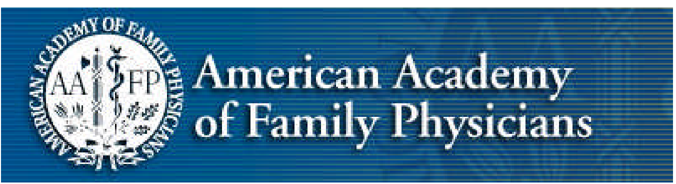

MEDICAID: Overview and Policy Issues

Tim M. Henderson, Consultant
Stephen Wilhide, Consultant

Background

- Congress enacted Title XIX of the Social Security Act in 1965 to establish a voluntary federal-state health care program known as Medicaid. The Medicaid program allows states "to furnish rehabilitation and other services to help such families and individuals attain or retain capability for independence or self care. The Act also requires that each state medical assistance program be administered in the "best interests of the recipients."
- Medicaid provides an entitlement to medically necessary health care for 42 million low-income and elderly individuals, families, and to certain people with disabilities. Children and youth make up nearly one-half of all Medicaid beneficiaries; people with disabilities are about one-fifth of the total Medicaid population. Medicaid is the largest program providing medical and health-related services to America's poorest people.
- Since 1996, Medicaid is no longer linked to welfare. As many as three fourths of all persons enrolled in Medicaid are not receiving any cash (welfare) assistance.
- Medicaid is a federal-state partnership insofar as Medicaid is authorized under federal law and is administered by each state. Federal funding is available to state Medicaid programs for the provision of health care services and various administrative functions. The amount of federal funding available to a state is referred to as federal financial participation (FFP) and is determined by comparing a state's per capita income to the national average. The FFP for any state will range from 50 - 83%, depending on this per capita income formula.
- Although each state is responsible for the operation of its Medicaid program, the Center for Medicare and Medicaid Services (CMS) is the federal agency charged with administrative oversight of all Medicaid programs. CMS promulgates regulations, develops policy, and guides states in the operation of their Medicaid programs, including the approval of each state plan, all state applications for Medicaid waivers, and any amendments to either the plan or to waiver programs.

Health Care Delivery

The Medicaid Act identifies numerous categories of medical services for which federal reimbursement is allowed. However, these broad categories of services do not describe specific medical treatments or procedures. Given the breadth of these categories, a specific medical treatment or health care service may fall within more than one category of service. These categories of service are classified as either mandatory or optional services.

Mandatory Services. States are required to cover 14 categories of services defined in federal regulations, including:

- Inpatient hospital care
- Prenatal care
- Outpatient hospital care
- Family planning services
- Physician services
- Nursing facility services for persons over age 21
  Nurse midwife services
- Home health care services for persons over age 21
- Pediatric and family nurse practitioner services
- Early and periodic screening, diagnosis and treatment for persons under age 21 (EPSDT)

- Federally qualified health center ("FQHC") services
- Laboratories and x-ray services
- Vaccines for children
- Rural health clinic services
- Transportation

Optional Services. In addition to the required services that each Medicaid program must provide, a state may choose from among thirty-four optional services to include in its state plan. The optional services authorized by the Medicaid Act include those listed below. Since 1989, Medicaid's EPSDT program has required states to cover all medically necessary services, including both mandatory and optional services, for Medicaid eligible children under the age of 21.

- Case management services
- Chiropractic services
- Clinic services
- Dental services
- Dentures
- Diagnostic services
- Emergency hospital services
- Home and community-based services for individuals with disabilities and chronic medical conditions
- Hospice care
- Inpatient psychiatric services for persons
- under age 22
- Intermediate care facility services
- Intermediate care facility services for persons
- with MR/DD and related conditions
- Nursing facility services for persons under
- age 21
- Occupational therapy
- Optometrists' services and eyeglasses
- PACE - Program for All-Inclusive Care for the Elderly
- Personal care services
- Physical therapy
- Podiatrists' services
- Prescribed drugs
- Preventive services
- Private duty nurses
- Prosthetic devices
- Rehabilitative services
- Respiratory care services
- Screening services
- Services for persons age 65 or older in mental institutions
- Speech, hearing and language therapy

Over half of all Medicaid beneficiaries are enrolled in managed care organizations rather than fee-for-service programs. Nearly all states have some Medicaid managed care programs. Major Medicaid managed care models include:

- **Risk-Based Plans.** A health plan is paid a fixed monthly fee per enrollee and assumes the financial risk for the delivery of a specified package of services.
- **Fee-for-Service Primary Care Case Management (PCCM).** In a PCCM plan, a provider (usually the patient's primary care physician), is responsible for acting as a "gatekeeper" to approve and monitor the provision of services to beneficiaries. These gatekeepers do not assume financial risk for the provision of services and are paid a per-patient monthly case management fee.

