

# Faces of the Pennsylvania Medicaid Program

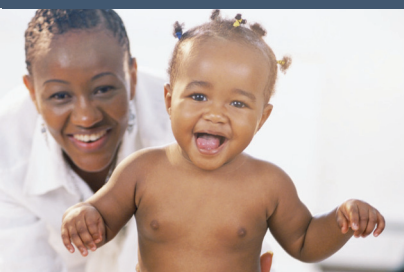
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<b>1</b>	<b>Preface</b>
<b>2</b>	<b>Report</b>
<b>13</b>	<b>Acknowledgements</b>
<b>14</b>	<b>Glossary</b>
<b>20</b>	<b>References</b>

## Preface

The Pennsylvania Medicaid Policy Center (PMPC) was established in 2006 with initial support from The Pew Charitable Trusts. Since then, the PMPC has received funding from other foundations in Pennsylvania: the Jewish Healthcare Foundation, the North Penn Community Health Foundation, the Brandywine Health Foundation and the Pottstown Area Health & Wellness Foundation.

The mission of the PMPC is to increase the understanding of Pennsylvania's Medical Assistance program and its role in the Commonwealth's health care system as well as to promote the development of policy solutions and long-term strategies that serve the program's constituents. PMPC will achieve its mission by serving as a resource for information and analysis on (1) characteristics of individuals who are covered under Medical Assistance and the services provided; (2) the importance of the program for selected populations; (3) specific elements of the program, such as long-term care or rural health delivery; (4) policy options under consideration within the Commonwealth; (5) the importance of the program for various providers; (6) initiatives by other states to improve the health of recipients and lower costs; and (7) the fiscal implications of the program for the state budget.

*Faces of the Pennsylvania Medicaid Program* is the PMPC's first report. It provides information on the Medical Assistance program and puts a "face" to the population served by Medicaid in Pennsylvania. It describes the characteristics of the individuals who are eligible for the program, provides data on the number of people who were covered in 2006 and examines the distribution of individuals and costs across the broad eligibility categories. It also gives information on the proportion of the overall population and the proportion of children who are covered by Medical Assistance in each county in the Commonwealth.

We would like to thank the Pennsylvania Department of Public Welfare for providing us with the state data utilized in this report. This report highlights various Pennsylvania Medicaid data and frames it in the context of enrollment, expenditures and services throughout the Commonwealth. The Pennsylvania data creates the unique "face" of our report.

Upcoming reports will cover issues such as: the importance of Medicaid for certain categories of providers in the Commonwealth; the distribution of births funded by Medical Assistance across the counties; initiatives by other states to modify the behaviors of Medicaid recipients in order to promote healthy behaviors; approaches for reallocating resources in the long-term care sector towards home and community-based services and away from nursing homes; and the fiscal implications of Medical Assistance for the state budget.

# Faces of the Pennsylvania Medicaid Program

*“We know that the people... appreciate the role of Medicaid as an extraordinary federal-state program that provides critical health care and a safety net for the most vulnerable Americans. This program is a lifeline for 1.8 million Pennsylvanians and their families.”*

Mary Hurtig, Policy Director, Mental Health Association of Southeastern Pennsylvania (2006)<sup>1</sup>

## Introduction

Since its inception, Medicaid has paid for medical care for millions of Americans. However, with its numerous eligibility categories, variations in covered services, and complicated rules governing the administration of the program, it is easy to become confused about whom and what services the Medicaid program covers. There are two major misperceptions about the Medicaid program: (1) Medicaid is a welfare program that primarily pays for medical services to individuals receiving government assistance, and (2) Medicaid is a program that pays for medical services to all people who are poor.

This report will provide information on Medicaid in Pennsylvania and put a “face” to the population that is served by the program. The intention is to provide state policy makers and stakeholders with a fundamental understanding of who the program serves and its significance across the state.

We begin by setting out the structure and parameters of the program. Next, we discuss the characteristics of the individuals who are eligible for assistance in Pennsylvania and describe the services that are covered. We then provide data on the number of people who were covered under the program in 2006 and examine the distribution of individuals and costs across the broad eligibility categories. Finally, we look at the proportions of individuals in each county that are covered under the Medicaid program.

