mental health services.
- States have relied heavily on its funding for community mental health services over the past two decades.
- Medicaid agencies have greatly influenced the development of public mental health care, especially related to organization, financing, services covered, and access.

Medicaid Spending on Mental Health

- Medicaid now pays for more than 50% of the public mental services that states administer.
- It is expected that Medicaid financing of mental health services will reach 60% by 2007.
- The beneficiaries of these services represent 30% of the Medicaid "high cost" enrollees.
- Depending on the state, between 25 and 50% of persons receiving state mental health services only receive them from Medicaid.
- Among 6-14 year olds, about 25% of Medicaid spending is for mental health services; in some states it is as high as 40%.

Medicaid and Mental Health Benefits

- States *must* provide all beneficiaries with a basic set of services (doctor visits, hospital care, lab and x-ray services). States *may* provide "optional" services, including mental health care, dental care, eyeglasses, speech therapy and prescription drugs.
- Medicaid has relatively generous coverage for mental health benefits, compared with private insurance plans. Substance abuse services are covered less often.
- Medicaid requires coverage for inpatient and outpatient mental health services and physician services, although the number of days or visits per year may be limited.
- Other key services in a mental health continuum such as rehabilitation and case management services are optional under Medicaid, although the majority of states cover them for children.
- Several states provide Programs for Assertive Community Treatment (ACT) services under the

"Rehabilitation Option." ACT programs deliver comprehensive community treatment, rehabilitation and support services to consumers in their homes, at work, and in community settings.

- Many states cover partial hospitalization/day treatment under outpatient care with a higher reimbursement rate.
- The Early Periodic, Screening, Diagnosis, and Testing (EPSDT) benefit of Medicaid is mandatory. EPSDT is a particular benefit for children with the need for mental health services since states use it to cover a broad continuum of mental health services.

Mental Health and Medicaid Managed Care

- Many public sector mental health services operate under managed care arrangements.
- The two prominent managed care mental health program designs are integrated and carve-out programs.
- Under integrated programs, a health plan is responsible for general and mental health services. These plans remain at financial risk, but may subcontract mental health treatment to another entity.
- Integrated programs tend to provide traditional care under Medicaid – inpatient, outpatient and pharmacy services.
- Under carve-out programs, a state contracts directly with a vendor to provide mental health services independently from the general health program.
- Carve-outs are more likely to include specialized benefits, including residential, rehabilitation, and support services.
- Some states have ended their contracts or programs due to a failure of these programs to provide needed care for certain populations, lateness in provider payments, and inadequate state funding.
- State mental health authorities also play an important role in public services through collaboration with Medicaid agencies, particularly for carve-out programs.
- State agencies work closely with local mental health authorities, which often have primary responsibility for managed mental health programs.

State Budgets and Medicaid

- The National Association of State Budget Officers' review of FY 2001 and 2002 state expenditures showed that state Medicaid spending increased by 11.6% and 12.7% respectively.

- Medicaid now amounts to more than 20% of total state spending.
- In 2002, over two thirds of states initiated budget reduction actions.
- Medicaid optional services have and will continue to be considered for cuts and restrictions in eligibility, benefits and payments.

Medicaid and Prescription Drugs for Mental Illnesses

- Medicaid plays a fundamental role in the provision of outpatient pharmacy services to lower-income populations.
- Prescription drug coverage is one of the most widely utilized benefits in Medicaid programs (second only to physician services) and it is the fastest growing area of Medicaid spending.
- Medicaid spending for prescription drugs increased annually between 1997 and 2000 by 18.1% compared to 7.7% for total Medicaid expenditures during the same period. General inflation has been rising only 2-3% annually during this period.
- In 2000, Medicaid spent \$16.6 billion on prescription drugs — federal and state combined.
- The Centers for Medicare and Medicaid Services (CMS) projects that Medicaid spending on prescription drugs will grow 70% faster than overall Medicaid growth between 2001-2006.
- Medicaid's drug benefit is particularly vital to those enrollees who depend most upon drugs to maintain or improve their health and functioning, including those with mental illnesses.
- To control Medicaid drug spending, a number of states have adopted or are considering restrictions on access to certain types of drugs, including psychotropic medications. Some of the cost containment strategies already adopted or being considered include:
 - > Using preferred drug lists;
 - > Requiring supplemental rebates from drug companies;
 - > Placing certain drugs on a list requiring prior authorization before dispensing;
 - > Limiting the number of prescriptions per month a patient can fill without prior authorization; and
 - > Requiring mandatory substitution of generic drugs.
- These strategies may pose significant health threats for Medicaid recipients with mental illnesses trying to access medications prescribed by their treating physicians.
- From an economic standpoint, the growing use of drugs to treat mental illnesses may yield savings as they reduce the need for costlier, intensive services.
- Studies show restrictive formularies end up shifting costs to other parts of the system, thus adding more

costs to the system through more hospitalizations, increased emergency room visits, more physician visits and a greater number of prescriptions per year needed.

- Patients with mental illnesses should have access to treatments that have been recognized as effective by the Food and Drug Administration (FDA), and choice of medications should be consistent with existing treatment guidelines.

Summary

Medicaid represents a major source for financing mental health care. In addition to representing a major financing source, Medicaid has also encouraged the expansion of innovative community-based treatment modalities for people with serious mental illnesses such as psychiatric rehabilitation, case management, and day treatment/partial hospitalization services. Prescription drugs available through the Medicaid program have been essential to the recovery of many persons with mental illnesses, but costs are escalating rapidly. State and federal governments currently face a very difficult economic climate and are planning to institute tighter Medicaid cost control efforts. Measures to control costs must be carefully designed and monitored to avoid negatively affecting lower-income populations with mental illnesses. Moreover, restrictive formularies shift costs to other parts of the system in the form of increased hospitalizations and emergency room visits, thereby increasing total Medicaid costs.

References and Reports

Buck, J., et al, "Mental Health and Substance Abuse Services in Ten State Medicaid Programs." *Administration and Policy in Mental Health*, 28:3, January 2001.

Making Sense of Medicaid for Children with Serious Emotional Disturbance, Bazelon Center for Mental Health Law, September 1999. (For a copy of this report, visit the Bazelon web site at www.bazelon.org or contact them at 202-467-5730.)

Mental Health and Substance Abuse Treatment: Results from a Study Integrating Data from State Mental Health, Substance Abuse, and Medicaid Agencies, U.S. Department of Health and Human Services, 2001. (For a copy of this report, visit the Substance Abuse and Mental Health Services Administration's web site at www.samhsa.gov or contact them at 1-800-729-6686.)

Mental Health and Substance Abuse Services in Medicaid, 1995, U.S. Department of Health and Human Services, 2002. (For a copy of this report, visit the Substance Abuse and Mental Health Services Administration's web site at www.samhsa.gov or contact them at 1-800-729-6686.)

Assuring Access to Appropriate Medications

Background

- Medicaid plays a fundamental role in the provision of outpatient pharmacy services to lower-income populations. Prescription drug coverage is one of the most widely utilized benefits in Medicaid programs (second only to physician services) and it is the fastest growing area of Medicaid spending.
- Medicaid's drug benefit is particularly vital to those enrollees who depend most upon drugs to maintain or improve their health and functioning, including those with severe mental illnesses.

Medicaid and Prescription Drug Costs

- It is estimated that total spending for outpatient prescription drugs in Medicaid was \$21 billion in 2000. This figure represents roughly 10% of total Medicaid expenditures in 2000.
- Prescription drugs were an important factor behind the growth of Medicaid spending in the late-1990s. Medicaid spending for outpatient prescribed drugs increased by 6.5 billion dollars from 1997 to 2000, or 16% of the \$40.2 billion increase in total Medicaid spending over that period.
- Viewed another way, Medicaid expenditures for outpatient prescribed drugs increased by an average of 18.1% per year from 1997 to 2000, compared to 7.7% for total expenditures.
- The current double-digit growth rates of Medicaid spending on prescription drugs has serious implications for states and the federal government as they face deteriorating economic outlooks and declining revenue growth.