Program Administration

State Plan
Each state must develop a state plan that describes Medicaid program administration, eligibility categories, and services provided. The plan must identify the required and optional health care services available through Medicaid. It also must describe how beneficiaries and advocates can review and obtain copies of all current policies and rules governing program operation.

Advisory Committee
The state plan must also establish a medical care advisory committee to participate in both policy development and program administration by the state agency. Testifying before the medical care advisory committee can be an effective way for state AAFP chapters to challenge proposed rules or policies.

Program Eligibility
Medicaid covers only those people who fit within special categories and who meet the program's stringent income and resource eligibility requirements. Examples of these categories include:

- **Low-income pregnant women and children through age 18** may be eligible for Medicaid. The minimum income guideline for pregnant women and children under the age of 6 is 133% of the federal poverty guideline. Children ages 6 through 18 are eligible if their family incomes do not exceed 100% of the federal poverty guideline. States may increase the income level of eligibility upon CMS approval.
- **Low-income parents and other caretakers of children** may qualify for Medicaid.
- **People who receive SSI because of disability or because they are 65 years of age or older** are automatically eligible for Medicaid in thirty-nine states. Eleven states (Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, Oklahoma, and Virginia are known as 209(b) states) each sets its own eligibility criteria for Medicaid. Individuals who meet the level of care requirement for nursing home care and whose incomes do not exceed 300% of the SSI benefit amount may be eligible for Medicaid nursing home services or Home and Community-Based Waiver Services.
- **Children in foster care** identified under Title IV-E of the Social Security Act and certain recipients of adoption assistance programs are also eligible for Medicaid. In addition, youth between the ages of 18 and 21 who were in foster care may be eligible for Medicaid through the Foster Care Independence Act of 1999.
- **Medicare beneficiaries** with low incomes and limited resources may be eligible to receive full Medicaid benefits. Other Medicare beneficiaries whose income exceeds the level for full Medicaid eligibility may be eligible to receive limited Medicaid benefits to cover some Medicare cost-sharing expenses such as premiums, deductibles, and coinsurance. These individuals are commonly referred to as the "dual eligibles."
- **Medically Needy individuals** who have income or resources above the required limits set by their state, but who have incurred or paid sufficient medical expenses to allow them to meet the "spend down" test, are Medicaid-eligible.

States Must Assure That Children Receive EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Services
EPSDT requires states to assess a child's health needs through initial and periodic examinations and evaluations to assure that health problems are diagnosed and treated before the problem becomes more complex and the treatment more costly. States must perform medical, vision, hearing, and dental check-ups according to standardized schedules, called a "periodicity schedule."
By statute, states must consult with recognized medical organizations to determine the appropriate scheduling to ensure timely EPSDT treatment, generally within an outer limit of six months after the request for screening services.

- The state must seek out eligible children and their families, inform them of the benefits of prevention and the health services and assistance available, and help them use health services rather than merely offer to cover services.
- EPSDT covers all medically necessary services. The Medicaid Act's definition of medical necessity for EPSDT is much broader than that used by private insurance. Under EPSDT, state Medicaid programs must cover "necessary health care, diagnostic services, treatment and other measures...to correct or ameliorate defects and physical and mental illnesses and conditions. Services must be covered if they correct, compensate for, or improve a condition, or prevent a condition from worsening even if the condition cannot be prevented or cured. States may place "tentative" limits on EPSDT services (e.g., 14 days of hospital care). However, the state must have an expeditious process in place to allow children to obtain treatment services beyond the tentative limits. The only absolute limit that may be placed on EPSDT services is that based upon medical necessity.

State-wideness
A state plan for medical assistance "shall be in effect in all political subdivisions of the state." States cannot limit health care services available under the state plan to a specific geographic location or simply fail to provide a covered service in a particular area. To comply with this requirement, state Medicaid programs must provide all medically necessary health care services available under the state plan without regard to the county of residence of the beneficiary who is seeking health care services.

