

Washington's Medicaid program at a glance

Providing health-care coverage for low-income children, adults and families

Mandatory vs. Optional

Medicaid medical care programs and benefits are divided into mandatory and optional categories. When the program was established under federal law in the mid-1960s, certain mandatory criteria were established for both eligibility and benefits. Above those limits, however, states were given the ability to raise income ceilings to cover additional clients – or to add additional services.. For example, prescription drug coverage is an “optional benefit” under federal rules, but Washington's program has added it to the benefit list.

Cover all children

Washington State's Legislature in 2007 adopted the same income criteria for all children's medical assistance programs. The federal government only mandates children's coverage at 133 percent of FPL (see table below.) But our legislators led a determined effort over the past decade to cover more low-income children – by raising the state's coverage limit. In July 2007, that limit moved to 250 percent of FPL for all children. In January 2009, the ceiling will move again, this time to 300 percent of FPL. The increases are part of an initiative to cover all children in the state by 2010.

Coverage of adults

The elderly and most non-disabled adults are covered at much lower levels -- about 70 percent of FPL. But a few adults with disabilities may be covered at as much as 400 percent of FPL under a program that tries to keep disabled clients on the job.

Federal Poverty Levels

Family size	FPL	250% FPL
1	\$10,210	\$25,525
2	\$13,690	\$34,225
3	\$17,170	\$42,925
4	\$20,650	\$51,625

-- Source: U.S. Department of Health & Human Services, 2007

Washington's Medicaid program constitutes the state's major public financing of health-care coverage for low-income residents. In 2008, approximately 860,000 Washington citizens, nearly two-thirds of them



children, depend on the Medicaid program for their health care. The Health and Recovery Services Administration (HRSA) of the Department of Social and Health Services (DSHS) operates Medicaid and several associated medical assistance programs. HRSA also includes the state's Mental Health programs and chemical dependency and

prevention treatments – also funded with Medicaid dollars. In Washington, Medicaid services are supported by both federal and state governments on a roughly 50-50 basis, although in some categories the federal funding may be higher. Eligibility standards vary, but Medicaid generally covers all children in families with income up to 200 percent of the Federal Poverty Level (FPL). The major categories of coverage are:

Categorically Needy (CN) Medicaid: This is a mandatory coverage provided to individuals who meet specific income criteria set by federal and state rules.

Medically Needy (MN) Medicaid: These clients are primarily elderly and disabled and must also meet set income guidelines, but in cases where their income exceeds the limit, they can share the cost of their health care by spending enough on services to bring their income within the guidelines. This is called “spend-down.”

State Children's Health Insurance Program (SCHIP): SCHIP is funded on a two-thirds federal/one-third state basis and covers children whose families have incomes between 201 and 250 percent of the Federal Poverty Level (FPL).

Children's Health Program (CHP): CHP is entirely funded by state dollars and is open to all children in families below 250 percent of FPL who cannot qualify for Medicaid and SCHIP.

Refugee Assistance: While federal Medicaid funds are generally only available to U.S. citizens, certified refugees are exempted and covered.

Medical Care Services: This program involves only state funds and covers incapacitated individuals who fall outside Medicaid. Most are classified as General Assistance-Unemployable (GAU). Coverage is comparable to Medicaid and often referred to as a “Medicaid lookalike.”

Today, medical assistance programs in Medicaid, CHP or SCHIP cover about one in every three children in the state and about 15 percent of the state's population overall. Nearly half of the state's births are covered by medical assistance. An additional 100,000 residents rely on Medicaid for family planning services. Medicaid's biannual health-care budget tops \$8 billion, with mental health budgeted at \$1.4 billion, and chemical dependency services at \$46 million.

Less than 4 percent of Medicaid spending goes to administrative expenses, including staff. The rest goes straight to providers for the services they render. The top four expenses for medical care are inpatient hospital care, prescription drugs, provider services, and hospital outpatient services.

Medicaid and Medicare

Medicaid is a state-federal partnership created in the mid-1960s to reimburse health care providers for the services and treatments given to low-income individuals and families unable to pay for their own health care. It is a comprehensive package of benefits, and the federal rules stipulate that all states must provide certain specific benefits and services to a core group of eligible clients. But Medicaid programs may vary a great deal from state to state, and federal funding varies -- poorer states get more federal help than wealthier states. Medicaid covers long-term care for special categories of people who can't afford or manage their own care. This includes many nursing home patients, as well as the developmentally disabled.

Medicare coverage for the elderly was also created in the 1960s, but this program was intended to supplement senior citizens' ability to purchase health care. It was never conceived to be a set of comprehensive benefits, and most recipients choose to buy special private "Medigap" insurance policies that cover the "gaps" in Medicare. Some employers provide these "Medigap" policies as part of their retirement benefits.

Nearly everyone qualifies for Medicare coverage by age -- people are eligible at age 65. But a few Medicare recipients qualify by reason of disability. "Dual-eligibles" are elderly clients who qualify for both Medicare and Medicaid.

Another state medical assistance program is **Basic Health**, a subsidized package of benefits for the working poor (under 200 percent of the Federal Poverty Level). Basic Health, which also contracts with private carriers for managed care services, is operated by the Health Care Authority, not HRSA.

FOR MORE INFORMATION

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Managed care and fee-for-service: How Medicaid delivers care

Medicaid clients receive health-care services either through enrollment in the Healthy Options **managed care** program or on a **fee-for-service** basis. Current caseload is divided about 50-50 between the two different delivery systems. For Healthy Options, MAA contracts with licensed health insurance carriers to provide a defined set of services to enrolled members. Fee-for-service care is delivered by licensed or certified health care providers who have a contract with DSHS to serve our clients.

MANAGED CARE: HRSA operates the Healthy Options program by contracting private Health Maintenance Organization (HMOs) and Health Care Service Contractors (HCSCs). These managed care plans are paid a capitated monthly premium to provide health care for Medicaid clients -- primarily WorkFirst families (drawing Temporary Assistance to Needy Families, or TANF), low-income pregnant women and low-income children. Healthy Options providers, in turn, are reimbursed by their plans at contracted rates. If the number of Healthy Options-eligible clients exceeds the capacity of contracted private carriers in certain counties, those clients are allowed to seek care on a fee-for-service basis.



For many patients, the managed care option is attractive because the customer is guaranteed access to a primary care provider as well as the managed care plan's network of specialists and other providers. When managed care clients enroll in Healthy Options, they can pick their providers from a list published and updated on the HRSA Web page.

FEE FOR SERVICE: Fee-for-service clients, on the other hand, must locate their own doctors. When fee-for-service clients begin their search for a provider, they can check with the Medical Assistance Customer Service Center via HRSA's toll-free hot line: 1-800-562-3022.

The fee-for-service program covers services to elderly and disabled Supplemental Security Income (SSI) clients, clients exempted from Healthy Options or in state-administered program, as well as wrap-around Medicaid services not covered by managed care plans. In fee-for-service, providers agree to accept Medicaid's rates as total payment for services rendered. Providers cannot bill clients even when the cost of treatment exceeds the reimbursement by Medicaid.

Washington State's medical assistance programs are authorized under state law (primarily Chapter 74.09 RCW). National health-care programs are authorized in the federal Social Security Act's Title XIX (Medicaid) and Title XXI (SCHIP).