Medicaid: What Any Serious Health Reform Proposal Needs to Consider

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Introduction: Medicaid—Not Just Medicare's Second Cousin

For the first time in history, total state and federal expenditures under the Medicaid program have exceeded those of Medicare. In 1998, Medicaid insured more than 40 million persons. Medicaid spending constituted between 15 percent and 20 percent of all state expenditures[1] and is slated to grow at an average annual rate of 8.5 percent between 2002 and 2012.[2] In 2001, Medicaid spending amounted to more than half of all national expenditures on means-tested entitlement programs.[3] Based on a specified formula tied to state financial conditions, the federal government contributes between 50 percent and 83 percent of state medical assistance expenditures[4] and between 50 percent and 90 percent of program administration costs.

Despite a considerable body of research, the full dimension of Medicaid's importance as a source of financing for state health care activities actually remains relatively little understood. In fact, Medicaid's very structure means that it has come to assume a seminal role in paying for health services that are essential to the success of numerous other state health and health-related programs; many of these services, particularly for children and adults with long-term and chronic health problems, lie beyond the limits of even the most generous private insurance plans. Careful examination suggests that Medicaid's unique legislative design has allowed the program to evolve into a central structural underpinning for health initiatives that transcend the bounds of conventional health insurance and extend into the broadest reaches of health care. Medicaid's very scope and elasticity complicates federal health reform efforts, since changes in federal Medicaid policies can have a significant impact on a broad range of state health and health-related services and programs as well as a wide array of provider groups.

Part I of this paper describes Medicaid's role in state health policy with regard to revenues, health care spending (particularly on populations whose needs extend beyond traditional health insurance), health care infrastructure support, and state and local government administrative support.

Part II examines how Medicaid's eligibility, coverage and benefits, and program administration costs distinguish the program from conventional health insurance.

Part III illustrates Medicaid's unique qualities by examining one state's use of the program to maintain its health activities.

Part IV concludes with a discussion of key issues raised by Medicaid that comprehensive health reform would need to address.

Part I: Medicaid's Role in the States

For nearly 40 years, Medicaid's broad program structure and federal financial contributions have made it the central vehicle for transforming state health care activities. In the early 1960s, states made

[1] National Governors Association. *The Fiscal Survey of States,* June 2001. http://www.nga.org (accessed January 10, 2002).

[2] Congressional Budget Office. *The Budget and Economic Outlook: Fiscal Years 2003–2012*, chap. 4. Washington, 2002. http://www.cbo.gov/showdoc.cfm?index=3277&sequence=0& (accessed February 8, 2002).

[3] Congressional Budget Office. 2001. *The Budget and Economic Outlook*.

[4] Family planning services and supplies are financed at a 90 percent contribution level.

modest investments in health care services for the poor, the elderly, and persons with disabilities; by 2000, states were administering health insurance programs that collectively insured more than 40 million persons and supported comprehensive health systems. Medicaid now accounts for 15 percent to 20 percent of state budgets, second only to spending on K–12 education. In fact, over the past decade, state and local governments have relied increasingly on the revenue Medicaid brings into a state to support government functions related to health care for millions of persons as well as the health care infrastructure. Over the years, some states have undertaken aggressive efforts to elevate federal contributions beyond their statutory limits through what have been termed "creative" financing schemes; at times, these efforts have tended to overshadow the important contributions to American health policy made by state Medicaid investments aimed at the nation's most vulnerable populations.

Congress established Medicaid as a shared responsibility of the federal government and the states. Because virtually all states, unlike the federal government, are obligated to balance their budgets annually, this shared arrangement has created a natural series of checks and balances on program size. Although Medicaid is an entitlement, states' budget balancing obligations create a brake of sorts on overall program expenditures (although Medicaid revenue maximization efforts have at times pushed federal expenditures upward at a far more rapid rate than state expenditure growth alone would indicate). At the same time that state budget constraints act as a check on overall program size, Congress has encouraged major program growth through creation of numerous options to expand program coverage. The very existence of these options has not only permitted expansion but in some cases has served to pressure states to adopt popular program expansions.

The state/federal Medicaid relationship has been challenging, particularly as federal program policy has expanded. State Medicaid expenditure data, when reported nationally, often tend to lag behind actual state experience, thereby creating an incomplete picture of state program conditions. States have reacted, particularly in times of tight budgets, against the breadth and depth of Medicaid's sometimes unpredictable growth. In such an environment, states have sought new ways to generate federal revenues beyond levels otherwise permissible under the federal financing formula, especially through intergovernmental transfer and provider contribution arrangements. Such Medicaid maximization activities were designed within the construct of Medicaid law and regulation but generally were seen as loopholes by the federal government and were quickly constrained. While most states used funds so generated for legitimate Medicaid purposes, a few used the revenue for non-Medicaid purposes and were the subject of well-publicized audits and penalties.

Expenditures and Revenues

Medicaid's role in state economies is best illustrated in a recent report by the Urban Institute that chronicles changes in state spending over the 1990s and in the process sheds important light on Medicaid's overall importance to state financial health.[5] Table 1 shows that over the 1988–1997 period, state governments' overall real per capita spending increased by almost 30 percent; within this overall increase, real public welfare expenditures grew by 71 percent, far exceeding any other spending category. Of this growth, medical payments to vendors (most of it through Medicaid) grew by more than 100 percent and accounted for over 80 percent of public welfare spending growth. Table 2 shows the role played by federal public welfare and health and hospitals grant funding in the rise in overall state revenue over this same time period while tables 3 and 4 underscore the magnitude of the increase of Medicaid revenues considered alone. Taken together, these statistics suggest that Medicaid has been the largest single source of direct federal funds transfers to states and has in turn driven a major increase in state investment in health care over the past decade. Over the 1988–1997 period, federal inter-governmental revenue accounted for 40 percent of the total increase in state revenue, and the primary source of these revenues was Medicaid.

[5] David Merriman. *What Accounts for the Growth of State Government Budgets in the 1990s?* Series A, No. A-39 Washington: Urban Institute, 2000.