Comparability of Services
The comparability requirement provides that medical assistance available to any eligible individual "shall not be less in amount, duration, or scope than the medical assistance made available to any other individual. This requirement ensures equity of health care in two ways. First, it assures that the services provided to individuals who are categorically eligible for Medicaid are comparable to those provided to the medically needy. Second, it also ensures that services are comparable among individuals within the group of beneficiaries who are categorically eligible for Medicaid.

Limits on Medications
Medicaid permits states to exclude certain drugs such as fertility drugs, barbiturates, benzodiazepines, and nonprescription drugs.

Durable Medical Equipment (DME)
States may use DME formularies as an administrative convenience, but the state must provide a reasonable and meaningful procedure for requesting items that do not appear on a State's approved list.

Reasonable Standards
According to the Medicaid Act, "[a] State plan for medical assistance must...include reasonable standards...for determining eligibility for and the extent of medical assistance under the plan which...is consistent with the objectives of this [Act]." Many courts applying this standard have concluded that states cannot exclude medically necessary services from coverage when this exclusion would result in a denial of all treatment for a particular medical condition.
Exclusions of treatment from coverage based upon non-medical criteria violate the reasonable standards requirement of the Medicaid Act.

Medical Necessity
All Medicaid-funded services must be medically necessary. Medical necessity is not defined in the Medicaid Act; however, state law and regulation often define the term. While the wording of these definitions may differ from state to state, numerous courts have concluded that the determination of what treatment is medically necessary must be consistent with accepted standards of medical practice and must be made by the beneficiary's treating physician.
The importance of the treating physician or other health care professionals in determining what treatment is medically necessary is clear from the legislative history of the Medicaid Act. Relying upon this legislative history, numerous courts have emphasized that State procedures that interfere with a treating physician's professional judgment concerning medically necessary treatment violate the Medicaid Act.

Home and Community-Based Waiver (HCBW) Services
Section 1915 (c) of the Social Security Act enables states to request a waiver of certain federal Medicaid requirements to provide enhanced community support services to those beneficiaries who would otherwise require institutional care. These HCBW programs can be used to fund services not otherwise authorized by the federal Medicaid statute, such as respite care, home modifications, and non-medical transportation. Waiver programs can also be used to provide optional Medicaid services for waiver participants not offered to other adult Medicaid beneficiaries, such as case-management or personal assistance services. The federal regulations contain a list of the types of services states may choose to provide through HCBW programs.

Due Process Protections for Medicaid Beneficiaries
Medicaid agencies must inform applicants and beneficiaries of the right to request a hearing, the method to obtain a hearing, and the ability to be represented by an attorney or other representative. A fair hearing must be available to any individual whose application is denied or is not acted upon in a reasonably prompt manner. A hearing is also available when a state Medicaid agency seeks to deny, terminate, or suspend services.

SCHIP
The State Children's Health Insurance Program (SCHIP) was enacted in 1997 to provide a capped amount of federal matching funds to states for coverage of children and some parents with incomes too high to qualify for Medicaid, but for whom private health insurance was either unavailable or unaffordable. Covering roughly 5 million children, SCHIP has played an important role in reducing the number of uninsured children in America. Between 1996 and 2002, the uninsured rate among low-income children dropped from 23% to 19%, largely due to increased in Medicaid and SCHIP coverage.

Income eligibility levels for children in Medicaid and SCHIP have remained relatively stable over recent years. As of July 2004, 38 states and the District of Columbia set their Medicaid and/or SCHIP income eligibility levels for children at or above the 200% of poverty, or $31,340 per year for a family of three. Low-income uninsured children typically live in working households and have little contact with government assistance programs. Uninsured but Medicaid-eligible children are twice as likely as those enrolled in Medicaid to have an unmet medical need, to have not seen a doctor, and to have substantial family out-of-pocket spending on health care. Studies have shown that children's enrollment is facilitated when the whole family can obtain coverage. However, in 34 states, Medicaid income eligibility levels for working parents are below poverty ($15,670 per year for a family of three). Eight states froze enrollment of eligible children, primarily in SCHIP, for at least a portion of the time period between April 2003 and July 2004. The ability to impose enrollment caps in SCHIP enables states to control spending and stay within a budgeted amount, but leaves eligible children without coverage.