## Overview of the Medicaid Program

The Medicaid program was created by Congress in 1965 under Title XIX of the Social Security Act. It has since evolved from a welfare program that primarily paid for health services to individuals receiving cash assistance into an insurance program that fills in some of the gaps in the health care financing system and pays

for medical and long-term care for eligible low-income American citizens and legal immigrants.\* It principally serves the nation’s most vulnerable citizens, such as children, pregnant women, individuals with disabilities, and seniors. In 2005, approximately 42.5 million individuals, or about 14 percent of the population, were covered by Medicaid in the United States.<sup>2</sup>

The Centers for Medicare and Medicaid Services (CMS) provide regulatory oversight and determine the Medicaid program rules. Medicaid is financed jointly by the federal and state governments and is administered by each individual state, as well as American Samoa, Guam, Northern Mariana Islands, Puerto Rico, Virgin Islands, and Washington, D.C. The federal government reimburses states for a portion of Medicaid expenditures, with the amount of the federal contribution tied to each state’s per-capita income. For example, the Federal Medical Assistance Percentage (FMAP) in Pennsylvania in 2007 is 54.39 percent<sup>†</sup>, which means that for every \$100 spent on services and populations covered by Medicaid, the federal government pays \$54.39, and the Commonwealth pays \$46.61.<sup>3</sup> The federal government also pays about 50 percent of the states’ costs of administering the Medicaid program.

Governed by federal regulations<sup>‡</sup>, states are required to cover a set of mandated services for specific groups of people in order to qualify for federal matching payments. However, subject to these requirements, the states have considerable flexibility in designing their own Medicaid programs. They can broaden Medicaid eligibility by covering individuals that they are allowed, but not required, to cover (i.e. women with breast or cervical cancer). Coverage can also be broadened by raising the income and asset ceilings,

\* With the implementation of The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, the rules governing legal immigrants have become increasingly restrictive. As a general rule, only qualified aliens are eligible for Medicaid and State Children’s Health Insurance Program (SCHIP) coverage. Qualified aliens include aliens legally admitted for permanent residence. Prior to PRWORA, all qualified aliens (who met the eligibility conditions) were eligible for Medicaid; after PRWORA, individuals who entered the country after 1996 were subject to a five year ban. Under the Deficit Reduction Act (DRA) of 2006, legal aliens have to provide documentary evidence of their residency status.

<sup>†</sup> The national average FMAP is 55 percent.

<sup>‡</sup> Title 42 of the Code of Federal Regulations

expanding the set of covered services, and establishing rules governing the receipt of services (such as imposing limits on the number of services provided). The states can also determine the amounts and methods by which they pay providers for services rendered to Medicaid recipients. Furthermore, they can obtain even greater flexibility by seeking a waiver of certain provisions of Medicaid law. Waivers allow states to do things not otherwise permitted by the Medicaid statute, including both expanding and limiting the program. In exchange for this additional flexibility, states must generally show that a waiver will be “budget neutral”; that is, it will not increase federal Medicaid spending. This system creates a decentralized program with at least 56 variations of coverage but with the same common objective of providing health care for low-income and special-needs populations.

**Overview of the Pennsylvania Medicaid Program**

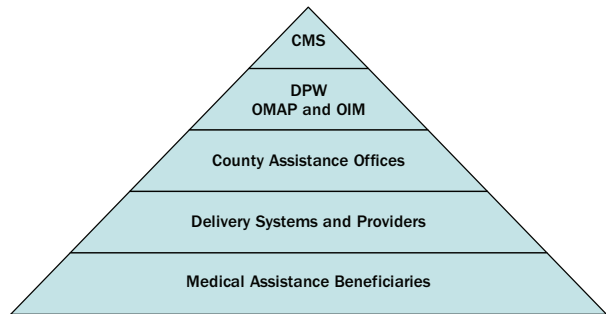
*“I’m currently looking for a part-time job, but I still need my Medicaid to help with medicine and doctor visits. My success in recovery depends on not eliminating financial help, but allowing Medicaid to be a tool to bridge the gap between dependency and independency.”*