TABLE 1

Real Per Capita Expenditures by State Governments, FY 1988 through FY 1997 (1992 Dollars)

YEAR	TOTAL EXPENDITURES	ELEMENTARY & SECONDARY EDUCATION	HIGHER EDUCATION	PUBLIC WELFARE	CORRECTIONS	HEALTH AND HOSPITALS	HIGHWAYS	INTEREST	OTHER GENERAL EXPENDITURES
1988	$2,034	$430	$271	$396	$63	$164	$191	$91	$427
1989	2,116	452	278	418	68	174	193	92	442
1990	2,164	448	285	447	74	182	188	92	449
1991	2,267	457	293	508	79	187	192	96	455
1992	2,419	477	305	618	80	190	193	97	459
1993	2,468	484	307	642	79	203	196	92	464
1994	2,533	484	309	683	85	209	199	88	476
1995	2,601	506	317	691	92	213	203	87	491
1996	2,595	520	319	673	94	213	200	87	488
1997	2,624	534	323	676	97	210	200	88	496
Percentage Change, 1988–1997	29%	24%	19%	71%	54%	28%	5%	-4%	16%

Sources: Expenditure data from U.S. Bureau of the Census, State Government Finances. Population data from U.S. Bureau of the Census, Population Estimates Program, Population Division. Data deflated using state and local government implicit price deflators from national income and product accounts; David Merriman. *What Accounts for the Growth of State Government Budgets in the 1990s?* Series A, No. A-39 Washington: Urban Institute, 2000.

Note: Rows may not add due to rounding.

Thus, Medicaid occupies not only a singular place in health policy but a singular role in the economies of state and local governments as well. It is the biggest single revenue producer for state governments, in part because of the federal financing formula that governs the program and, in part (as has become evident in recent years), because of states' ability to further enhance their nominal, statutorily defined federal contribution rate through such techniques as favored payment rates to governmental health facilities. But regardless of whether states are receiving revenues at the statutory rate or at artificially enhanced levels, there is no question that the program funds overwhelmingly are invested in states' efforts to sustain vast and complex health services related to a wide array of public programs for children and non-elderly and elderly adults. Medicaid's greatest contribution from a state vantage point lies in the degree to which the program is structured through its eligibility, coverage, payment, and administrative provisions to recognize services and costs that transcend conventional insurance and reach into the broader levels of health spending to support overall social welfare goals.

Infrastructure Investment

Two clear examples of Medicaid's investment in a state's health care infrastructure are disproportionate share hospital (DSH) payments and enhanced reimbursement for federally qualified health centers (FQHCs). The DSH program allocates federal funds to all states to support the cost of hospitals that treat a higher number of uninsured and low-income patients—regardless of their potential eligibility for Medicaid. In 1998, Medicaid DSH payments amounted to approximately $10 billion, or 9 percent of total program spending.

A second principal form of infrastructure support is the enhanced payment system (based on the concept of reasonable cost per encounter) for federally qualified health centers (FQHCs) and rural health clinics (RHCs) to support the mission of these two classes of health providers as a source of care for uninsured and underserved persons. Feder-

TABLE 2

Real Per Capita State Government Expenditures for Public Welfare, FY 1988 through FY 1997 (1992 Dollars)

		COMPONENTS OF THE STATE PUBLIC WELFARE EXPERIENCE			
YEAR	ALL PUBLIC WELFARE EXPENDITURES	MEDICAL VENDOR PAYMENTS	CATEGORICAL CASH ASSISTANCE	CATEGORICAL ASSISTANCE—INTER-GOVERNMENTAL TO COUNTIES	OTHER PUBLIC WELFARE
1988	$396	$202	$46	$38	$110
1989	418	217	45	41	116
1990	447	239	45	42	120
1991	508	287	49	46	126
1992	618	370	53	62	132
1993	642	388	55	61	138
1994	683	416	54	65	149
1995	691	427	50	64	151
1996	673	418	44	61	149
1997	676	426	39	59	152
Percentage Change, 1988–1997	71%	111%	-14%	54%	38%

Sources: Expenditure data from U.S. Bureau of the Census, State Government Finances. Population data from U.S. Bureau of the Census, Population Estimates Program, Population Division. Data deflated using state and local government implicit price deflators from national income and product accounts; David Merriman. *What Accounts for the Growth of State Government Budgets in the 1990s?* Series A, No. A-39 Washington: Urban Institute, 2000.

Note: Rows may not add due to rounding.

al Medicaid expenditure data alone do not permit calculation of the national value of the reasonable cost payment method (which was updated in 2000 by replacing the earlier retrospective cost-based system with a prospective formula); but its value presumably would equal the difference between the amount of Medicaid compensation received for covered services by FQHCs and RHCs and the amount states might receive were they to use their standard fee schedules to purchase the same services. However, separate data on state Medicaid payment supplements to federally funded health centers as part of the cost-based payment reconciliation process suggest that this increment is considerable. In 2000, it amounted to $350 million, or 26 percent of the $1.343 billion in total Medicaid payments received by health centers.[6] This amount reflects both reconciliation up to reasonable cost levels for payments made directly by state agencies and supplemental payments made by state agencies that represented the difference between health centers' managed care contractual payments and their reasonable costs.

State and Local Government Administrative Support

A critical dimension of Medicaid spending is the extent to which program administration functions are carried out by other state and local agencies with formal interagency relationships with the Medicaid agency. For example, Medicaid agencies purchase quality assurance services from health agencies, as well as administrative health care case management services from numerous public agencies services to children and adults with special needs (for example, children in the child welfare system, children with illness and disabilities who receive special education services, adults with physical or developmental disabilities, and the frail elderly). In all of these cases,

[6] Uniform Data System; calculations by Daniel R. Hawkins, Vice President for Federal and State Affairs, The National Association of Community Health Centers, Washington D.C., 2002.