As of July 2004, 33 states charged premiums or enrollment fees for children's coverage, typically in SCHIP programs, as states are restricted from charging premiums to children and families in Medicaid unless the state obtains a federal waiver. Sixteen of these states have recently implemented new or increased existing premiums.

Trends and Current Concerns
In 2005, Medicaid program services are being threatened by costs that far exceed the increases in state revenue. Federal budget pressures to slow spending and federal rules that limit states ability to shape and control their programs are also severely impacting Medicaid programs. Budget pressures are forcing Governors to propose budget cuts that would affect all enrollees, including senior citizens, persons with disabilities, pregnant women, children and families. These cuts may also have significant implications for family physicians and other healthcare providers.

Spending

- Medicaid is the country's largest single health program. Medicaid spending of over $300 billion surpasses even the cost of Medicare (estimated to be $290 billion in 2005).
- In just four years, 2001-2004, total Medicaid spending increased by over 50%.
- Medicaid spending accounted for 17 percent of all U.S. health care expenditures in 2003.
- Medicaid paid for 19 percent of the entire prescription drug market in 2003.
- Medicaid payments accounted for 46 percent of all nursing home revenues in 2003. Long term care accounts for 35 percent of all Medicaid spending.
- Fifteen million seniors and persons with disabilities account for most of Medicaid spending. They represent less than 30 percent of enrollees but account for over 70 percent of Medicaid spending.

Medicaid Growth and the Uninsured

- Medicaid enrollment jumped 40 percent in the past five years during the economic downturn.
- Because of Medicaid, the growth in the number of uninsured was not as large as otherwise would have occurred. (Persons on Medicaid are not counted as "uninsured").
- Medicaid growth is occurring due to a loss of jobs that had provided health coverage.
- Rates of employer sponsored health insurance is decreasing.

- Increasing healthcare costs are causing some employers to stop offering insurance or to require employees to pay a larger share which may not be affordable.

Medicaid as Gap Filler for Medicare

- Forty-two percent of all Medicaid expenditures are for individuals who are also on Medicare ("dual eligibles").
- Medicaid pays the Medicare premiums, coinsurance and deductibles.
- Medicaid pays for services not covered by Medicare such as nursing home care and prescription drugs.

Future of Medicaid

- Spending growth for Medicaid will continue at rates far exceeding state revenue growth and continue to place pressure on the ability of states to fund other important spending priorities such as education. Medical inflation has increased on average twice as fast as general inflation.
- Medicaid growth is expected to continue at high rates due to caseload growth and medical inflation; neither of which states control
- Demographic changes will continue to increase Medicaid enrollment of the elderly and disabled. The baby boomers will contribute to an increase in the Medicaid eligible population while better medical care has increased life expectancies for the disabled. These are the most expensive eligibility categories.
- Spending and enrollment in children and family categories are projected to be relatively flat over the next decade.
- Projections are for Medicaid cost growth to far exceed overall state budget growth.

Policy Issues and Options Issues

- **Affordability**. Most states are required to balance their budgets annually. Medicaid spending was eight percent of state budgets in 1985 but increased to 22 percent in 2003.
- **Formula for Federal Matching Funds** is based on average state personal income which changes from year to year and has a significant lag resulting in a potential drop in the federal matching rate when state revenues are declining due to an economic downturn.
- **Medicaid as a Medicare subsidy.** Medicaid has assumed a disproportionate share of costs for Medicare.
- **Rules are outdated.** Eligibility guidelines reflect the rules in effect when Medicaid was linked to welfare cash assistance. States have been prevented from attempts to expand coverage to additional optional eligibility groups without also extending the full benefit package thereby making it difficult for states to extend coverage to the uninsured. Beneficiary cost sharing rules were written in the 1980s and are outdated (e.g., maximum co-payments are limited to $3). States may not consider minimal cost sharing even for optional populations (i.e., persons with incomes above the poverty level).
- **Medicaid could subsidize employer-sponsored health insurance,** but the opportunities that do exist are very cumbersome for states.

Current Trends and Policy Shifts in the Medicaid Marketplace

The President is proposing ten billion dollars in Medicaid cuts over ten years. The governors are concerned the burden will fall to the states at a time when states are experiencing revenue shortfalls with increasing Medicaid costs.