Perfect Storm Conditions are Upon the States

- There has been a dramatic deterioration in state fiscal conditions over the last year. Rapidly declining tax revenues have led state policymakers to implement significant reductions in public services.
- The short-term outlook for state fiscal conditions is bleak, as a number of states have recently increased their estimates of budget deficits in 2003, and some states have begun to forecast significant shortfalls in 2004.

- States managed to maintain a small amount of spending growth in 2002 by relying heavily on one-time budget balancing measures such as spending down "rainy day" funds and using tobacco settlement funds. But those funds are now depleted.

Feeding the Storm – Rising Prescription Drug Costs

- As governors and state legislatures struggle to balance their budgets for 2003, many are turning to reducing projected spending for their Medicaid programs. States are reporting that uncontrolled growth in Medicaid prescription drug costs could threaten efforts to balance their budgets and other social priorities.
- The threat to mental health services is beginning to play itself out at the state level with a tidal wave of initiatives to limit Medicaid expenditures for prescribed drugs.
- Many states have implemented programs to limit their spending on prescription drugs. These strategies include:
 - > Using preferred drug lists;
 - > Requiring supplemental rebates from drug companies;
 - > Placing certain drugs on a list requiring prior authorization before dispensing;
 - > Limiting the number of prescriptions per month a patient can fill without prior authorization; and
 - > Requiring mandatory substitution of generic drugs.
- It is likely that antipsychotic and antidepressant medications for people with severe mental illness are going to be scrutinized and targeted for cost containment and utilization control strategies employed by Medicaid agencies.

What is at Risk for Mental Illness Treatments?

- Access to quality care and recovery is at risk when battles over cost containment and medication pricing occur.
- Proposals to control pharmaceutical spending will appear in legislation, appropriations bills or regulations developed by Medicaid programs.

Summary

Concerned with escalating costs, Medicaid agencies have developed a variety of ways to restrict access to medications. Sometimes these policies are appropriate to avoid the inappropriate use of medications. In other cases, the limitations may be designed in a way to discourage the use of more expensive medications, which are often the most effective treatments. Medicaid officials find themselves in a difficult situation of balancing costs and access in challenging economic times. Advocates will need to highlight for policymakers the implications of denying or delaying care to patients and the potential economic results.

References

Kaiser Commission on Medicaid and the Uninsured. The Kaiser Family Foundation through the Commission issues periodic reports and surveys on the Medicaid program. (For copies of their reports, visit the Kaiser Family Foundation web site at www.kff.org or call 1-800-656-4533 to request publications.)

Notes

Medicaid Committees and Prescription Drugs

Background

- State Medicaid programs have established committees to advise state officials on administrative and implementation issues.
- Due to major significant budget shortfalls and rising Medicaid costs, states are considering or have adopted a variety of strategies to control spending on prescription drugs, which is the fastest growing cost center in Medicaid programs.
- Medicaid committees will be responsible for determining which medications are approved for coverage and reimbursement.

Key Committees

- **Medical Care Advisory Committee**
The Medical Care Advisory Committee (MCAC) participates in policy development and program administration to the Medicaid agency. It is composed of Medicaid recipients and other consumers, as well as health care professionals.
- **Pharmacy and Therapeutics (P&T) Committees**
P&T Committees are official groups that advise Medicaid programs on drugs and medications. The panel of physicians and pharmacists usually develop the list of drugs that the Medicaid program will pay for and how those drugs can be used for particular diseases and conditions. The lists are called “drug formularies.”
- **Drug Utilization Review (DUR) Committees**
All states are required to have DUR programs for outpatient drugs to ensure that prescriptions paid for by Medicaid are appropriate, medically necessary, and not likely to result in adverse medical outcomes. DUR programs must include both prospective and retrospective review.

Prospective DUR programs involve a review of each prescription before it is filled to screen for potential drug therapy problems, including drug-to-drug interactions and clinical abuse. Retrospective DUR involves a review of claims data to identify fraud, abuse, or inappropriate or medically unnecessary care among physician prescribing patterns.

States report that DUR programs can produce substantial savings: 10 of the 44 programs responding to a 2000 Kaiser Family Foundation survey found prospective DUR as a major cost containment strategy.

Summary

Medicaid committees serve as an important vehicle for state officials to examine policy issues. They represent important opportunities for consumers to weigh in on policy and offer information to state decision makers.

References

An Advocate's Guide to the Medicaid Program, National Health Law Program, June 2001.

Schwalberg, R, et al, Health Systems Research, and Elam, L., Kaiser Commission on Medicaid and the Uninsured, *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey and Selected Case Study Highlights* (October 2001).

EPSDT: Medicaid Early and Periodic Screening, Diagnosis and Treatment for Children and Adolescents with Mental Illness

Background

- Medicaid is a joint federal and state program that finances health care coverage for 21 million children, or more than one in four of our nation's children.
- One of the central services that states must provide to children is to screen them for various conditions so that health concerns can be found early and treated before they worsen.
- Federal law requires states participating in the Medicaid program, to provide Early and Periodic Screening, Diagnosis and Treatment (EPSDT) to children and adolescents under age 21 who qualify for Medicaid coverage. States must engage in outreach to inform all Medicaid eligible persons under the age of 21 that EPSDT services are available.
- The EPSDT benefit is designed to ensure early assessment of children to identify the existence of illnesses, including mental illnesses, and to ensure early diagnosis and treatment. Federal law requires states to provide the treatment necessary for Medicaid eligible children to improve from the illnesses detected in the periodic screening process.
- The EPSDT mandate requires states to set schedules so that children who need checkups can see a health care provider for screening to determine whether or not the child needs treatment for an illness, including mental illnesses.

EPSDT Services

- The Medicaid EPSDT mandate requires states to provide the following services to Medicaid eligible children and adolescents:
 - Screening** – states must provide children with early, periodic and comprehensive assessments of both physical and mental health development;
 - Diagnosis** – when a screening examination indicates the need for further evaluation, states must ensure that referrals to treatment and service providers are made without delay and follow-up must be done to ensure that a child receives a complete diagnostic evaluation; and
 - Treatment** – states must ensure that children receive the health care and treatment necessary to treat their physical or mental condition discovered by the screening services.

Delivery and Financing

- Research shows that the percentage of children receiving preventive care of any kind through the Medicaid EPSDT requirement is low. States routinely fail to inform families that they are eligible for Medicaid.
- Moreover, for those families that are fortunate enough to be identified and enrolled, unduly complicated rules, procedures and other administrative barriers often exist in the Medicaid program that prevent families from accessing the critically-needed screening and follow-up services required by the EPSDT mandate.
- Increasingly, states are contracting with managed care organizations (MCOs) to provide Medicaid-covered services.
- MCOs are often paid a fixed dollar amount for each Medicaid enrollee by the state, which creates an incentive for MCOs to restrict services that are provided to Medicaid recipients.
- States must monitor the performance of Medicaid MCOs to ensure that enrollees are receiving the EPSDT services that federal laws require them to provide.

Research and Issues

- The failure of states to provide Medicaid eligible children with adequate screening, diagnosis and treatment is consistent with the other research and information reported in the Surgeon General's 2001 report on children's mental health.
- According to the report, in the United States, 1 in 10 children and adolescents suffer from mental illness severe enough to cause impairment while less than 1 in 5 of these children receives needed treatment. The long-term consequences of undetected and untreated childhood mental illnesses are significant, in both human and fiscal terms.
- The evidence is strong that as many of 90% of children and adolescents who commit suicide have untreated mental disorders.
- Other consequences include high risk for incarceration and greatly diminished prospects for a productive and meaningful future.

- We now know with certainty that children do experience serious mental illnesses as well as a range of emotional and behavioral disorders that require and respond to treatment in the same way as other illnesses do.
- If properly identified and treated, these children have real hope for recovery and improving their lives dramatically.

Summary

States are required to identify Medicaid eligible children and engage in outreach to inform families of the comprehensive EPSDT services and assistance that is available to them. Family inclusion at every point of the outreach, screening, diagnosis, treatment planning, and implementation stages is vital to the recovery of children and adolescents with mental illnesses. It is critical to work toward improving our systems of care, including the Medicaid programs, for children and adolescents with mental illnesses and their families.