TABLE 3

Real Per Capita State Federal Inter-governmental Revenues, FY 1988 Through FY 1997 (1992 Dollars)

		COMPONENTS OF THE STATE PUBLIC WELFARE EXPERIENCE				
YEAR	TOTAL FEDERAL INTER-GOVERNMENTAL GRANTS TO STATES	EDUCATION	HEALTH AND HOSPITALS	HIGHWAYS	PUBLIC WELFARE	OTHER
1988	$473	$85	$20	$63	$226	$80
1989	488	88	22	65	234	79
1990	504	91	23	59	253	78
1991	551	95	25	58	294	79
1992	629	102	27	57	360	83
1993	677	107	31	63	388	88
1994	708	111	33	66	408	90
1995	718	113	37	69	408	92
1996	715	117	38	65	406	89
1997	719	112	39	64	410	93
Percentage Change, 1988–1997	52%	32%	99%	2%	82%	16%

Sources: See Expenditure data from U.S. Bureau of the Census, State Government Finances. Population data from U.S. Bureau of the Census, Population Estimates Program, Population Division. Data deflated using state and local government implicit price deflators from national income and product accounts; David Merriman. *What Accounts for the Growth of State Government Budgets in the 1990s?* Series A, No. A-39 Washington: Urban Institute, 2000.

Note: Rows may not add due to rounding.

TABLE 4

Real Per Capita Federal Inter-governmental Grants to State Governments for Public Welfare

	FY 1997	FY 1988
Total	$410.00	$226.00
Medicaid	315.00	141.00
Non-Medicaid total	96.00	84.00
DETAIL ON NON-MEDICAID TOTAL		
AFDC	32.00	50.00
Food Stamp Administration	8.00	5.00
Low-income Energy Assistance	4.00	7.00
Social Services Block Grant	9.00	12.00
Community Services Block	0.08	1.79
Work Incentive Program	0.0	0.57
Other Non-Medicaid	43.00	7.00

Sources: Federal grant data by program is from the U.S. Bureau of the Census. *Federal Expenditures by State by Fiscal Year 1997 and 1998.* Population data from U.S. Bureau of the Census; David Merriman. *What Accounts for the Growth of State Government Budgets in the 1990s?* Series A, No. A-39 Washington: Urban Institute, 2000.

Note: Numbers may not add due to rounding. Data deflated using state and local government implicit price deflators from national income and product accounts.

other public agencies are conducting activities and carrying out responsibilities that arise out of their essential governmental functions for state residents. But a portion of their administration and oversight budget derives from Medicaid payments made to support that aspect of a public agency's undertaking whose costs are attributable to the Medicaid population. The relationships between Medicaid agencies and other agencies that carry out complementary activities for the Medicaid populations underscore a practical truth: despite the fact that federal Medicaid law requires that each state establish a "single state agency," in fact, in nearly all states, multiple public agencies are involved in program administration through inter-governmental contracts. Indeed, the programs under which these other agencies operate (such as federal child welfare and special education laws) contain virtually no federal spending authority for medical care and instead assume the existence of Medicaid to finance medical and medical support services for eligible populations.

Covered Services and Populations Outside of Conventional Insurance

The Medicaid program contains a number of coverage mandates and options reflecting federal policies that aim the program in great part at individuals and families whose health status or family circumstances place them outside a conventional health insurance environment and within the classes of persons for whom states historically have assumed responsibilities. To be sure, in recent years, Medicaid has been expanded (through both direct amendments and the complementary State Children's Health Insurance Program [S-CHIP]) to more actively reach lower-income workers and their families. But this aspect of public coverage—health insurance for working families—is only one of Medicaid's numerous roles. The very concept of coverage under Medicaid bears only limited resemblance to the coverage principles that guide private insurance. From its inception (and with the notable exceptions of the exclusion of expenditures for inpatient mental illness and expenditures for persons who are inmates of public institutions), the term, "medical assistance," was shaped to reflect the realities of state social welfare spending imperatives for poor, disabled, and medically at-risk populations. The definition of medical assistance has evolved considerably over the past 35 years, with numerous expansions in the definition of medical assistance at the urging of state and local public officials whose social welfare obligations compelled various types of health care spending that fall outside the realm of private insurance. Whether the issue was special education-related services, home and community-based services for persons with physical and developmental disabilities or the frail elderly, services in smaller residential settings for persons with mental illness, community treatment for persons with tuberculosis, insurance for disabled workers, treatment of uninsured women with breast and cervical cancer, emergency services for undocumented aliens, or other health care imperatives, state and local officials have played a role over the years in reshaping Medicaid to effectively serve the sickest and most disabled persons in the most flexible settings possible.[7] The states have sometimes responded to federal mandates; at other times, states have initiated innovations through policy and programmatic waivers.[8]

Part II: Populations and Services Covered under Medicaid

In many respects, the basic structure of Medicaid has not changed in 35 years, despite the most profound changes in health care organization, delivery, and finance in a century. States have jury-rigged reform through a series of waivers, making the program idiosyncratic by state. States struggle with program requirements and cost, and program scope and design vary considerably among states. It is essential that proposals to reform Medicaid (either standing alone or as part of a broader national health reform effort) proceed only with a full understanding of the unique "policy space" Medicaid has come to occupy.

To be sure, Medicaid's role parallels private, employer-sponsored insurance for working-age adults and children. At the same time, Medicaid is the means by which states insure "uninsurable" populations, such as disabled workers, and finance medical and health services that conventional health insurance, which depends on medical risk avoidance and carefully circumscribed rules of coverage,[9] simply is not structured to support.

But this deceptively simple characterization of Medicaid masks a program of uncommon complexity, subtlety, and flexibility (particularly for one of its size). Medicaid coverage rules are legendary in their complexity. Federal law designates certain categories of individuals as mandatory coverage groups for participating states.[10] These groups consist mainly of families with children that satisfy eligibility criteria

[7] See, for example, the Medicaid Resolutions of the National Governors Association. http://www.nga.org.

[8] Sara Rosenbaum, "Health Policy Report: Medicaid." *New England Journal of Medicine 346* (8): 635–9.

[9] Deborah Stone. "The Struggle for the Soul of Health Insurance." *Journal of Health Politics, Policy, and Law* (5): 187–204; Alain Enthoven and Richard Kronick. "A Consumer Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy." *New England Journal of Medicine 320* (2): 29–37; Mark Pauly and Sean Nicholson. "Adverse Consequences of Adverse Selection." *Journal of Health Politics, Policy, and Law* (Special Issue: The Managed Care Backlash) *24* (5): 930–931.