More specifically, the governors have the following concerns:

- The increasing trend of employers to either drop employee health coverage or to increase the employee share whereby lower income employees can not afford to purchase insurance and go on Medicaid. This is especially prevalent with lower wage employees enrolling children in SCHIP due to the more liberal eligibility.
- Increasing drug costs are a major issue for the states and perceived to be an area of greatest potential savings. This issue gets into the definition of "generic" drugs and preferred drug lists (formularies).
- Dual eligibles (Medicare/Medicaid) are driving costs in many states. In Virginia, for example, sixty percent of nursing home residents are covered by Medicaid. Asset transfers occur among older individuals in order to qualify for Medicaid coverage for long term care.
- Ending of intergovernmental transfers that have enabled states to maximize Medicaid dollars.

The governors are proposing or desire:

- "Medicaid reform plus" plans that would diminish Medicaid eligibles through overall healthcare reform that would make health insurance more affordable.
- Greater flexibility overall in the Medicaid program so states could design and operate their programs in the most cost-efficient way without having to go through time consuming waiver processes. More flexibility in benefit packages and eligibility is sought by the states.

On September 1, 2005, the recently created Medicaid Reform Commission released its recommendations to Congress for short-and-long term reforms to the program which the Commission says will reduce Medicaid spending growth by $11 billion over the next five years. Short-term options include:

- Restrict beneficiaries' transfer of assets to qualify for long-term care under Medicaid. *Savings: $1.6 billion over 5 years.*
- Permit states to use the average manufacturer price instead of the average wholesale price to determine payments to drug companies. *Savings: $4.3 billion over five years.*
- Allow Medicaid managed care plans to be involved with the drug manufacturer rebate program. *Savings: $2 billion over 5 years.*
- Expand the number of beneficiaries who are permitted to be charged co-payments and the amount of co-payments for prescription drugs, physician visits and other services. *Savings: $2 billion over 5 years.*

The Commission's next report due December 31,2006 will include recommendations for stabilizing Medicaid over the long term.

Options for Medicaid Reform

- Provide states the option to eliminate categorical eligibility and base eligibility simply on income.
- Allow states to design benefit packages for higher income population groups that might not be as comprehensive as provided for lower income populations.

- Eliminate the need for certain waivers and simplify those that remain. Give states the option to provide home and community based services under regular Medicaid coverage.
- Allow states the flexibility for innovation in services delivery and financing of services.
- Allow states to adopt beneficiary cost sharing based on income and cost sharing in employer-sponsored health insurance plans.
- Allow states to promote preventive care using enhanced reimbursement strategies with providers and care managers.
- Provide incentives for states to design affordable benefit packages that look more like commercial plans, using SCHIP as a model.
- Allow states to coordinate with employer-sponsored health insurance; including supplementing costs when necessary to encourage coverage.
- Amend the Medicare law so the federal government assumes responsibility for low-income Medicare-Medicaid dual eligibles, including full payment of premiums, coinsurance and deductibles for these low income beneficiaries.
- Provide incentives for states to adopt policies that ensure those who can afford to pay for long-term care can do so. Provide incentives for states to encourage greater reliance on long-term care insurance.
- Allow states to offer long-term care services in the most appropriate setting such as care in their home or community, without the need for time-limited waivers.
- Update the formula for calculating the state-specific federal matching rates to be more responsive to economic downturns and to state fiscal capacity.

Table 1
Total Medicaid Enrollment, FY2001

	United States	47,060,700[1]
1	California	8,528,300
2	New York	3,548,600
3	Texas	2,729,600
4	Florida	2,462,200
5	Illinois	1,798,800
6	Ohio	1,660,400
7	Pennsylvania	1,647,500
8	Tennessee	1,603,300
9	Michigan	1,430,200
10	North Carolina	1,375,800
11	Georgia	1,328,400
12	Massachusetts	1,125,600
13	Missouri	1,032,300
14	Washington	1,005,400
15	New Jersey	923,100
16	Louisiana	886,500
17	South Carolina	871,600
18	Indiana	825,500