We gratefully acknowledge Darcy Gruttadaro, Director of NAMI's Child and Adolescent Action Center, for her significant contribution to this fact sheet.

References and Reports on Medicaid and EPSDT

Children's Health Under Medicaid: A National Review of Early and Periodic Screening, Diagnosis and Treatment, National Health Law Program, August, 1988, updated September, 2001. (For a copy of this report, visit the National Health Law Program's web site at www.healthlaw.org or contact them at 310-204-6010.)

Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services, U.S. General Accounting Office (GAO), July, 2001. (For a free copy of this report, visit the GAO web site at www.gao.gov and request GAO-01-749 or contact them at 202-512-6000.)

Where to Turn: Confusion in Medicaid Policies on Screening Children for Mental Health Needs, Bazelon Center for Mental Health Law, September, 1999. (For a copy of this report, visit the Bazelon web site at www.bazelon.org or contact them at 202-467-5730, ext. 41.)

Notes

ACT: Assertive Community Treatment

Background

- For several years, experts believe that many people with severe mental illnesses require long-term assistance to achieve optimal integration or reintegration into community life.
- Assertive Community Treatment (ACT) is one model of community care for providing long-term assistance.

Description of the ACT Model

- ACT consists of a multidisciplinary group of mental health professionals who work as a team to provide intensive services to patients with severe mental illnesses.
- Fully staffed ACT teams include psychiatrists, nurses, social workers and vocational rehabilitation specialists, substance abuse counselors, and peer specialists.
- Consumers in the ACT programs receive all services from the ACT team, not from loosely linked mental health, substance abuse, housing, and rehabilitation agencies.
- The majority of services are delivered where consumers live, work, and spend their leisure time, not in the program office.
- Through its multidisciplinary structure, ACT provides an integrated approach offering:
 - > Direct provision or coordination of all medical care, both psychiatric and general health care;
 - > Help in managing symptoms of the illness;
 - > Immediate crisis response;
 - > Up-to-date, careful use of medications;
 - > Supportive therapy; and
 - > Practical on-site support in coping with life's day-to-day demands including: help in obtaining housing, help with learning how to socialize, job placement, and support, education, and skills-education for family members.

ACT and Quality of Care

- A variety of governmental agencies and professional organizations in the U.S. have issued practice guidelines recognizing ACT as an evidence-based practice.
- The most influential guideline is the Schizophrenia Patient Outcomes Research Team guidelines produced by the Agency for Healthcare Research and Quality, which recommended ACT services for persons with schizophrenia who are either at high risk for rehospitalization or are heavy service users.

- ACT is endorsed by the National Institute of Mental Health as an effective, evidence-based, outreach oriented treatment, rehabilitation and support model.
- ACT is currently the only community treatment model approaching the standards needed for managed care protocols.
- Research shows that ACT substantially reduces hospitalization, increases housing stability, and moderately improves symptoms and subjective quality of life.
- In one study, only 18% of ACT clients were hospitalized the first year compared with 89% of the non-ACT treatment group.
- Research shows that the more closely case management programs follow ACT principles, the better the outcomes.
- Studies on ACT documents positive community outcomes for the 10-20% of people most severely disabled by mental illnesses.

ACT and Health Care Costs

- The staff for an ACT team costs approximately \$10,000 to \$15,000 per client per year.
- Medication and housing are additional costs that must be considered which could bring the cost up to \$16,000 to \$21,000.
- In many communities, the cost for high-quality ACT treatment will be less than the cost of inappropriately putting a mentally ill person in the county jail.
- Costs for a year in a residential treatment facility approach \$50,000, and state hospital costs are usually more than \$100,000 a year.
- The ACT model has shown an economic advantage over institutional care. In a Veterans' Administration study over two years, ACT costs were \$33,300 less per consumer than standard care.

ACT and Medicaid

- In 1999, President Clinton directed the Centers for Medicare and Medicaid Services (CMS), to authorize ACT as a Medicaid-reimbursable treatment.
- Several states have already changed their Medicaid plans to include ACT services.
- Efforts by states to finance ACT services through Medicaid have been complicated by confusing and conflicting rules in Medicaid law.

- While many of the services that are central to the ACT model are part of the menu of services states can offer in their Medicaid programs under the “Rehabilitation Option,” few states have elected to integrate ACT as a distinct service.

Summary

Using a recovery oriented, 24-hours-a-day, seven-days-a-week, multidisciplinary team approach, ACT programs deliver comprehensive community treatment. In the current economic climate when state budgets are tight, ACT makes good financial sense. The ACT model has an impressive, 30-year track record of achieving good outcomes for individuals and at the same time saving money.

References

Bond, G., et al, “Assertive Community Treatment for People with Severe Mental Illness,” *Disability Management Treatment Outcomes*, 9(3): 2001.

The PACT Advocacy Guide, NAMI, 2001.

What About Assertive Community Treatment, NAMI, 2001.

Notes

FMAP or Medicaid Economics 101

Background

- FMAP (Federal Medicaid Assistance Percentage) is the statutory term for the Medicaid matching rate – the share of the costs of Medicaid services or administration that the federal government bears.
- Payments to states are calculated according to a federal formula.

Payments for Services

- The federal government pays at least half of the cost of Medicaid in every state – 57% on average.
- The federal government matches at least 50% of the cost of each Medicaid program and can match as much as 83%, depending on the state's per capita income.
- Relatively poorer states receive a higher federal matching rate.
- Federal financing of state Medicaid programs is open-ended. Each participating state is entitled to payments up to a federally approved percentage of state expenditures, and there is no limit on total payments to any state.

Payments for Administrative Services

- In addition to matching funds for payments for services, FMAP is also available to match 50% of most of the state's administrative costs.
- For particular administrative activities, however, FMAP is available to cover 75% to 100% of costs.
- Enhanced FMAP is also available to assist states with the additional administrative expenses attributable to eligibility determinations incurred as a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Medicaid Budget Issues and FMAP

- The Medicaid budget problems states are experiencing are being exacerbated by reductions in FMAP.
- The rates for 2002 were based on economic data from the late 1990s, when states' economies were booming.
- Current FMAP rates are based on data from years prior to the recession, placing a number of states in the position of having to fund their Medicaid programs with fewer federal dollars in a fiscally-challenging period.

- The economy has weakened greatly since then and the matching rates for 29 states declined in 2002.
- Matching rates for 17 states will be lower in 2003 than 2002.
- The 29 states where Medicaid matching rates dropped in 2002 are Alaska, Arkansas, Florida, Georgia, Kentucky, Louisiana, Minnesota, Montana, Nebraska, New Mexico, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.
- The 17 states where FMAPs will drop in 2003 are California, Idaho, Indiana, Kansas, Kentucky, Maine, Michigan, Nebraska, North Dakota, South Dakota, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

State Funding Reductions = Lost Federal Matching Rates

- A state that implements Medicaid funding reductions to offset budget shortfalls, will also lose significant amounts of open-ended federal matching funds.
- A severe financing cycle could be set in motion due to deteriorating state finances.
- How much a state loses depends on its matching rate.
- In a state with a 50% matching rate, such as New York or Illinois, the state will lose \$1 in federal funds for every \$1 in state funding reductions.
- In a state with a 75% matching rate, such as West Virginia, the state loses \$3 in federal funds for every \$1 it cuts.

Needed Relief for States

- As states contemplate cuts in response to this growth, lawmakers are faced with the reality that every dollar of state appropriations cut for Medicaid forfeits anywhere from \$1 to \$3 of federal funds through the FMAP.
- Realizing the economic development impact of the loss of federal funds, governors and state legislators are aggressively supporting attempts in Congress to increase the federal match rates.
- Proponents of an FMAP increase contend that increased federal support will temper the need for drastic cuts in Medicaid programs.

Summary

The Medicaid program is based on a federal-state partnership. During this difficult economic period, Congress and the Administration are exploring ways to provide some needed fiscal relief to states. The National Governors Association has had discussions with federal policymakers that would provide for a temporary increase in the FMAP which could help to ensure that lower-income children, families, elderly people, and persons with disabilities continue to receive the medical care they need. It would also help to ensure that there are sufficient financial resources for hospitals, clinics, nursing homes, physicians, and other health care providers to continue to offer health care services to lower-income people.