Ruth Ann Allison, Medicaid consumer, Somerset, PA (2006)<sup>4</sup>

In Pennsylvania, the Medicaid program is called Medical Assistance, and the Department of Public Welfare (DPW) is responsible for its management. Within the DPW, Medical Assistance is administered by the Office of Medical Assistance Programs (OMAP) and the Office of Income Maintenance (OIM). OIM sets eligibility standards and, through local county assistance offices, conducts eligibility determinations and recertifications. OMAP establishes medical benefits, provider payments, and the level of beneficiary cost-sharing. It also reimburses medical providers and makes payments to health plans. (Figure 1) Budget considerations and laws also shape the Medicaid program in Pennsylvania. Like other states, Pennsylvania must submit a plan to CMS that describes its Medicaid program (covered groups, covered services, cost-sharing requirements, etc.).

Medical Assistance provides health insurance coverage for many low-income people, offers long-term care assistance to individuals who are 65 and older, and covers individuals with disabilities and the gaps in the Medicare program. Consequently, Medical Assistance is a major source of funding for health care institutions

**Figure 1: Pennsylvania Medical Assistance Administrative Diagram**



that serve a disproportionately large population of low-income and otherwise uninsured patients. Through Medicaid, the Commonwealth is the second largest health insurer in Pennsylvania after Blue Cross/Blue Shield affiliates.<sup>5</sup> In the average month during 2006, approximately 14.8 percent of Pennsylvania’s population was enrolled in Medicaid.<sup>6</sup>

Between July 1, 2005 and June 30, 2006 (the state’s fiscal year), Pennsylvania’s total Medicaid expenditures were \$16,638 million.<sup>7</sup> Of this amount, the state paid \$7,518 million (\$5,450 million came from the general fund and \$2,068 million from other sources, such as the Tobacco Fund and taxes on providers). The federal government paid \$9,120 million, or 54.8 percent of the total cost of the Medicaid program in Pennsylvania.<sup>8</sup>

**Program Eligibility**

*“My wife and I aren’t looking for any loopholes. We don’t have time to do that. We’re simply trying to care for our son in a safe and responsible manner. We are in a fight for our son’s life every day, and we need the help and understanding of our community.”*

Albert Freedman, Medicaid parent, Philadelphia, PA (2006)<sup>9</sup>

As stated above, general rules governing **who** is eligible for the federal Medicaid program are established by federal law. In most cases, individuals in Pennsylvania must: (1) fit into a specified coverage group; (2) meet the income requirements for that specific coverage group (these income limits are usually specified in terms of a certain percentage of the federal poverty level, FPL); (3) meet the asset requirements for that specific coverage group; (4) be a United States citizen or a qualified lawful alien; and (5) be a Pennsylvania resident.

*Figure 2* provides information on who is eligible for Medicaid coverage in Pennsylvania.<sup>§</sup> We group Medicaid recipients into the broad eligibility categories: Children; Pregnant Women; Families with Children (including adult recipients); Individuals with Disabilities; and the Elderly. Most of these categories are self-explanatory. However, in order to be classified as disabled, individuals must meet the Social Security Administration (SSA) definition of a disability. In the 1980s, the federal government classified people with Acquired Immunodeficiency Syndrome (AIDS) as being disabled for the purpose of Medicaid coverage. *Figure 2* also contains the income and asset limits that individuals in each group must meet to qualify for coverage. Individuals who are eligible for Medicaid must meet an income test (i.e., their incomes cannot exceed a specified percent of the FPL). The term “income” refers to “countable income.” Medicaid applicants can deduct certain expenditures (such as child care) from their incomes in calculating the income used to determine their eligibility. In most cases, people who are eligible for Medicaid must also meet an asset test. The term “assets” refers to “countable assets.” Some assets, such as the value of a car or household items, are not counted in determining the household’s assets.\*\* For each of the broad categories, we distinguish between those groups that are mandatory (the states must cover them) and those that are optional (the states may extend coverage to them). This latter group is called “Pennsylvania Extensions” in *Figure 2*.