[10] Op. cit. at note 9.

under states' 1996 Aid to Families with Dependent Children (AFDC) programs; elderly, disabled, and blind persons who receive federal Supplemental Security Income (SSI) benefits; "poverty-level" children and pregnant women; and (for limited assistance) Medicare beneficiaries with incomes at or below the federal poverty level (known as qualified Medicare beneficiaries). Indeed, eligibility varies significantly among states, in part because of federal law and regulations that allow states to set different eligibility levels for some populations and to use different strategies to define eligibility. For example, federal law allows states to disregard certain types of family income (for example, child support payments) or expenditures (work-related expenditures) in calculating family income, and there is variability in how states do so. Moreover, states' economies vary considerably, and Medicaid policies reflect that. A family living at 185 percent of the federal poverty level in a high cost-of-living state may face a different situation from one living in a state in which the cost of living is relatively low.

Medicaid's unique flexibility rests in its essential characteristics and, more important, in its roots, which lie not in private insurance, but in social welfare spending aimed at addressing the health needs of the sickest, neediest, and least insurable residents and services.[11] In recent years, as the gaps in and limitations of private health insurance have become more visible, particularly for lower-income workers and their families,[12] Medicaid reform has focused on this particular program role, most notably through amendments enacted in 1996 and 1997 that offer states expanded options to cover lower-income working families[13] as well as near-poor children who are uninsured but are ineligible for basic Medicaid coverage.[14] But federal financing still is not available to cover non-disabled adults without children, for example, unless a state receives waivers to extend coverage under Section 1115 demonstration authority.[15]

But in recent years, equal public policy focus has been on Medicaid's other roles as the principal funder of chronic care, companion health care systems aimed at high-risk populations, and the safety net. Examples of these reforms are expansion of state eligibility options for uninsurable persons (for example, uninsured women with breast and cervical cancer and working-age adults with severe disabilities who seek to return to work), expanded support of the health care safety net (for example, FQHC payment reforms), and expanded coverage of low-income Medicare beneficiaries.[16] The Bush administration has proposed using Medicaid as the legislative vehicle to expand outpatient prescribed drug coverage for lower-income elderly persons,[17] still further evidence of Medicaid's role in accommodating national priorities that do not lend themselves easily to a commercial insurance market. Thus, while in certain respects Medicaid resembles conventional insurance, in fact, in its structure it extends far beyond commercial bounds, thereby according states the power to address complex health policy problems that require unique interventions.

Figure 1, which displays Medicaid enrollment and expenditures, suggests that rather than thinking of Medicaid as a single program, it is more useful in a public policy context to approach the program as a legislative "vessel" holding several distinct and very large population groups.[18]

Families with Children

The first component of this legislative vessel is a

[11] Robert and Rosemary Stevens. *Welfare Medicine in America.* New York: Basic Books, 1975; Paul Starr. *The Social Transformation of American Medicine.* New York: Basic Books, 1982.

[12] Ellen O'Brien and Judy Feder. *Employment-Based Health Insurance Coverage and Its Decline: The Growing Plight of Low Wage Workers.* Washington: Kaiser Commission on Medicaid and the Uninsured, 1999.

[13] Sara Rosenbaum and Kathleen Maloy. "The Law of Unintended Consequences: The 1996 Personal Responsibility and Work Opportunity Reconciliation Act and its Impact on Medicaid for Families with Children." *Ohio State Law Journal 60:* 1423–78.

[14] The State Children's Health Insurance Program 42 U.S.C. §1397. See Pernice, K. Wysen, T. Riley, N. Kaye. *Charting CHIP: Report of the Second National Survey of the State Children's Health Insurance Program.* Portland, ME: NASHP, 2001. http://www.nashp.org.

[15] In 2001, the Bush administration announced the Health Insurance Flexibility and Accountability Demonstration, which permits states to use program savings to expand coverage to the uninsured, encouraging coordination with the private sector. But states have been hard-pressed to secure funds for such expansions and have found that the federal rules related to using Medicaid to purchase employer-sponsored insurance are difficult to implement.

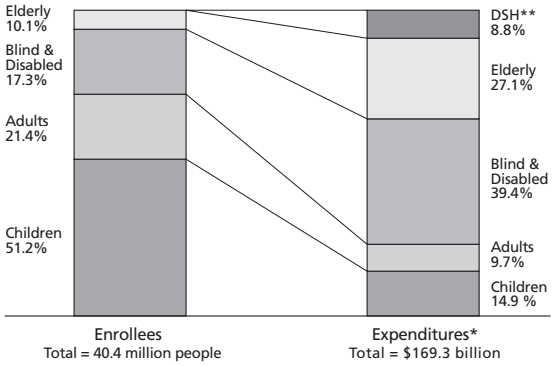
[16] Health Policy Report: Medicaid, op cit., note 9.

[17] The Budget of the United States, 2002. http://www.omb.gov

[18] "Health Policy Report: Medicaid op. cit., note 9.

FIGURE 1

Medicaid Enrollees and Expenditures, by Enrollment Group, 1998



*Total expenditures exclude administrative expenses.

**Disproportionate Share Hospital payments.

Source: Kaiser Commission on Medicaid and the Uninsured. "The Medicaid Program at a Glance." *Medicaid Facts,* Jan. 2001, www.kff.org/content/2001/2004b/2004b.pdf.

mechanism for providing health insurance to low-income, working-age individuals and their family members. In fact, however, spending on "acute care services" for individuals who fall into this general description (for example, families headed by non-disabled parents and other caretaker relatives and their children, poverty-level children, and pregnant women) amounts to a small portion of total program spending. Figure 2 shows that in 1998, acute care spending for mandatory and optional coverage groups made up of non-disabled adults and children, amounted to slightly less than 25 percent of total program spending.

The Elderly and Adults with Disabilities

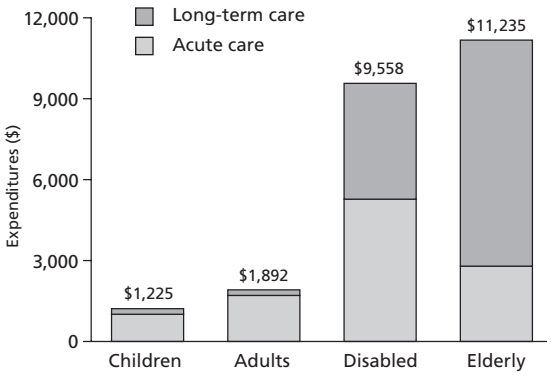
Medicaid's second and third coverage components focus on groups and services that lie almost completely outside the commercial health insurance markets: the program funds both acute and long-term care services for persons with disabilities and the elderly poor, two groups with virtually no access to private health insurance, whose needs place them outside of any market that most private health insurers would seek to develop. Figure 1 shows that in 1998, less than 28 percent of all Medicaid enrollees were elderly or persons with disabilities, but expenditures on these populations amounted to more than two-thirds of total program spending.