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Notes

Medicaid and SCHIP - Health Care Coverage for Lower-Income Children: The Role of Medicaid and SCHIP

Background

- SCHIP was established in 1997 to provide funds to states to expand coverage to children who were not eligible for Medicaid under state standards in place in 1997.
- Uninsured children under 200% of the poverty are the target population.
- States can use their SCHIP funds either to expand Medicaid coverage for children or create a separate SCHIP program.
- In implementing SCHIP, 16 states expanded Medicaid, 16 created separate state programs, and 19 have a combination plans.
- Medicaid program rules apply in SCHIP-funded Medicaid expansions. In separate SCHIP programs, states have broader authority to design their programs subject to federal standards.
- Nearly 3.5 million children are enrolled in the program as of December 2001.

An Introduction to Medicaid

- Established in 1965, the Medicaid program is a federal-state partnership that assists states in providing medical services to eligible, lower-income individuals.
- Federal guidelines establish a framework that states must follow in order to receive federal funding, known as federal matching payments or FMAP.
- States are required to cover certain groups of individuals and offer a minimum set of services, such as physician, hospital and nursing facility services.
- States may also choose to provide optional services – such as vision and dental services and prescription services. (For more information, see our fact sheet on *Medicaid Basics – Key Facts About the Program*)

Medicaid – A Critical Health Care Safety Net for Children

- Over 21 million children are enrolled in Medicaid.
- Children represent over half of all Medicaid enrollees, but account for only 17% of program spending.
- States are required to cover children in families with incomes at or below 133% of poverty; children in families above this level may also be covered at a state's option.

- Medicaid pays for a comprehensive set of services for lower-income children, including physician and hospital visits, screening and treatment (EPSDT), well-child care, vision care, and dental services, with no cost-sharing.

An Introduction to SCHIP

- Enacted in 1997, SCHIP is designed primarily to help children in working families with incomes too high to qualify for Medicaid but too low to afford private family coverage.
- Like Medicaid, SCHIP is administered by the states under broad federal guidelines to offer coverage to children in families with incomes up to 200% of poverty who do not qualify for Medicaid.
- Whereas Medicaid is an open-ended entitlement program, the SCHIP program was appropriated a fixed amount for the program known as a “matched block grant” program, and allocated \$40 billion in federal matching funds over 10 years.
- The federal government pays a higher share of states' expenditures under SCHIP than Medicaid, known as an “enhanced” federal match to encourage states to participate.
- States have implemented SCHIP to uninsured lower-income children through either a separate state program (e.g., BadgerCare in Wisconsin) or by broadening Medicaid — or both. In states that used the Medicaid option, children were entitled to full Medicaid coverage.
- Due to federal funding dips built into the legislation that created SCHIP and state budget deficits, SCHIP programs face financing problems that may force states to shrink their SCHIP enrollments over the next few years, thus affecting people with mental illnesses who will lose their health coverage.

SCHIP and Mental Health Services

- State SCHIP programs must offer a benefit package that is comparable to one of three private “benchmark” plans:
 - > the Federal Employees Health Benefits Blue Cross standard option plan;
 - > the State's employee health benefit plan, or
 - > the HMO with the largest number of commercially insured in the state.

- SCHIP plans must include coverage that is equivalent to 75% of the actuarial value of the benchmark plan for mental health services and prescription drugs.
- Hospital day limits vary from 15 days per year to an unlimited number of days. Most states have an unlimited number of days for mental illnesses.
- Limits on mental illness outpatient visits vary from a low of 20 per year to an unlimited number of visits.
- Most SCHIP programs include benefits for residential and/or IMDs, partial hospital/day treatment and case management.
- Limits are more common in state-designed programs compared to Medicaid expansion programs.
- SCHIP programs are also allowed to charge copayments for services which is not allowed under Medicaid.

Summary

All in all, Medicaid and SCHIP provide a broad safety net for children. SCHIP gives states an opportunity to build on the poverty-related expansions initiated under Medicaid, by expanding coverage to children with family

incomes too high to qualify for Medicaid, using Medicaid, a separate program, or some combination of the two. SCHIP has provided health care coverage to 3.5 million children since its inception, but faces severe funding problems. These funding issues could have serious implications for children with mental illness who lose their health insurance coverage. Access to high-quality care will be likely be disrupted for hundreds of thousands lower-income children.

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Notes

The Medicaid Psychiatric Rehabilitation Option

Background

- Federal Medicaid law defines a rehabilitation service as “any medical or remedial services (provided in the facility, a home, or any other setting) recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.”
- Medicaid programs cover several “optional” services including rehabilitation services.

Psychiatric Services Under the Rehabilitation Option

- Psychiatric services under the Rehabilitation Option that are covered include:
 - > Restoration of basic skills necessary to function independently in the community;
 - > Redevelopment of communication and socialization skills;
 - > Family education and other family services exclusively related to treatment or rehabilitation of the covered individual;
 - > Substance abuse services which includes screening;
 - > Case management services, including Assertive Community Treatment (ACT), targeted case management and intensive case management programs; and
 - > Peer services that are run by consumers.
- Targeted case management, under Medicaid law can be limited to a target population, such as people with serious mental illnesses.
- Vocational services such as job training and academic education are not covered services but some states do define work as a goal of rehabilitation services.

Medicaid and the Psychiatric Rehabilitation Option

- All states but one have selected the rehabilitation option and the great majority (39) have chosen the targeted case management option for adults with serious mental illnesses.

- In 42 states, rehabilitation services are to be furnished through defined provider agencies.
- In those 42 states:
 - > All states cover daily living-skills training
 - > 38 cover social-skills training
 - > 30 cover employment-related services
 - > 25 cover residential-based services
 - > 31 cover family-education services
- Only 10 states cover peer services of any form and only 6 states cover integrated mental health and substance abuse treatment for consumers.
- While a great majority of states offer a significant scope of activities under their rules, several do not cover basic rehabilitation activities. Twelve (12) states do not cover either basic living-skills training, social-skills training or both.
- A state failing to cover these essential services is unlikely to be offering a rehabilitation or recovery-oriented approach.
- Many states need to redesign their rehabilitation rules to make them more recovery-based.

Effectiveness of Psychiatric Rehabilitation Services

- Research shows that individuals who receive psychiatric rehabilitation services experience significant shorter hospitalization, improved social functioning, and greater satisfaction and fulfillment through the employment, and are more likely to return to school or work as productive members of society.
- More than 50 studies show that social-skills training helps reduce relapses, alleviates stress on the family and increases social capacity.
- The evidence base for supported employment shows improved employment outcomes.

Summary

Nearly all states are using the Medicaid rehabilitation option to furnish services to adults with serious mental illnesses. The option allows states to offer a range of services to address the impact of disorders on an individual's functioning, particularly on the services the person needs to live and work in the community. Several states have also adopted recovery-oriented approaches to

include peer services and social and recreational activities, as well as intensive case management and PACT programs. But wide variation remains in the degree to which states offer recovery-focused services that assist people in managing their disability. There is room for improvement in the details of state rules on rehabilitation and targeted case management. States now have examples of strong provisions based on a recovery philosophy.

References:

This fact sheet was adapted from the Bazelon Center's report on "*Recovery in the Community – Funding Mental Health Rehabilitative Approaches Under Medicaid,*" November 2001.

Notes

TEFRA and Medicaid Home- and Community-Based Services Waivers: Options to Increase Access to Children’s Mental Health Services

Background

- According to the Surgeon General’s Conference Report on Children’s Mental Health, “The nation is facing a public crisis in mental health care for infants, children and adolescents.”
- Three consequences of lack of access to quality children’s mental health services are:
 - > *Stuck Kids* – also known as “Kidlock” – which necessitates for coverage and reimbursement purposes that children receive care in emergency rooms, hospitals, and residential treatment facilities.
 - > *Relinquishment of parental custody in order to access services*. This situation occurs in at least 50% of the states and affects approximately 20% of families of children with serious emotional disturbance (SED). Recent studies suggest that at least 12-15% of the child welfare population is in state custody in order to access health care services.
 - > *Criminalization of children with SED* – 36% of families that have children with SED have reported that their children were in the juvenile justice system because mental illness services were unavailable.