States can also provide medical coverage to individuals who are not eligible for federal matching funds. These are usually individuals or married couples without children. In general, income and resource limits are much more restrictive for these individuals and the scope of covered services is much narrower. In the charts that follow, we will refer to these individuals as “State Only.” They are also sometimes referred to in reports by Pennsylvania as “chronically ill adults” or “adults without children.”

<sup>§</sup> It does not include information for very small coverage groups such as refugees and people who use emergency room care. It also does not include information on children who are enrolled in the SCHIP Program—Pennsylvania’s child health insurance program. SCHIP extends coverage to children with incomes above the Medicaid cut-off.

\*\* Subject to federal requirements, the states have some flexibility in how they count income and assets.

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## Figure 2: Medicaid Eligibility in Pennsylvania

In this figure, the terms “income” and “assets” always refer to “countable” income and assets.

### Children

#### MANDATORY COVERAGE

- Children under age 1 whose family incomes are at or below 185 percent of the Federal Poverty Level (FPL)
- Children between the ages of 1 and 6 whose family incomes are at or below 133 percent of the FPL
- Children age 6 to 19 whose family incomes are at or below 100 percent of the FPL
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act

#### PENNSYLVANIA EXTENSIONS

- Children with disabilities regardless of their families’ incomes and assets
- Medically Needy—Children in families where the medical bills are sufficiently high that the family income minus the medical bills is between 33 percent and 50 percent of the FPL depending on family size.

### Pregnant Women

#### MANDATORY

- Pregnant women whose family incomes are below 133 percent of the FPL. They are covered by Medicaid for the duration of pregnancy and through the postpartum period (60 days after delivery and any additional days to complete the last month of coverage).

#### PENNSYLVANIA EXTENSIONS

- Pregnant women whose family incomes are between 133 percent of the FPL and not more than 185 percent of the FPL
- Medically Needy—Pregnant women whose medical bills are so high that their family income minus their medical bills is less than or equal to 33 percent of the FPL

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### **Families with Children**

#### MANDATORY COVERAGE

- Families with children who have incomes less than 25 percent of the FPL; families on TANF (Temporary Assistance for Needy Families)

#### PENNSYLVANIA EXTENSION

- Medically Needy—Families with children whose incomes minus medical bills are less than or equal to 33 percent of the FPL

### **Individuals with Disabilities**

#### MANDATORY COVERAGE

- Supplemental Security Income (SSI) recipients (Individual incomes must be less than 76 percent of the FPL and assets cannot exceed \$2,000.)
- Individuals with disabilities who lose their SSI cash assistance due to earnings from work or from increased Social Security benefits

#### PENNSYLVANIA EXTENSIONS

- Individuals with disabilities with incomes between 76 percent of the FPL and less than 100 percent of the FPL and with assets less than \$2,000
- Individuals with disabilities who work and have family incomes of less than 250 percent of the FPL and assets less than \$10,000. These individuals must pay a small premium to enroll in Medicaid.
- Women with breast or cervical cancer with family incomes below 250 percent of the FPL who were screened for breast and cervical cancer through a program administered by the Centers for Disease Control and Prevention (CDC). (Women with breast or cervical cancer are included with the disabled category because that is where they are placed for reporting purposes.)
- Medically Needy—Individuals with disabilities whose incomes minus their medical expenses are less than 50 percent of the FPL

#### WAIVERS

- Individuals who would be Medicaid eligible if institutionalized but who live in the community and receive home and community-based services

### **Elderly (65 and Over)**

#### MANDATORY COVERAGE

- SSI recipients (For individuals, their incomes must be less than 76 percent of the FPL, and their assets cannot exceed \$2,000.)
- Medicare beneficiaries with incomes below 100 percent of the FPL and with assets less than \$4,000. Medicaid must pay the Medicare Part B premium and Medicare cost-sharing. Medicaid does not cover other services.
- Medicare beneficiaries with incomes between 100 and 120 percent of the FPL and assets less than \$4,000. Medicaid must pay the Medicare Part B premium. Medicaid does not cover other services.