19	**Arizona**	808,300
20	**Alabama**	780,500
21	**Kentucky**	761,900
22	**Maryland**	704,600
23	**Virginia**	700,600
24	**Mississippi**	681,200
25	**Oklahoma**	677,700
26	**Wisconsin**	673,600
27	**Minnesota**	658,500
28	**Oregon**	594,600
29	**Arkansas**	550,700
30	**Connecticut**	444,200
31	**New Mexico**	423,500
32	**Colorado**	410,700
33	**West Virginia**	351,600
34	**Iowa**	331,100
35	**Kansas**	281,100
36	**Maine**	277,900
37	**Nebraska**	249,200
38	**Utah**	214,700
39	**Rhode Island**	193,800
40	**Hawaii**	190,000
41	**Idaho**	172,400
42	**Nevada**	167,200
43	**District of Columbia**	152,600
44	**Vermont**	152,100
45	**Delaware**	133,100
46	**New Hampshire**	108,500
47	**South Dakota**	106,200
48	**Montana**	101,900
49	**Alaska**	100,300
50	**North Dakota**	65,400
51	**Wyoming**	57,900

Notes: Enrollment estimates are rounded to the nearest 100. Figures may not sum to totals due to rounding.
Enrollees are presumed to be unduplicated (each person is only counted once), though limited duplication may occur.
The enrollment estimates differ slightly from similar estimates posted by CMS because adjustments to the data have been made for several states where some individuals appeared to be categorized incorrectly.

Definitions: "Enrollees" are individuals who participate in Medicaid for any length of time during the federal fiscal year. They may not actually use any services during this period, but they are reported as enrolled in the program and are eligible to receive services in at least one month.

Sources: The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on

data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2005.

Footnotes:

1. An estimated 3.7 million enrollees received less than full Medicaid services and never received full benefits in any month. These included enrollees in family planning waivers programs, those receiving restricted benefits because of their eligibility status as aliens, dual Medicare-Medicaid eligibles, and a small number of enrollees eligible for prescription drug coverage.

Table 2

Distribution of Medicaid Payments by Enrollment Group (in millions), FY2001

United States	Percent
Children	16.3%
Adults	10.6%
Elderly	28.9%
Blind and Disabled	39.5%
Unknown	4.7%

Alabama	Percent	0% - 100.0%
Children	18.0%	
Adults	4.5%	
Elderly	29.0%	
Blind and Disabled	26.4%	
Unknown	22.2%	

Alaska	Percent	0% - 100.0%
Children	29.6%	
Adults	13.7%	
Elderly	14.9%	
Blind and Disabled	32.4%	
Unknown	9.3%	

Arizona	Percent	0% - 100.0%
Children	23.8%	
Adults	18.0%	
Elderly	20.3%	
Blind and Disabled	37.3%	
Unknown	0.7%	

Arkansas	Percent	0% - 100.0%
Children	21.0%	
Adults	6.2%	
Elderly	28.9%	
Blind and Disabled	42.7%	
Unknown	1.2%	

California	Percent	0% - 100.0%
Children	17.9%	
Adults	14.0%	
Elderly	27.3%	
Blind and Disabled	38.6%	
Unknown	2.2%	

Colorado	Percent	0% - 100.0%
Children	18.4%	
Adults	7.7%	
Elderly	27.0%	
Blind and Disabled	40.4%	
Unknown	6.5%	

Connecticut	Percent	0% - 100.0%
Children	10.0%	
Adults	3.6%	
Elderly	42.4%	
Blind and Disabled	38.4%	
Unknown	5.7%	

Delaware	Percent	0% - 100.0%
Children	17.9%	
Adults	19.0%	
Elderly	22.8%	
Blind and Disabled	39.6%	
Unknown	0.7%	

District of Columbia	Percent	0% - 100.0%
Children	18.1%	
Adults	10.0%	
Elderly	23.8%	
Blind and Disabled	47.4%	
Unknown	0.7%	

Florida	Percent	0% - 100.0%

Children	14.9%	
Adults	8.8%	
Elderly	29.1%	
Blind and Disabled	40.5%	
Unknown	6.8%	

Georgia	Percent	0% - 100.0%
Children	20.6%	
Adults	12.8%	
Elderly	26.1%	
Blind and Disabled	35.0%	
Unknown	5.4%	

Hawaii	Percent	0% - 100.0%
Children	16.5%	
Adults	17.8%	
Elderly	26.6%	
Blind and Disabled	29.2%	
Unknown	9.9%	

Idaho	Percent	0% - 100.0%
Children	16.5%	
Adults	9.8%	
Elderly	23.3%	
Blind and Disabled	49.2%	
Unknown	1.2%	

Illinois	Percent	0% - 100.0%
Children	17.1%	
Adults	10.2%	
Elderly	21.2%	
Blind and Disabled	37.9%	
Unknown	13.7%	