The TEFRA Option

- The TEFRA option was enacted as part of the Tax Equity and Fiscal Responsibility Act of 1982 and also known as the “Katie Beckett” option – named after an institutionalized ventilator-dependent child who was unable to live at home, not for medical reasons, but because it would have made her ineligible for Medicaid.
- This option allows states to provide Medicaid coverage for home- and community-based services for children with serious mental illnesses who are living at home – provided the following conditions are met:
 - > The child is under 18 years old;
 - > The child must qualify as a disabled individual under the Social Security provisions – under SSI rules there is no automatic deeming of parental income to an institutionalized child after one month of institutionalization;

- > The child must require the level of care provided in a hospital, nursing facility or ICF/MR;
 - > The child can be cared for in the home; and
 - > The cost to Medicaid must not be greater for in-home care than it would have been in an institutional setting – cost neutrality.
- TEFRA provides eligible children with access to the standard list of services covered by Medicaid.

Use of TEFRA Option by States

- Twenty (20) states have the TEFRA option for children with disabilities, but only 10 states have children on TEFRA who qualified as a result of a mental or emotional disorder.
- Compared to the total enrollment in the Medicaid program, TEFRA enrollment is small and varies widely between states, ranging from extremely low (10 children in Michigan) to large (4,300 children in Wisconsin).
- In the states that include children with a primary diagnosis of mental or emotional disorders on TEFRA, these children are a very small percentage of total TEFRA enrollment – their average number per state is only 250.

The Medicaid Home- and Community-Based Waiver Option

- The Home- and Community-Based Option – also known as section 1915(c) waivers is a potentially helpful strategy to states in addressing the custody issue.
- This approach requires a state to file an application to the Centers for Medicare and Medicaid Services (CMS) to request a waiver that would make available home- and community-based services to certain groups of individuals who would be eligible for Medicaid if institutionalized and, but for the services, would be institutionalized in a hospital.
- The HHS Secretary is authorized to grant waivers that meet comparability, statewideness, and financial eligibility requirements.
- States must show cost neutrality — the cost of community services would not exceed the cost of institutional care.

- States are permitted to put limits on the number of waiver slots available.
- Waiver programs are initially approved for 3 years and may be renewed at 5-year intervals.

- > The federal rule which prevents children in or at risk of placement in a residential treatment center being eligible; and
- > The requirement that community services be no more expensive than the alternative institutional placement.

Use of Home- and Community-Based Waivers by States

- Only three states currently have these waivers to serve children with serious mental illnesses – Kansas, New York and Vermont.
- Many states considered developing waivers but due to the following barriers they stopped their efforts:
 - > A lack of funds to furnish the state's share of Medicaid costs;

- Experience from the three states demonstrates that costs of a home- and community-based waiver for children with mental or emotional disorders are quite low per child.
- First year costs in Kansas were only \$1 million. The average annual per child cost was \$12,900, compared with institutional costs of \$25,600; in New York —\$40,000 compared to \$77,400.

Summary of TEFRA and Home- and Community-Based Waivers

TEFRA Option

Children qualify without regard to family income

All children who qualify are eligible regardless of whether their disability is physical or mental

Children are covered for the same array of Medicaid services as all other Medicaid-eligible children

Children from all parts of the state are eligible

The TEFRA option can be approved by the federal regional office

Home- and Community-Based Waivers

Children qualify without regard to family income

Waiver can be limited to children with certain disabilities, such as SED. States can establish a limited number of slots

Children can receive additional services as well as those covered in the regular Medicaid program

Eligibility can be limited to particular geographic area

CMS national office must approve the waiver

Summary

There are new initiatives supported by several groups inside and outside the mental health field that would not require parental relinquishment in order to qualify for Medicaid. The TEFRA and home- and community-based waivers offer real strategies and opportunities to families to address the lack of services for children and the custody relinquishment problem in this country.

This fact sheet was adapted from a presentation by Mary Giliberti, Senior Attorney with the Bazelon Center for Mental Health Law, *Using the TEFRA Option to Increase Access to Children's Mental Health Services*, Presented at the Medicaid and Mental Health Service Conference, September 18, 2002.

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Medicaid and the Federal Waiver Policy

Background

- Under section 1115 of the Social Security Act, the federal government can allow states to develop comprehensive demonstration, experimental projects that modify (waive) federal Medicaid and State Children's Health Insurance Program (SCHIP) requirements related to benefits, cost-sharing and eligible populations.
- Waivers have allowed states to experiment with the provision of new benefits, like hospice care or community-based care as an alternative to nursing home care, and to extend family planning services to women.
- Recently, several states have relied on waivers to require Medicaid beneficiaries to enroll in managed care programs, to extend coverage to new lower-income populations, or to require cost sharing when coverage has been extended beyond children and other groups with incomes well above traditional Medicaid coverage levels.

Section 1115 Medicaid Waiver Process

- Until recently, there had not been any clearly delineated federal guidance on Medicaid waiver policy.
- Generally, states have developed their proposals for consideration by the Health and Human Services (HHS) Secretary, following a format designed by the Centers for Medicare and Medicaid Services (CMS).
- The waiver process has been a subject of frequent criticism from interested groups because it can result in major changes that may affect coverage and benefits for vulnerable populations.
- Waiver proposals usually take months to be reviewed by CMS.
- In FY 2001, 17 states had statewide section 1115 Medicaid waivers. The primary demonstrations included 11 waivers that allowed states to expand coverage to parents whose children were covered.
- About 27 billion in federal dollars – 21% of total federal Medicaid spending – are spent under waiver programs

Section 1115 Medicaid Waiver Financing

- Any new waivers must be “budget neutral” to the federal government. This means that federal spending can be no higher under the waiver than it would have been without the waiver.

- Several states have combined coverage expansions with a new managed care delivery system and used the anticipated managed care savings to offset the cost of the coverage expansion.

The Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative

- The latest waiver process, called the Health Insurance Flexibility and Accountability Act (HIFA), allows an expedited approval process for demonstrations that expand coverage to uninsured groups but only in a budget-neutral way.
- The HIFA waiver process encourages states to use waivers to expand coverage, with an emphasis on covering people with incomes below 200% of the federal poverty level.
- To keep the waiver plan from costing more, states can reduce benefits or increase cost sharing on optional populations.
- HIFA provides clear direction to states to provide coverage to non-categorically linked populations (e.g., single adults and childless couples) that doesn't involve either savings or payment diversions.
- HIFA emphasizes state coordination with employer-sponsored health insurance coverage, primarily through premium assistance to individuals who have access to private employer coverage.
- The flexibility being extended to states would not apply to mandatory groups. However, mandatory groups can be affected by a HIFA waiver in order to help finance coverage of other groups.
- In order to measure and enforce budget neutrality, each state under a HIFA waiver will be subject to a cap on federal expenditures.

To date, Arizona, California, Michigan, New Mexico and Washington have submitted HIFA applications. Arizona, California and Utah have received approval. The initiatives attempt to expand coverage to children and adults above previous income levels.

Issues Raised by the New Waiver Initiatives

- The HIFA waivers could affect current Medicaid beneficiaries as well as newly eligible individuals and alter key elements of Medicaid, including the guarantee of coverage, the scope and affordability of the benefits provided, and the open-ended federal

financing arrangement that governs the Medicaid program.

- States may look to HIFA for new cost-savings options as the downturn in the economy and rising health care costs are pushing states to constrain state spending.
- Reductions in benefits could result in shifting costs back onto local cities or towns and safety net providers.
- Changes in cost sharing arrangements for very low-income people could affect utilization of needed services.
- Many policy analysts are concerned that people who have been eligible could either lose their coverage or face severe cuts in their benefits under HIFA waivers.