#### PENNSYLVANIA EXTENSIONS

- Individuals with incomes between 76 percent of the FPL and 100 percent of the FPL with assets less than \$2,000
- Individuals residing in institutions, such as nursing homes, whose incomes are under 300 percent of the Federal SSI Benefit Rate (FBR) and whose assets have been spent down to the state authorized level. (The process for determining assets for purposes of Medicaid coverage in a nursing home is complicated and depends on a number of factors including whether there is a living spouse in the household.)
- Medically Needy—Seniors whose income minus their medical expenses is less than the 50 percent of the FPL. There are some seniors in nursing facilities with income over the 3 x FBR limit—but whose income minus the cost of care in the facility is less than 50 percent of the FPL.

#### WAIVERS

- Individuals who would be Medicaid eligible if institutionalized, but who are living in the community and receiving care and home and community-based services.

The Medicaid eligibility criteria, described above, indicate the extensive reach of the program as well as its complicated structure with its range of eligibility categories. It is a health insurance program that provides basic and supplemental coverage to individuals who are poor and have disabilities (either physical or mental) for their health and long-term care. It also fills in some of the gaps that emerge in the current health care system. This gap closing theme is discussed in more detail below.

Medicaid is an important source of health care coverage for children with disabilities and Pennsylvania's coverage policy is unique because it extends to all children with disabilities, regardless of income and assets. Although many of these children are also covered under their parents' health insurance policies, their private insurance policies usually do not include the types of long-term care services, such as attendant services, ventilator services, and intensive mental health services that are needed by children with physical and/or mental disabilities. Providing medical coverage for these children allows parents to continue working instead of impoverishing themselves to obtain Medicaid. It allows children to be cared for at home by their families as an alternative to requiring an institutional placement. In 2005, there were 39,876 children with disabilities that were covered by the Medicaid program in Pennsylvania.<sup>10</sup>

Furthermore, Medicaid pays for health care for many adults with disabilities who often find it difficult to purchase insurance in the private market, particularly in the nongroup market or individual market. Not only are private health insurance policies very expensive, but they often do not cover pre-existing conditions. To qualify as disabled, an individual must meet the SSA definition of disability, which has expanded over time. As noted above, AIDS was made a qualifying condition in the 1980s. In addition, Pennsylvania extends coverage to individuals with disabilities who are employed, even as little as one hour a month, and who have incomes at or below 250 percent of the FPL. One argument for extending coverage to such individuals is to encourage them to continue working rather than reduce their incomes to the qualifying level in order to get needed medical care. Thus, Medicaid in Pennsylvania provides individuals with disabilities the opportunity to engage in the community and earn income while retaining necessary health benefits.

Medicaid provides coverage for some low-income individuals who have specific health issues, but who ordinarily would not be categorically eligible for Medicaid. For example, the CDC has established designated screening centers to test for breast and cervical cancer because early detection can save lives. Low-income women have been encouraged to use this service. If uninsured women were diagnosed with cancer or a precancerous condition, they would then face significant financial constraints and have difficulty obtaining the necessary follow-up medical services. Complete Medicaid coverage is extended to this group of women to cover the time that they are in treatment. In this case, Medicaid has identified a group of individuals with a specific condition and provided medical coverage and services. However, individuals with other cancers, who are not categorically eligible for Medicaid, are not covered by Medicaid.

Medicaid also helps to fill in gaps in the Medicare program. Medicare covers most individuals over the age of 65, individuals under the age of 65 who have been enrolled in the Social Security Disability Program for two years, and most individuals with end-stage renal disease (kidney failure). While individuals who are eligible for Medicare are automatically enrolled in Part A (that covers institutional services), they have to pay a premium to enroll in Medicare Part B (that covers physician and outpatient services). Moreover, Medicare has significant cost-sharing provisions and limited coverage for long-term care and does not cover services such as dental care, vision care, and hearing care. Community-dwelling Medicare beneficiaries may qualify for full Medicaid benefits if their incomes are less than 100 percent of the FPL and their countable assets are less than \$2,000. In this case, Medicaid pays the premium for Medicare, Medicare cost-sharing, and for the services that Medicaid covers, but Medicare does not. In addition, Medicaid covers institutionalized Medicare beneficiaries with incomes up to 300 percent of the FPL or who have spent down their income and assets.<sup>††</sup> As a result, Medicaid pays for about 67 percent

<sup>††</sup> Many Medicare beneficiaries enter nursing homes as self-pay patients. However, if they are in a nursing home for an extended period of time, they may delete their assets. If their assets fall below a designated amount and if their income is below 300 percent of poverty, they will have "spent down" to Medicaid. It should be noted that most of their remaining income will be used to pay for the nursing home. They must spend all their income on nursing homes with the exception of a small monthly allowance.



of nursing home care in Pennsylvania.<sup>11</sup> As noted in *Figure 2*, Medicaid provides some support for low-income Medicare beneficiaries by paying their Part B premiums and cost-sharing.