Figure 2 underscores that significant levels of acute care spending occur for elderly individuals and persons with disabilities. It also shows that the per capita rate of acute care spending on these two groups vastly exceeds per capita spending levels for non-disabled children and adults who more closely approximate covered individuals in the commercial market. In other words, were persons with disabilities and the elderly to be covered in the commercial market and only for a standard commercial package, their resource demands would far surpass standard actuarial norms.

An important consideration in Medicaid is the health status of its beneficiaries. In isolation, expenditures on persons with disabilities appear to consume about 40 percent of the program, as Figure 1 indicates. But this figure understates Medicaid spending on persons with chronic illness and disabilities, since the proportion of children and adults with chronic illness and disability who are enrolled in Medicaid far exceeds the percentage who technically gain eligibility based on a formal finding of disability. For example, it has been estimated that only 14 percent of children enrolled in Medicaid who

FIGURE 2

Medicaid Expenditures per Enrollee, by Acute and Long-term Care, 1998



Source: Kaiser Commission on Medicaid and the Uninsured. "Medicaid Role for the Disabled Population Under Age 65." *Medicaid Facts,* April 2001, www.kff.org/content/2001/2171/2171.pdf.

have a chronic illness or disability enrolled in the program on the basis of a formal disability determination; the overwhelming majority receive Medicaid based on their status as "poverty-level" or "AFDC-related" children.[19] Medicaid's role for elderly and disabled Medicare beneficiaries is similarly unique. Medicaid not only pays premiums, deductibles, and coinsurance for low-income Medicare beneficiaries, but, in the case of the poorest beneficiaries, supplements Medicare's coverage with additional coverage for services that are basic but omitted from Medicare, most notably prescribed outpatient drugs and long-term care services.

Children (and Some Adults) with Special Needs

Medicaid's fourth component—and the one that is the least well studied or understood—is the program's role as the principal funder of medical care services for individuals (typically children) who may or may not have standard insurance but who are at high medical risk and who are receiving a blend of medical and social services through other systems of care. Most of these population groups are distinguished by health status factors that an individual private market would consider uninsurable: severe pre-existing physical and mental health conditions, permanent disability or impairment, age, institutional status, and other characteristics that would virtually exclude them from the individual insurance market.[20] Not only do their health conditions place them beyond the limits of conventional coverage, but their service needs extend beyond the range and scope of benefits found in a conventional insurance plan.

In any state, there may be numerous companion health and health-related systems of care that coexist with Medicaid. Examples are state child welfare systems, medical and aftercare programs for children with special health care needs, school health programs, mental health and developmental disabilities programs for children and adults, special education and early intervention programs, state juvenile justice programs, state public health agency-operated programs designed to address and control public health threats such as the transmission of disease or the treatment of lead exposure in children, and programs for the frail elderly. The children and adults who receive medical care and clinical case management services through these other systems are disproportionately poor and Medicaid-dependent. All of these programs have an obligation to address not only the social/educational but also the medical needs of clients and patients, yet their funding for necessary medical care is either very low in relation to need or virtually non-existent (for example, the federal special education program bars states from using funds to pay for necessary medical care, provoking a demand at the state level for Medicaid support).

As a result, Medicaid is the primary means by which states finance and carry out these other essential health and health-related services. Even in states in which managed care enrollment is extensive, these services typically are "carved out" of state managed care contracts and remain under the direct administrative control of state Medicaid programs and other state agencies.[21] These expenditures show up in aggregate national data on medical assistance expenditures, but, given the structure of the Medicaid expenditure reporting system and the absence of specialized studies, it is impossible to accurately disaggregate these special expenditures from the broader program spending data. Recent negotiated federal/state settlements in the hundreds of millions of dollars for Medicaid payments related to medical care for children in special education is a fair indicator of just how essential Medicaid is to a range of medical and health-related social welfare programs.[22]

Benefits Covered for These Population Groups

While Medicaid creates enforceable rights and bene-

[19] Ibid., p. 637; Center for Health Care Strategies. *The Faces of Medicaid.* Princeton, NJ, 2000. http://www.chcs.org

[20] Karen Pollitz, Richard Sorian, and Kathy Thomas. *How Accessible Is Individual Health Insurance for Consumers in Less than Perfect Health?* Washington: Georgetown University Institute for Health Care Research and Policy, 2001.

[21] Sara Rosenbaum et al. *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracting.* Washington: George Washington University Medical Center, 2000. The full study can be viewed at http://www.gwhealthpolicy.org.

[22] Kaiser Daily Health Reports (May 22, 2002).

fits that resemble those found in private insurance policies, in certain fundamental respects Medicaid coverage design rules and options are unlike private plans. Indeed, not only in whom it covers but what it pays for, Medicaid is the antithesis of private insurance in both theory and operation.

Private insurance benefits are structured to impose strict contractual limits on what is considered medical care and the circumstances under which benefits will be covered and paid.[23] Even in employment-based insurance, pre-existing condition limitations and waiting periods are common.[24] Benefit plans are structured for a population of workers and family members without serious underlying health conditions, with an emphasis on preventive and acute services and just enough institutional and home care to permit an otherwise healthy person to "recover" to "normal function." Within the typically modest constraints of state insurance law and federal laws governing employee health benefit plans, insurers and issuers have discretion to design limited coverage plans, restricting or excluding otherwise available coverage by condition (for example, less coverage for mental illness, lower lifetime coverage limits for persons with human immunodeficiency virus [HIV]).[25]

Insurers and health plans also have the flexibility to adopt restrictive definitions of when otherwise covered benefits will be considered medically necessary, by building in limitations based on whether a service or intervention will allow an individual to "recover" lost functioning. This type of definition effectively excludes coverage when the individual who requires it needs the benefit to prevent deterioration, maintain functioning, or "recover" to levels that might be expected in a person with a disability rather than an individual with no underlying health conditions.[26] Finally, in private insurance, cost sharing can be considerable and lifetime payment rules restrictive.