Summary

At a time when budget deficits are mounting, and the rising cost of health care and coverage are emerging as major issues for the federal government and the states, waiver-based changes in Medicaid rules pose challenges for maintaining Medicaid coverage for its 44 million beneficiaries. According to several policy analysts, early indications are that the waiver activity ushered in by the HIFA guidance could lead to some significant reductions in Medicaid coverage. However, states will continue to pursue strategies to expand coverage while curtailing other benefits and services. Proposed state waiver

initiatives may affect beneficiaries currently receiving mental health services.

References and Reports

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Notes

Federal Medicaid Reform Initiatives

Background

- Over the last year, several policymakers have discussed ways to modernize Medicaid in a period where health care costs and enrollment in the program are increasing significantly.
- Policymakers have been concerned that the old Medicaid rules have restrained creative approaches to preserving coverage, as well as expanding coverage to lower-income uninsured populations.
- State policymakers have also been asking for more flexibility to design health care programs that best meet the needs of their citizens and expand coverage to more people, including the mentally ill and the chronically ill.

State Health Care Partnership Allotment (SCHPA) – Overall Plan

- The Bush Administration has recently proposed (January 31, 2003) to offer states \$12.7 billion of Medicaid funds from 2004 to 2010 that would restructure the Medicaid program. States would be offered as much as \$3.25 billion in 2004. The overall proposal is tentative in nature and needs congressional approval.
- In exchange for these funds, states would receive all of their Medicaid and State Children's Health Insurance Program (SCHIP) monies thereafter as a combined block grant. Federal funding for Medicaid and SCHIP would be provided in annual allotments, with one allotment for acute care and another for long-term care. States will be allowed to transfer a small amount of money (10%) between allotments.
- The amount of a state's allotment will be based on its expenditures in fiscal year 2002. States will be required to continue a financial commitment to Medicaid and SCHIP that will be based on their expenditures in fiscal year 2002.
- Under the block grant, states would have broad authority to change the scope of coverage for optional Medicaid and SCHIP beneficiaries without a waiver from the federal government, but there will be some minimum requirement for coverage of mandatory beneficiaries.
- States that decide to not accept block grants would continue to operate their traditional Medicaid and SCHIP programs, but they will not receive any federal fiscal relief.

- The plan encourages coverage for entire families – not just children in a lower-income family. The goal is to encourage continuity of care through “medical homes”, so that all members of the family are treated by the same provider.
- The proposal also supports increased use of home and community-based services for people with disabilities, enabling them to be served outside of institutional setting.
- The plan would also require maintenance of effort (MOE), so states continue to invest and maintain their commitment to health care.

SCHPA Funding Process

- The proposal advances \$12.7 billion of Medicaid funds to states over the next seven years. It is designed to be budget-neutral over 10 years.
- States would receive smaller allotments in 2011, 2012, and 2013 to “repay” the \$12.7 billion they received earlier.
- It is unknown whether the formula will account for differences between a state's Medicaid FMAP and its enhanced SCHIP rates.
- States that accept this deal may receive fewer funds than they would have received with traditional Medicaid funding.
- Some policy analysts believe that states could be constrained in their ability to respond to increased demand for Medicaid in the case of a future economic downturn, increases in the number of people who are unemployed or have disabilities, health care price inflation or increased health care needs due to the aging of the baby boom generation, for example.

SCHPA and Mandatory Beneficiaries

- The proposed plan treats mandatory beneficiaries differently from optional beneficiaries and other individuals that a state may choose to cover Centers for Medicare and Medicaid Services (CMS) has referred to these as “expansion” beneficiaries in the context of HIFA waivers).
- Under this plan, mandatory beneficiaries are provided some protection: states will be required to provide a minimum benefit package for mandatory beneficiaries, and will continue to be required to cover mandatory beneficiaries.
- The minimum benefit package for mandatory

beneficiaries is described as “comprehensive” by the Administration, but the definition of “comprehensive” remains unclear at this time.

- Medicaid requires EPSDT (early and periodic screening, diagnosis and treatment) services for children. It is unclear that if states opt for the block grant it could eliminate the protections of EPSDT for “optional” children (see below).
- It is also unclear whether EPSDT would be part of the “comprehensive” benefit plan that Health and Human Services (HHS) would require for mandatory populations.

SCHPA and Optional Beneficiaries

- The plan could eliminate the Medicaid entitlement for the nearly 12 million optional beneficiaries (particularly people with disabilities and the elderly) currently enrolled in Medicaid. Under the new structure, states would apparently have a great deal of flexibility to design eligibility levels, benefit packages, and cost-sharing provisions for optional and other enrollees without a waiver from HHS.

- State Medicaid expenditures for optional beneficiaries and optional services (e.g., prescription drugs, vision care and dental care) are 66% of all Medicaid spending and accounted for some \$100 billion in fiscal year in 2001.

Summary

If the Medicaid reform proposal passes Congress, states will face a choice of accepting immediate fiscal assistance and reducing coverage in later years in order to live within a capped allotment, or continuing to provide traditional Medicaid coverage without any federal fiscal relief.

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National Health Law Program, *The Administration's Proposal for Medicaid: Block Grants Revisited*, National Health Law Program, February 7, 2003.

Notes

Glossary of Medicaid Terms

Beneficiary – An individual who is eligible for and enrolled in the Medicaid program in the state in which he or she resides. Millions of individuals are eligible for Medicaid but not enrolled and are therefore not program beneficiaries.

Benefits - The health care services provided under terms of a contract by a managed care organization (MCO) or other benefits administrator.

Budget Neutrality – Refers to the requirement that if a State applies for Medicaid waivers under sections 1115, 1915(b) and/or 1915(c), they must demonstrate that the program does not exceed what the federal government would have spent without approving the waiver. States can do this by showing that the average per capita expenditure estimated by the state in any fiscal year for medical assistance provided with respect to the group affected by the waiver does not exceed 100% of the average per capita expenditure that the state reasonably estimates would have been made in that fiscal year for expenditures under the state plan for such individuals if the waiver had not been granted. States are required to submit data as proof to the federal Centers for Medicare and Medicaid Services (CMS) on a periodic basis to prove that the waiver remains cost neutral.

Capitation - A dollar amount established to cover the cost of all health care services delivered per person during a specified period of time. This term may refer to either the amount paid to an MCO by its private and public sector clients or a negotiated per capita rate to be paid periodically to a health care provider by an MCO. The MCO or provider is then responsible for delivering or arranging the delivery of all health services required by the covered person under the conditions of the contract.

Capitation Payment – A payment made by a state Medicaid agency under a risk contract, generally to the MCO. The payment is usually made on a monthly basis at a fixed amount on behalf of each Medicaid beneficiary enrolled in the MCO. In exchange for the capitation payment, the MCO agrees to provide (or arrange for the provision of) services covered under the contract with the state Medicaid agency to enrolled Medicaid beneficiaries. **See Fee-For-Service, MCO.**

Carve-In - A model of delivering and financing health care services in which mental health and/or substance abuse services are provided under the same delivery system as

physical healthcare; the integration of behavioral health care and physical healthcare.

Carve-Out - The practice of having a specific benefit, such as mental health or substance abuse, operated as a distinct program, separate from the general health program.

Categorical Eligibility – a phrase describing Medicaid's policy of restricting eligibility to members of certain groups or categories, such as children, the aged, and individuals with disabilities. Certain categories of individuals – e.g., childless adults under 65 without disabilities – are generally ineligible for Medicaid regardless of the extent of their impoverishment. Individuals who fall into approved categories must also satisfy financial eligibility requirements, including income and, in most cases, resource tests imposed by the states in which they reside.

Categorically Needy - A term that describes the group of individuals that states are generally required to cover under Medicaid in order to receive federal funds. This group includes people who receive assistance through Temporary Aid for Needy Families (TANF) and Supplemental Security Income (SSI), as well as other federally assisted income maintenance payments.

Centers for Medicare and Medicaid Services (CMS) – The federal agency in the U.S. Department of Health and Human Services (HHS) responsible for the administration of Medicaid, Medicare, and SCHIP (formerly the Health Care Financing Administration, HCFA).