Collectively, all individuals who are covered under both Medicare and Medicaid are called the “dual eligibles.” The relationship between Medicare and Medicaid is very complex, and there is considerable policy debate about the appropriate division of responsibility for providing health care services to this group of beneficiaries. In Fiscal Year 2006, there were 265,544 dual eligibles on the average month in Pennsylvania, most of whom were elderly (65 percent).

### Services and Delivery Systems

*“I have spent years of my life not being able to get simple medical treatment for many physical illnesses, from dermatology to digestive disorders to sinus conditions to gynecological and dental treatment. My life was impaired in every way. I don’t want to go back to that existence. It is non-human.”*

Anne Alter, Medicaid consumer, Pittsburgh, PA<sup>12</sup>

As with any health insurance product, the Pennsylvania Medicaid program must define the set of services that it will cover. As noted above, the federal government allows states flexibility in determining the amount, duration, and scope of medical services covered by the Medicaid program. As a condition of receiving federal matching funds, states are statutorily required to provide the services classified as mandatory and may cover some or all of the services the regulations classify as optional. With the exception of some services for children, states will not receive matching funds for providing a service which is not classified as either mandatory or optional (e.g., cosmetic surgery). However, with respect to children, the states **must** cover medical services that a provider deems to be medically necessary as a result of the Early Periodic Screening and Treatment Program (EPST), the child health component of the Medicaid program, even if that service is not generally covered by the state. Until recently, with the exception of the medically needy, the states were required to provide all covered services to all individuals enrolled in the program. In 2006, the Deficit Reduction Act (DRA) was enacted. This legislation increases state flexibility in defining coverage groups and covered services. Pennsylvania has not yet changed its state plan in response to the DRA.

*Table 1* lists the services that all Medicaid programs must cover as well as the “optional services” that are currently covered under the Pennsylvania Medicaid program.

Cost-sharing for Medicaid services is limited by law. Pennsylvania Medicaid benefits are more generous than benefits provided under most private insurance policies and especially by Medicare. As is clear from *Figure 2*, individuals on Medicaid generally have very low incomes and thus lack the ability to purchase services that are not covered or to meet cost-sharing obligations. Some argue that it is in the state’s interest to ensure that people on Medicaid have access to services that would reduce reliance on hospital and institutional care. Therefore, Medicaid’s broad benefit package and minimal cost-sharing is not just “generous” but also practical.

Pennsylvania Medical Assistance purchases services through contracts with managed-care organizations and under an indemnity, or traditional, fee-for-service system. Services for dual eligibles and long-term care are paid through fee-for-service. A medical provider that enrolls in the Medicaid program is required to meet applicable national, federal, and state licensing and credential requirements.<sup>13</sup> The Medical Assistance provider network in Pennsylvania comprises approximately 68,000 providers, including hospitals, long-term care facilities, dentists and physicians.<sup>14</sup>

*Table 2* shows the distribution of Medicaid expenditures by types of medical services in Pennsylvania in 2005.<sup>15</sup> Approximately 52.4 percent of Medicaid payments are made for acute care services while 42.5 percent are made for long-term care services. Within long-term care expenditures, approximately 65 percent pay for nursing home care services and 23.9 percent went for community based care. The other 5.1 percent, Disproportionate Share Hospital Payments, are based on the federal law requirement that state Medicaid programs “take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs” when determining payment rates for inpatient hospital care.