Medicaid operates under highly different rules, even as it maintains a basic medical necessity test. The Medicaid program provides federal funds to states to offset the cost of "medical assistance" furnished to eligible persons by qualified providers. However, the term, "medical assistance," only superficially resembles a conventional insurance benefit plan. It includes such services as long-term institutional care; long-term case management; personal attendant services; long-term rehabilitation and habilitation services; special medical, personal, and environmental services and supports needed to maintain severely disabled children and adults in their homes; and other services not typically found in private insurance plans. States have considerable flexibility in benefit design and, indeed, more than two-thirds of all state Medicaid spending can be attributed to optional services.[27] At the same time, certain classes of benefits (including nursing home and home health benefits) are mandatory,[28] and in the case of children under age 21, mandatory coverage includes the full range of federally defined medical assistance services.[29]

Federal law also sets certain limits on states' discretion over terms such as medical necessity; a preventive standard of coverage is required in the case of children.[30] Pre-existing condition exclusions and waiting periods are not allowed. Furthermore, feder-

[23] Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum. *Law and the American Health Care System.* (New York: Foundation Press, 1997); 2001–02 update.

[24] The Health Insurance Portability and Accountability Act (HIPAA) limited but by no means prohibited the use of waiting periods and pre-existing condition limitations.

[25] The Employee Retirement Income Security Act (ERISA) gives employers near total discretion over health plan benefit design. Subsequent laws have limited this discretion only in the most modest ways. The Mental Health Parity Act of 1996 (which expired in 2001) prohibited only annual and lifetime dollar caps on mental health benefits but permitted ongoing coverage limits stated in terms of defined benefits. Furthermore, to the extent Congress anticipated that diagnostic-based discrimination would no longer exist following enactment of Title I of the Americans with Disabilities Act (which prohibits discrimination against persons with disabilities in employment or employment-related benefits), this expectation has not been borne out; courts have ruled virtually uniformly that diagnostic-based limits are lawful as long as they are applied uniformly to all covered individuals; Law and the American Health Care System, op cit., note 25.

[26] Law and the American Health Care System, op. cit., note 25.

[27] Kaiser Commission on Medicaid and the Uninsured. *Summary of Mandatory and Optional Services,* 2001. http://www.kff.org/medicaid.

[28] 42 U.S.C. §§1396a(a)(10)(A) and 1396d(a) (2002).

[29] 42 U.S.C. §§1396a(a)(10)(A), 1396d(a), and 1396d(r) (2002).

[30] For additional information on coverage standards for children, see Sara Rosenbaum and Colleen Sonosky. *Federal EPSDT Coverage Policy,* December 2000. http://www.gwhealthpolicy.org/downloads/epsdt_execsum.pdf

al "amount, duration, and scope" standards require that state coverage levels meet certain tests of reasonableness and prohibit state programs (at least in the case of required services) from discriminating on the basis of particular conditions).[31]

Certain types of exclusions typically found in insurance contracts, such as "educational" or "social" exclusions in the case of medical care furnished to children in school or foster care, are not permitted in Medicaid. For example, private insurance typically excludes "educational" services (that is, otherwise covered medical care that is furnished during the school day as part of a special education plan); federal Medicaid law specifically prohibits this type of exclusion.[32] Finally, even where permitted, cost sharing is circumscribed to nominal levels as a matter of federal law, in view of the financial situation of the eligible population.[33]

State Medicaid agencies also have flexibility over compensation methodologies and payment rates. Federal law sets certain substantive compensation standards in the case of federally qualified health centers and rural health clinics and for payments to state- and county-operated health care providers. Federal law also requires certain payment adjustments in the case of managed care organizations and disproportionate share hospitals and establishes certain procedural requirements in the case of rate setting for nursing home and hospital payments. But the level of federal incursion into Medicaid payment standards and methodologies is relatively modest.

Beyond these requirements, state agencies are free to devise payment methodologies and rates that meet the needs of their providers. For example, a state can use a reasonable cost payment methodology in the case of public hospitals, health department clinics, and other public providers, thereby ensuring that these providers (and thus the public agencies or entities of which they are a part) are compensated at favorable rates that reflect the full reasonable cost of care to the Medicaid population. Budget pressures constrain states in their ability to invest through Medicaid. Faced with difficult choices in times of budget austerity to eliminate or restrict eligible populations, reduce services, or restrict provider payments, states have placed limits on provider reimbursement. A recent report shows only eight states paid average Medicaid provider fees equal to or above Medicare rates; the remainder paid less than Medicare, ranging from 41 percent to 127 percent of Medicaid rates.[34]

Program Administration

States have considerable flexibility in how they administer their programs. They can elect to administer their programs on a traditional fee-for-service basis or through the use of limited or comprehensive managed care arrangements, including primary care case management systems and networks of preferred institutional and specialty providers overseen by a state agency as well as full-service managed care organizations furnishing both general and specialized care.

As of 2001, all states used some form of managed care. Over the past decade, state Medicaid programs have become extremely sophisticated purchasers of managed care services, buying coverage through managed care products for both non-disabled and disabled beneficiaries.[35] States' managed care purchasing practices span a broad range of approaches, including buy-ins to employer-sponsored plans and the direct purchase of managed care products through individual enrollment of children and adults enrolled in Medicaid and S-CHIP.

However, to equate this trend toward use of managed care with what is actually covered under state Medicaid programs would be misleading.

[31] This type of discrimination (that is, singling out certain conditions such as AIDS or mental illness for lesser treatment) is common in conventional insurance. See Law and the American Health Care System, op cit., note 25., chap. 2F.

[32] 42 U.S.C. §1396b(e) (2002).

[33] In fact, cost sharing can be considerable for medically needy persons who "spend down" to eligibility levels by incurring high medical expenses. Even with special spousal impoverishment rules enacted under the Nursing Home Reform Act of 1987, the protected income and assets of families with medically needy persons are relatively modest.

[34] "Comparing Physician and Dentist Fees Among Medicaid Programs." The Lewin Group, Medi-Cal Policy Institute, June 2001. http://www.medi.cal.org.