Indiana	Percent	0% - 100.0%
Children	19.4%	
Adults	8.3%	

	Percent
Elderly	30.8%
Blind and Disabled	40.8%
Unknown	0.8%

Iowa	Percent	0% - 100.0%
Children	14.6%	
Adults	8.5%	
Elderly	30.1%	
Blind and Disabled	44.5%	
Unknown	2.3%	

Kansas	Percent	0% - 100.0%
Children	14.0%	
Adults	5.5%	
Elderly	32.0%	
Blind and Disabled	46.9%	
Unknown	1.6%	

Kentucky	Percent	0% - 100.0%
Children	19.8%	
Adults	8.2%	
Elderly	27.0%	
Blind and Disabled	43.6%	
Unknown	1.4%	

Louisiana	Percent	0% - 100.0%
Children	15.1%	
Adults	8.1%	
Elderly	26.1%	
Blind and Disabled	47.1%	
Unknown	3.6%	

Maine	Percent	0% - 100.0%
Children	20.4%	
Adults	9.0%	
Elderly	21.8%	
Blind and Disabled	48.0%	

	Percent
Unknown	0.8%

Maryland	Percent	0% - 100.0%
Children	21.7%	
Adults	11.6%	
Elderly	22.7%	
Blind and Disabled	42.6%	
Unknown	1.3%	

Massachusetts	Percent	0% - 100.0%
Children	11.6%	
Adults	9.8%	
Elderly	32.7%	
Blind and Disabled	45.0%	
Unknown	0.9%	

Michigan	Percent	0% - 100.0%
Children	13.1%	
Adults	8.2%	
Elderly	24.4%	
Blind and Disabled	29.0%	
Unknown	25.3%	

Minnesota	Percent	0% - 100.0%
Children	16.7%	
Adults	8.7%	
Elderly	32.1%	
Blind and Disabled	41.8%	
Unknown	0.7%	

Mississippi	Percent	0% - 100.0%
Children	17.2%	
Adults	8.6%	
Elderly	31.8%	
Blind and Disabled	41.7%	
Unknown	0.7%	

Missouri	Percent	0% - 100.0%
Children	21.8%	
Adults	8.3%	
Elderly	30.7%	
Blind and Disabled	38.7%	
Unknown	0.5%	

Montana	Percent	0% - 100.0%
Children	21.6%	
Adults	9.9%	
Elderly	29.1%	
Blind and Disabled	37.0%	
Unknown	2.5%	

Nebraska	Percent	0% - 100.0%
Children	21.5%	
Adults	8.4%	
Elderly	28.8%	
Blind and Disabled	35.9%	
Unknown	5.4%	

Nevada	Percent	0% - 100.0%
Children	19.1%	
Adults	12.5%	
Elderly	20.4%	
Blind and Disabled	41.0%	
Unknown	7.0%	

New Hampshire	Percent	0% - 100.0%
Children	21.9%	
Adults	5.3%	
Elderly	34.0%	
Blind and Disabled	38.2%	
Unknown	0.6%	

New Jersey	Percent	0% - 100.0%
Children	13.9%	

Adults	13.6%	
Elderly	37.9%	
Blind and Disabled	33.5%	
Unknown	1.1%	

New Mexico	Percent	0% - 100.0%
Children	29.8%	
Adults	9.0%	
Elderly	19.5%	
Blind and Disabled	32.8%	
Unknown	9.0%	

New York	Percent	0% - 100.0%
Children	10.4%	
Adults	11.3%[1]	
Elderly	33.1%	
Blind and Disabled	44.4%	
Unknown	0.9%	

North Carolina	Percent	0% - 100.0%
Children	15.4%	
Adults	11.1%	
Elderly	29.6%	
Blind and Disabled	43.0%	
Unknown	0.9%	

North Dakota	Percent	0% - 100.0%
Children	11.5%	
Adults	6.6%	
Elderly	39.9%	
Blind and Disabled	40.3%	
Unknown	1.6%	

Ohio	Percent	0% - 100.0%
Children	13.2%	
Adults	7.9%	
Elderly	33.7%	

Blind and Disabled	42.2%	
Unknown	3.1%	

Oklahoma	Percent	0% - 100.0%
Children	23.7%	
Adults	5.3%	
Elderly	27.0%	
Blind and Disabled	37.0%	
Unknown	7.0%	