Copayment - A cost-sharing arrangement in which a consumer pays a specified charge for a specified service (e.g., \$10 for an office visit). The consumer is usually responsible for payment at the time the service is rendered.

Covered Expenses - Hospital, medical and other health care expenses paid for under a health insurance policy.

Deductible - A specified amount of money a consumer must pay before insurance benefits begin. Usually expressed in terms of an annual amount.

Drug Formulary - A listing of medications that consumers may readily access through their health plans. Non-formulary medications may not be accessible or may be accessible only if prior authorization is obtained. Often, the medications on the formulary tend to be the cheapest, rather than the most effective.

Drug Utilization Review (DUR) - Efforts to control drug utilization and costs by a facility or a health plan. Common methods include the use of a formulary (see above), substitution of generic products for more expensive name brands and encouraging use of drugs that will trigger rebates or discounts.

Dual Eligibles – A term used to describe an individual who is eligible both for Medicare and for full Medicaid coverage, including nursing home services and prescription drugs as well as payments of Medicare premiums, deductibles, and co-insurance. Some Medicare beneficiaries are eligible for Medicaid payments for some of all of the Medicare premiums, deductibles, and co-insurance requirements, but not for Medicaid nursing home or prescription drug benefits.

Entitlement – A program that creates a legal obligation on the federal government to any person, business, or unit of government that meets the criteria set in law. Federal spending on an entitlement program is controlled through the program's eligibility criteria and benefit and payment rules, not by the appropriation of a specific level of funding in advance. Entitlement programs such as Medicare and Medicaid are also referred to (for federal budget purposes) as “direct” or “mandatory” spending. Medicaid is both an individual entitlement and an entitlement to the states that elect to participate.

Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) – One of the services that states are required to include in their basic packages for all Medicaid-eligible children under age 21. EPSDT services include periodic screenings to identify physical and mental conditions as well as vision, hearing, and dental problems. EPSDT services also include follow-up diagnostic and treatment services to correct conditions identified during a screening, without regard to whether the state Medicaid plan covers those services with respect to adult beneficiaries.

Fail-First Policies – Requirement that as a prerequisite for authorization of a specific, often non-formulary medication, the patient fail on at least one other medication (often involves multiple tries).

Federal Medicaid Assistance Program (FMAP) – The statutory term for the federal Medicaid matching rate – i.e., the share of the costs of Medicaid services or administration that the federal government bears. In the case of covered services, FMAP varies from 50 to 83% depending upon a state's per capita income; on average, across all state, the federal government pays at least 57% of the costs of Medicaid. FMAPs for administrative costs vary not by state, but by function. The general FMAP for administrative costs is 50%; some functions (e.g., survey and certification, fraud control units) qualify for enhanced FMAPs of 75% or more.

Federal Poverty Level (FPL) – The federal government's working definition of poverty that is used as the reference point for the income standard for Medicaid eligibility for certain categories of beneficiaries. Adjusted annually for inflation and published by the Department of Health and Human Services in the form of Poverty Guidelines, the FPL in calendar year 2001 was \$14,630 for a family of 3 in the U.S., \$18,290 in Alaska, and \$16,830 in Hawaii.

Fee-For-Service – A traditional method of paying for medical services under which providers are paid for each office visit, treatment, procedure, or other service rendered. See **Capitation Payment**.

Generic Substitution – The practice of substituting a cheaper, generic, medication for a brand-name medication. This can be mandated by the state to occur at the point of sale or can occur at consumer request. However, clinicians and consumers must be aware when such policies are in place.

Health Insurance Flexibility and Accountability (HIFA) – A Medicaid and State Children's Health Insurance Program (SCHIP) demonstration waiver that offers states greater flexibility in setting benefits and cost-sharing for some groups of Medicaid beneficiaries. Under this policy, states can use section 1115 waivers to cut benefits and/or increase cost-sharing for certain Medicaid beneficiaries and invest resulting savings into expanding coverage of uninsured individuals through the Medicaid and SCHIP programs.

Health Maintenance Organization (HMO) - An entity that provides, offers or arranges for coverage of designated health services needed by members for a fixed, prepaid premium. There are three basic models of HMOs: group model, individual practice association (IPA) and staff model.

Home-and Community-Based Services (HCBS) Waiver – Also known as the “1915c waiver” after the enabling section in the Social Security Act, this waiver authorizes the Secretary of HHS to allow a state Medicaid program to offer special services to beneficiaries at risk of institutionalization in a nursing facility or facility for the mentally retarded. These home- and community-based services, which otherwise would not be covered with federal matching funds, include case management, homemaker/home health aide services, personal care services, adult day health services, habilitation services, and respite care. They also include, in the case of individuals with chronic mental illness, day treatment and partial hospitalization, psychosocial rehabilitation services, and clinic services.

Institution for Mental Diseases (IMD) - A facility of more than 16 beds in which at least 50% of the residents have a primary diagnosis of a mental illness. IMDs cannot receive Medicaid funds for services to persons ages 22-64.

Managed Care Organization (MCO) – An MCO is an entity that has entered into a risk contract with a state Medicaid agency to provide a specified package of benefits to Medicaid enrollees in exchange for a monthly capitation payment on behalf of each enrollee. See **Capitation Payment**.

Mandatory – State participation in the Medicaid program is voluntary. However, if a state elects to participate, as do all, the state must at a minimum offer coverage for certain services to certain populations. These eligibility groups and services are referred to as “mandatory” in order to distinguish them from the eligibility groups and services that a state may, at its option, cover with federal Medicaid matching funds. See **Optional**.

Means Testing – The policy of basing eligibility for benefits upon an individual’s lack of means, as measured by his or her income or resources. Means testing by definition requires the disclosure of personal financial information by an applicant as a condition of eligibility. Medicaid and SCHIP are means tested programs; Medicare is not.

Medicaid - A nationwide health insurance program, adopted in 1965, for eligible disabled and low-income persons. It is administered by the federal government and participating states. The program’s costs, paid for by general tax revenue, are shared by the federal and state governments.

Medical Necessity - The determination that a specific health care service is: medically appropriate; necessary to meet a consumer’s health needs; consistent with the diagnosis; the most cost-effective option; and consistent with clinical standards of care.

Medically Needy – A term used to describe a Medicaid eligibility group that is optional and is composed of individuals who qualify for coverage because of high medical expenses, commonly for hospital or nursing home care. These individuals meet Medicaid’s categorical requirements – i.e., they are children or parents or aged or individuals with disabilities – but their income is too high to enable them to qualify for “categorically needy” coverage. Instead, they qualify for coverage by “spending down” – i.e., reducing their income by their medical expenses. States that elect to cover the “medically needy” do not have to offer the same benefit package to them as they offer to the “categorically needy.” See **Categorically Needy, Spend-Down**.

Medicare - A nationwide, federally administered program that covers the costs of hospitalization, medical care and some related services for elderly and select other individuals. Medicare has two parts: Part A generally covers inpatient costs; and part B primarily covers outpatient costs. Pharmaceutical benefits are excluded.

Optional – The term used to describe Medicaid eligibility groups or service categories that states may cover if they so choose and for which they may receive federal Medicaid matching payments at their regular matching rate, or FMAP. About half of all federal Medicaid funds are used to match the cost of optional services or optional populations.

Outcomes Measure – A tool that systematically evaluates the impact that services have on the health and mental health of consumers and their families. The measure typically focuses on functioning issues.

Out-of-Pocket Expenses - Costs borne by the consumer that are not covered by a healthcare plan.

Outpatient Prescription Drug Program - A program that provides prescription drug services on an outpatient basis.

Pharmaceutical Benefits Manager (PBM) - An entity that is responsible for managing prescription benefits.

Point-of-Service (POS) - A health plan arrangement in which consumers may choose to receive a service from a participating or a non-participating provider or facility. Generally, the level of coverage is reduced, or the consumer pays more out-of-pocket, for services associated with the use of non-participating providers.

Preferred Provider Organization (PPO) - An organized network of healthcare providers, typically reimbursed on a discounted fee-for-service basis. Coverage may or may not be available outside of the network for a higher copayment.

Premium - Money paid in advance for insurance coverage.