[35] Negotiating the New Health System, op cit., note 22.

Despite the fact that all state programs now buy private health insurance and managed care products to some degree, these arrangements continue to be supplemented by services and benefits covered under state Medicaid plans but extending beyond the outer limits of insurance. Some states have begun to experiment with more organized approaches to this supplementation through articulation of carefully defined "wraparound" plans for both Medicaid- and S-CHIP-enrolled children as well as disabled adult workers.

Part III. Medicaid's Multiple Roles in Operation: The Case of Rhode Island

Perhaps the best way to understand the Medicaid program in operation is through the example of a single state, Rhode Island. It is important, however, to recognize the considerable variability among states. Over the years, Rhode Island has become known as an innovator in Medicaid through its broad efforts to insure lower-income families and workers with disabilities and because of the breadth of its programs for children and adults with physical and mental disabilities and the frail elderly. In this regard, Rhode Island offers a particularly pronounced example (and one that cannot be said to be indicative of all states) of what a state can do in Medicaid, by both exercising of coverage and financing options and using federal demonstration authority.

At the same time, Rhode Island is an exemplary model of what state Medicaid programs throughout the country do in their efforts to shape their coverage and activities to meet multiple responsibilities related to the health care needs of the entire population, both those who need Medicaid as a form of basic insurance and those who require the more complex and long-term services that only Medicaid ensures.

Rhode Island's annual Medicaid report presents a clear picture of the program's reach and importance.[36] In FY 2000, Rhode Island's Medicaid program covered 14 percent of all state residents, a higher proportion than all but 14 states. As of 2000, the state's total uninsured population stood at 6 percent, the lowest in the nation.[37] Much of this progress can be attributed to Medicaid reforms. The state's total average monthly caseload approached 150,000 persons, with considerable growth between 1999 and 2000, even in the face of a strong economy.

But as is true generally, the proportion of Medicaid spending devoted to creating public insurance alternatives for working families without access to employer-sponsored arrangements accounts for only a small proportion of overall program activities. The qualities that make Medicaid unique show up in Rhode Island's special initiatives aimed at uninsurable persons and services. Adults with disabilities and the elderly made up 26 percent of enrollees but accounted for 69 percent of total program spending; children with special health needs and children in sponsored foster care accounted for 9 percent of the total caseload and 13 percent of total expenditures. Thus, Medicaid spending on health coverage for working-age adults and their children accounted for only a small part of the state's overall program.

Even a cursory examination of the initiatives described in the state's annual Medicaid report, supplemented by discussions with state Medicaid officials,[38] underscores the range of activities in which Medicaid is involved. Indeed, Rhode Island Medicaid officials estimate that some 40 percent of total program spending is tied to initiatives for special populations undertaken in collaboration with other public agencies responsible for the care and management of certain populations:

- Medicaid collaborates with the state's agencies on aging and disabilities to develop and support an expanded assisted living network, including homemaker services; personal care and case management services; and other services and supports aimed at populations with serious activity limitations.
- Medicaid offers special insurance and health

[36] http://www.dhs.state.ri.us/dhs/reports/ma2000.

[37] Kaiser Family Foundation State Health Facts Online. *Population Distribution by Insurance Status 1999–2000.* http://www.kff.org (accessed June 21, 2002).

[38] Interview with Tricia Leddy, Administrator, Center for Child and Family Health, Rhode Island Department of Human Services), February 13, 2002.

support programs for individuals making the welfare-to-work transition as well as adults with disabilities who are transitioning into the workforce and who will need continuous access to comprehensive public insurance during employment.

• Medicaid funds expanded case management services for high-risk pregnant women, including home visiting, intensive therapies, and comprehensive preventive services.

• Medicaid is involved in health promotion activities such as school-based lead screening and treatment programs.

• Medicaid is the principal source of funding for children and adolescents with special health needs, such as juvenile drug court treatment programs, special "CEDARR" family centers for families with special needs children, and special services for children in foster care.

In collaboration with Rhode Island's Department of Mental Health, Retardation and Hospitals, the state Medicaid program supports a full continuum of services for enrollees, beginning with detoxification and complemented by rehabilitative support services. The program funds comprehensive treatment and rehabilitation services for enrolled adults with mental illness, including—but not limited to—counseling and therapy, crisis intervention, residential services, multi-disciplinary treatment planning, and assertive community treatment.

As a result of the landmark U. S. Supreme Court decision in *Olmstead v L.C.*[39], the state has expanded its institutional and community placement services and is one of the few states without a waiting list for community-based waiver placements.

Special programs have been created for persons suffering from traumatic brain injury and those with multiple sclerosis and other long-term physical disabilities.

The state financed health care for some 5,500 children in foster care and special adoption placements; for children in foster care, behavioral health represented 86 percent of total per child per month expenditures, underscoring the unusual nature of health care for special needs children.

The state's "Ticket to Work and Rhode to Independence" program, funded by both Medicaid and special grants, furnished employment assistance, case management, and Medicaid "buy-in" programs for employed persons with disabilities.

Part IV. Issues Reformers Must Address

This paper has examined Medicaid's role in the American health care system from the perspective of states' overall role in the financing and provision of health services for their populations. Originally, Medicaid was structured to reach only populations such as women and children on welfare, persons with profound disabilities, and the elderly, who fell outside the workforce with its presumed access to employer-sponsored coverage. State Medicaid activities were aimed exclusively at these populations, although even in Medicaid's earliest days, several states used their own funds to cover their poorest workers.

As evidence mounted regarding the weakness of the employment-based health insurance system (particularly related to coverage of workers with chronic illness and disabilities), a series of congressional amendments to Medicaid made it possible for and sometimes required states to significantly expand covered populations and services and to experiment with alternative delivery systems. Over the years, states have taken significant advantage of these options, particularly in the case of children.