Oregon	Percent	0% - 100.0%
Children	19.4%	
Adults	25.2%	
Elderly	23.5%	
Blind and Disabled	31.0%	
Unknown	0.8%	

Pennsylvania	Percent	0% - 100.0%
Children	16.4%	
Adults	7.5%	
Elderly	36.4%	
Blind and Disabled	39.4%	
Unknown	0.4%	

Rhode Island	Percent	0% - 100.0%
Children	15.2%	
Adults	8.4%	
Elderly	32.7%	
Blind and Disabled	42.8%	
Unknown	0.8%	

South Carolina	Percent	0% - 100.0%
Children	18.5%	
Adults	8.1%	
Elderly	20.6%	
Blind and Disabled	33.2%	
Unknown	19.6%	

South Dakota	Percent	0% - 100.0%
Children	19.3%	
Adults	8.1%	
Elderly	31.6%	
Blind and Disabled	39.9%	
Unknown	1.1%	

Tennessee	Percent	0% - 100.0%
Children	19.1%	
Adults	27.4%	
Elderly	19.5%[2]	
Blind and Disabled	33.9%	
Unknown	0.1%	

Texas	Percent	0% - 100.0%
Children	22.0%	
Adults	10.8%	
Elderly	27.8%	
Blind and Disabled	37.1%	
Unknown	2.3%	

Utah	Percent	0% - 100.0%
Children	20.0%	
Adults	9.5%	
Elderly	12.0%	
Blind and Disabled	34.0%	
Unknown	24.5%	

Vermont	Percent	0% - 100.0%
Children	22.1%	
Adults	13.6%	
Elderly	26.7%[3]	
Blind and Disabled	37.0%	
Unknown	0.7%	

Virginia	Percent	0% - 100.0%

Children	16.4%	
Adults	6.8%	
Elderly	30.3%	
Blind and Disabled	45.7%	
Unknown	0.9%	

Washington	Percent	0% - 100.0%
Children	15.4%	
Adults	13.1%	
Elderly	16.3%	
Blind and Disabled	22.8%	
Unknown	32.4%	

West Virginia	Percent	0% - 100.0%
Children	16.3%	
Adults	7.3%	
Elderly	24.4%	
Blind and Disabled	42.6%	
Unknown	9.3%	

Wisconsin	Percent	0% - 100.0%
Children	10.8%	
Adults	6.5%	
Elderly	37.0%	
Blind and Disabled	45.0%	
Unknown	0.7%	

Wyoming	Percent	0% - 100.0%
Children	17.3%	
Adults	10.5%	
Elderly	26.3%	
Blind and Disabled	45.8%	
Unknown	0.1%	

Notes: Spending includes both state and federal payments to Medicaid. The payment amounts from the source data reflect payments for services during federal fiscal year 2001, based on date of payment. Spending also includes payments to Medicare for dual eligible enrollees (elderly, blind, and disabled).
Definitions: Elderly: includes all people age 65 and older.
Blind and Disabled: includes younger persons (age 64 and under) who are reported as eligible due to a disability.

Adults: are generally people age 18 to 64.
Children: are generally people age 17 and younger.
However, some people under age 18 may be classified as "adults" and some people age 18 and older may be classified as "children" depending on why they qualify for the program and each state's practices.
Sources: The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2005.

Footnotes:
1. New York's estimated payments per enrollee for non-disabled adults is higher than expected. This is largely due to much-higher-than-average inpatient hospital payments for this group. It has not been determined if New York actually spends much more than average for non-disabled adults or if this is an error caused by data problems.

2. The source data contain mostly negative payments for nursing facilities in Tennessee in FY 2001. According to CMS, the state changed its reimbursement methodology, resulting in "massive payment adjustments affecting mostly the aged population." These adjustments lead to "negative" payments, masking the true payments for nursing facilities for aged enrollees and leading to errors.

3. The estimate of payments per enrollee is relatively low for elderly enrollees in Vermont due to a waiver program that added many enrollees who only receive coverage for prescription drugs and have very low per-capita costs. Roughly 8,000 people participated in this program in 2001, most of whom are reported as elderly.

References

Centers for Medicaid and Medicare Services	**www.cms.hhs.gov**
Southern Disability Law Center	**www.nls.org.rog/con2003/medicaid-intro.htm**
Kaiser Family Foundation	**www.kaisernetwork.org/healthpolicyreport**