Primary Care Case Manager (PCCM) – PCCMs are physicians, physician groups, or entities having arrangements with physicians that contract with state Medicaid agencies to coordinate and monitor the use of covered primary care services by enrolled beneficiaries. State Medicaid contracts with PCCMs tend to be less comprehensive in their coverage of benefits and involve less financial risk than those with MCOs.

Primary Care Provider (PCP) - The provider that serves as the initial interface between the consumer and the healthcare system. The PCP is usually a physician, selected by the consumer upon enrollment, who is trained in one of the primary care specialties and who coordinates the treatment of consumers under his/her care.

Prior Authorization/Approval - A cost-control procedure in which a payor requires a service to be approved for coverage in advance of delivery.

Rebate – As part of the Omnibus Reconciliation Act of 1990, Congress required that a pharmaceutical company would have to pay a rebate on its products to receive reimbursement by the Medicaid program. For all innovator products, the rebate is the greater of 15.1% of the average manufacturer's price (AMP) or the difference between the AMP and the manufacturer's "best price," (the lowest price offered to any other customer, excluding Federal Supply Schedule (FSS) prices, prices to state pharmaceutical-assistance programs, and prices that are nominal in amount, and includes all discounts and rebates). An additional rebate is required for any price increase for a product that exceeds the increase in the Consumer Price Index for all items since 1990. A rebate of 11% of each product's AMP is required for generic drugs.

Reference-based Formulary – Identifies categories of drugs that are similar in effectiveness, but with a range of cost. The most cost-effective drug would become the reference drug and set the maximum price paid by the state for that category.

Section 209(b) State – In amendments to the Social Security Act enacted in 1972, Congress created the Supplemental Security Income (SSI) program of cash assistance for low-income elderly and disabled individuals. Section 209(b) of those amendments allowed states the option of continuing to use their own eligibility criteria in determining Medicaid eligibility for the elderly and disabled rather than extending Medicaid coverage to all of those individuals who qualify for SSI benefits. As of 1998, eleven states had elected the "209(b)" option to apply their 1972 eligibility criteria to aged or disabled individuals receiving SSI benefits for purposes of determining Medicaid eligibility.

Section 1115 Waiver – Under section 1115 of the Social Security Act, the Secretary of Health and Human Services is authorized to waive compliance with many of the requirements of the Medicaid statute to enable states to demonstrate different approaches to "promoting the objectives of" the Medicaid program while continuing to receive federal Medicaid matching funds. In 1999, 17 states or counties were operating Medicaid section 1115 waivers affecting some or all of their eligible populations and involving \$38.3 billion in federal matching funds, or over one-third of all federal Medicaid spending that year. The waivers are administered by CMS and are granted for 5-year periods, after which they may be renewed.

Section 1915(b) Waiver – Under section 1915(b) of the Social Security Act, the Secretary of HHS is authorized to waive compliance with the "freedom of choice" and "statewideness" requirements of federal Medicaid law in order to allow states to operate mandatory managed care programs in all or portions of the state while continuing to receive federal Medicaid matching funds. The waivers,

which are granted (or renewed) for 2-year periods, are administered by CMS.

Section 1931 Parent Coverage – Under section 1931 of the Social Security Act, states can "de-link" eligibility for Medicaid from eligibility for cash assistance in the case of parents with dependent children. Section 1931 gives a state the option of extending Medicaid coverage to parents with family incomes and resources higher than those that would allow the parents to qualify for cash assistance under the state's TANF program.

Section 1932 State Plan Option – Under section 1932 of the Social Security Act, states may require Medicaid beneficiaries to enroll in managed care entities (MCEs) by submitting an approvable state plan amendment (SPA) to CMS. Unlike section 1915(b) or 1115 waivers, section 1932 SPAs need not be periodically renewed by CMS.

Spend-Down – For most Medicaid eligibility categories, having countable income above a specified amount will disqualify an individual from Medicaid. However, in some eligibility categories – most notably the "medically needy" – individuals may qualify for Medicaid coverage even though their countable incomes are higher than the specified income standard by "spending down." Under this process, the medical expenses that an individual incurs during a specified period are deducted from the individual's income during that period. When the individual's incurred medical expenses have been subtracted from his or her income and the difference is at or below the state-specified income standard, the individual qualifies for Medicaid benefits for the remainder of the period. See **Medically Needy**.

State Children's Health Insurance Program (SCHIP) – Enacted in the 1997 Balanced budget Act as title XXI of the Social Security Act, SCHIP is a federal-state matching program of health care coverage for uninsured low-income children. In contrast to Medicaid, SCHIP is a block grant to the states; eligible low-income children have no individual entitlement to a minimum package of health care benefits. Children who are eligible for Medicaid are not eligible for SCHIP. States have the option of administering SCHIP through their Medicaid programs or through a separate program (or a combination of both). The federal matching rate for SCHIP services (on average, 70%) is higher than that for Medicaid (on average at least 57%), but the federal allotment to each state for SCHIP services is capped at a specified amount each year.

State Medicaid Plan – Under Title XIX of the Social Security Act, no federal Medicaid funds are available to a state unless it has submitted to the Secretary of HHS, and the Secretary has approved, its state Medicaid plan (and all amendments to the state plan). The state Medicaid plan must meet over 60 federal statutory requirements.

State Plan Amendment (SPA) – A state that wishes to change its Medicaid eligibility criteria or its covered benefits or its provider reimbursement rates must amend its state Medicaid plan to reflect the proposed change. Similarly, states must conform their state plans to changes in federal Medicaid law. In either case, the state must submit a state plan amendment (SPA) to CMS for approval.

Statewideness – The requirement that states electing to participate in Medicaid must operate their programs throughout the state and may not exclude individuals residing in, or providers operating in, particular counties or municipalities. This requirement may be waived with Section 1115 Waivers.

Temporary Assistance for Needy Families (TANF) – A block grant program that makes federal matching funds available to states for cash and other assistance to low-income families with children. TANF was established by the 1996 welfare law that repealed its predecessor, the Aid to Families with Dependent Children (AFDC) program. Prior to this repeal, states were required to extend Medicaid coverage to all families with children receiving AFDC benefits. States may but are not required to extend Medicaid coverage to all families receiving TANF benefits; states must, however, extend Medicaid to families with children who meet the eligibility criteria that states had in effect under their AFDC programs as of July 16, 1996.

Texas Medication Algorithm Project (TMAP) – A project designed to ensure that consumers have access to a range of new, atypical medications and helps to avoid restrictions on access to mental health treatment.

Therapeutic Class Substitution – A different medication from the same therapeutic class is substituted. Often a formulary will list one or two medications from each therapeutic class, rather than allowing access to a full array of medications.

Tiered Co-payment Structure – Different co-payments are set for brand and generic medications.

Title XIX – Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., is the federal statute that authorizes the Medicaid program. Related titles of the Social Security Act are Title IV-A (TANF), Title IV-E (Foster Care and Adoption Assistance), Title XVI (SSI), Title XVIII (Medicare), and Title XXI (CHIP).

Utilization - The extent to which beneficiaries within a covered group use a program or obtain a particular service, or category of procedures, during a given period of time. Usually expressed as the number of services used per year or per 1,000 persons covered.

Utilization Management - The process of evaluating the medical necessity, appropriateness and efficiency of health-care services against established guidelines and criteria.

Utilization Review (UR) - A formal review of healthcare services for appropriateness and medical necessity. UR may be conducted on a prospective, concurrent or retrospective basis.

Waivers – Various statutory authorities under which the Secretary of HHS may, upon the request of a state, allow the state to receive federal Medicaid matching funds for its expenditures even though it is no longer in compliance with certain requirements or limitations of the federal Medicaid statute. In the case of program waivers such as the 1915(c) waiver for home- and community-based services, states may receive federal matching funds for services for which federal matching funds are not otherwise available. In the case of demonstration waivers such as the section 1115 waivers, states may receive federal matching funds for covering certain categories of individuals for which federal matching funds are not otherwise available, and they may restrict the choice of providers that Medicaid beneficiaries would otherwise have.

Adapted from the National Mental Health Association's Glossary of Healthcare Terms

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