The heightened attention focused on some states' efforts to manipulate federal financial arrangements to maximum funding advantage has tended to obscure Medicaid's essential role in helping states to meet their essential health care obligations to low-income, vulnerable, and special needs populations. Over the decades, Medicaid has permitted states to fundamentally reconceptualize their role in American health care. The state vision of Medicaid today spans both health insurance for lower-income families and long-term care and services to promote community integration and support children and adults with disabilities and special needs. Finally, many states tend to define as part of their Medicaid-

[39] 119 S. Ct. 2176 (1999); see also Health Policy Report: Medicaid, op. cit., note 9.

financed mission an obligation to maintain an essential health care infrastructure of clinics, inpatient facilities, and special-purpose services and programs, ranging from community mental health services to school-based clinics and adult day treatment facilities.

In reconceptualizing their health roles, states also have modernized their thinking about how to approach the task. For example, in furthering access to health insurance for working families, many states have sought to build their initiatives around the public purchase of private coverage, either through subsidizing enrollment in employer-sponsored health plans where available or, more commonly, sponsoring beneficiaries in privately administered managed care arrangements. Thus, to the extent that reform advocates emphasize use of premium support systems and greater reliance on private insurance arrangements, it is fair to say that state Medicaid programs have pursued these goals steadily over the years.

But this paper also documents Medicaid's numerous other roles, all of which pertain to the responsibility of state governments to provide health care for persons who, by virtue of their health status and need for services, lie beyond the farthest reaches of even a strong private market. Indeed, in many respects, Medicaid makes a vibrant private market possible precisely because it offers a means of coverage for millions of persons with disabilities and chronic illness who otherwise would have no coverage or would obtain insurance only through heavy market regulation and at considerable expense.

The data presented in this paper suggest that most Medicaid expenditures are for services and populations tied to the program's unique role as a form of health insurance that departs from commercial insurance principles and norms. While reforms for working families have been notable, their overall impact on total Medicaid spending has been modest: most Medicaid expenditures are tied to the program's historic mission of supporting persons with disabilities, the elderly, and the health service obligations of public agencies generally. These costs are high, rise at a significantly greater rate than the general rate of inflation, and would be untenable in terms of state budgeting in the absence of Medicaid. As the Urban Institute study suggests, Medicaid is the single most important source of state revenue and expenditure growth.

Any federal health care reform proposals must therefore take into serious consideration the consequences of such reform on Medicaid and state financial health. This issue of how to ensure that states can continue their basic role in shaping health care for all populations is central to national health reform and cannot be dismissed through a single-minded focus on debates over whether states are getting more than their so-called fair share of federal financial contributions.

Because the Medicaid program is most certainly not a single, monolithic health care financing mechanism, any proposals to reform it or to make it part of a larger national reform must carefully consider the breadth and depth of Medicaid's financing and service delivery, which varies by state and by community. Any reform proposal addressing Medicaid must be able to answer four questions:

1. Will the open-ended nature of the federal financing system continue as long as states make reasonable investments in their programs? In light of overall financial constraints in state governments and the impact of these financial realities on states' abilities to invest, is it time to recalibrate the federal contribution level, with special incentives built into federal financial arrangements for state investments that further national policies such as de-institutionalization and community integration, investments in working families, use of employer-sponsored arrangements when available, and positive utilization controls that promote efficiency without adversely affecting necessary health care access among low-income persons?

2. How will the proposal affect the trend toward increasing state-federal investment in the health care infrastructure designed to support uninsured and non-eligible populations as well as Medicaid eligibles?

3. How will the proposal affect the extensive use of Medicaid funds to support a variety of state and local direct care and administrative functions outside of the single state agency?

4. How will the proposal affect populations and services that fall outside conventional insurance products? Does the proposal address how each of the four major population groups, and the services provided through Medicaid for them, will be handled?

- Families with children
- Adults with disabilities
  - Those disabled before age 21
  - Those disabled after age 21
- The elderly
- Children with special health care needs

The Future of Health Care Reform and Medicaid

In theory, it might be possible to untangle Medicaid and alter a series of other federal programs to permit the types of expenditures that Medicaid now supports. Special education and early child development laws could be re-drafted to include health spending authority and guaranteed funding. Programs to aid persons with mental illness and developmental disabilities and the frail elderly could be dramatically expanded. The Medicare program could be restructured to improve coverage of workers with disabilities who otherwise would lose assistance when they return to the workforce. Medicare also could be expanded to cover prescriptions and long-term care services. Separate insurance programs could be established for persons with HIV, women with breast and cervical cancer, and persons with tuberculosis. A special federal safety net enhancement program could be created. For each proposal, state and federal financing responsibilities and formulas must be outlined.

Medicaid has evolved into one of our most important health care programs at both the state and federal level. It is not a stagnant program: a host of federal legislative and regulatory reforms and initiatives over the years have dramatically expanded the program's importance to people, health care providers, and state governments. Program variability among states has increased to a point where Medicaid is a radically different program in every state, meeting state-defined needs within expenditure levels states may be willing and able to commit to. How this complex and complicated program can be made more efficient to face changing health policy priorities remains an open question. Its size and rapid growth suggest that the time for a reform that balances state, federal, consumer, and provider interests is upon us—and it is a task that requires a full understanding of Medicaid's many roles and complex financing to assure success. Whether federal and state policy makers have the vision and political will to come together around a common vision for what Medicaid needs to be in the 21st century is one of the great "unknowns" in national health reform. ■

Ferguson, Riley, and Rosenbaum

Commentary Abstract

Christine Ferguson, **Patricia Riley**, and **Sara Rosenbaum** argue that reformers who would replace or significantly change the structure of Medicaid need to understand and consider carefully the crucial roles that Medicaid plays in state government. Failure to do so could jeopardize key activities of state government and leave many people without social services that are vital to their well-being.

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CHRISTINE C. FERGUSON has served in the highest levels of state and federal government with honor and distinction for more than two decades. As the Director of Human Services in the State of Rhode Island from 1995 to 2001, Ms. Ferguson managed the largest agency in the state as an appointee of Governor Lincoln Almond. She oversaw nearly one-third of the state's annual budget, providing critical programs for veterans, senior citizens, low-income families, children, and the disabled. As a result of her innovative and progressive approach, Ms. Ferguson has been applauded as a national leader in human services policy. Prior to serving in Governor Almond's cabinet, Ms. Ferguson was counsel and deputy chief of staff to the late U.S. Senator John H. Chafee. She spent a total of 13 years working for the Senator, eventually managing his entire legislative agenda from defense budget priorities to health care.

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