**Table 1: Covered Services Under the Pennsylvania Medicaid Program**

MANDATORY MEDICAL SERVICES	"OPTIONAL" MEDICAL SERVICES*
EPSDT Services for Children Under Age 21	Ambulatory Surgical Center
Family Planning Services and Supplies	Birthing Center Services
Home Health Care for Individuals Eligible	Case Management (Targeted)
Inpatient Hospital Services	Chiropractic
Laboratory and X-Ray Services	Dental, including Orthodontics
Medical and Surgical Dental Services	Drug and Alcohol Outpatient Clinic
Nurse Midwife Services	Hospice
Nursing Facility Services	Inpatient Hospital and Nursing Facility Services for 65+ in an Institution for Mental Disease
Outpatient Hospital Services	Intermediate Care Facilities for Persons with Mental Retardation
Nurse Practitioner Services	Intermediate Care Facilities/Other Related Conditions
Physician Services	Independent Medical Clinic/Surgical Center Medical Supplies and Equipment
Rural Health Clinic and Federally Qualified Health Clinic Services Offered by These Entities	Optometry
All Medically Necessary* Care for Eligibles Under Age 21	Partial Hospitalization
	Primary Care Case Management Services
	Prescription Drugs
	Podiatrist
	Prosthetic Devices
	Psychiatric Clinic
	Rehabilitation Services
	Renal Dialysis
	Tuberculosis-Related
	Therapy (Occupational, Physical, and Speech for Adults Limited to Those Provided by a Hospital, Outpatient Clinic or Home Health Provider)
	Transportation To and From Appointments
	Home and Community-Based Services are Covered Under a Waiver

\* Adults eligible under the Medically Needy Only Medicaid category are not eligible for these services with some exceptions.

+ *Medically Necessary* is a service or benefit that is reasonably expected to prevent the onset of an illness, condition or disability; reduce or ameliorate the physical, mental or developmental affects of an illness, condition, injury, or disability; assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and those functional capacities that are appropriate for members of the same age.

**Table 2: Distribution of Pennsylvania Medicaid Expenditures by Type of Medical Service (2005)**

MEDICAL SERVICE	EXPENDITURE	PERCENT OF EXPENDITURES
Acute Care	\$8,313 million	52.4% of total Medicaid expenditures
Long-Term Care	\$6,745 million	42.5% of total Medicaid expenditures
Nursing Home	\$4,403 million	65.3% of Medicaid long-term care expenditures
Community Based Care	\$1,615 million	23.9% of Medicaid long-term care expenditures
Disproportionate Share Hospital Payments (DSH)	\$815 million	5.1% of total Medicaid expenditures

*Note.* Information from Kaiser Family Foundation (2005).<sup>16</sup>

**The Number and Distribution of Medicaid Recipients in Pennsylvania**

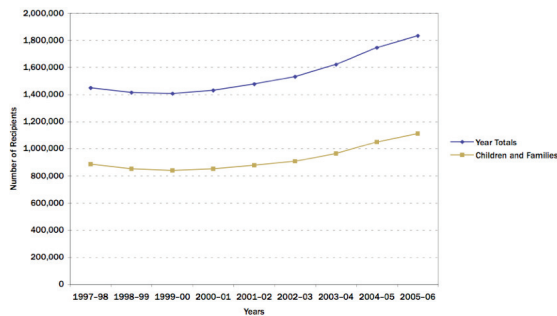
*"We have today in Pennsylvania... people with developmental disabilities waiting for services. Some day their needs will be addressed by the Commonwealth and they will be able to pursue their own life and happiness."*

Pedro Geraldino, Medicaid parent, Philadelphia, PA (2006)<sup>17</sup>

In 2006, there were 1,833,769 Medicaid recipients in Pennsylvania in the average month, representing 14.8 percent of the state's population. About 7 percent of Pennsylvania Medicaid recipients were covered because they were medically needy. Approximately 17.3 percent of Medicaid recipients (not including SSI) received some cash welfare payments.<sup>18</sup>

As shown in *Figure 3*, the number of Medicaid recipients has been increasing steadily since 2000, a period that overlaps the economic downturn in Pennsylvania. There have been two major contributors to enrollment growth over this period. First, private insurance coverage in Pennsylvania decreased partly as a response to that downturn. As a result, many children shifted from private to public health insurance coverage. Second, in 2002, Pennsylvania extended Medicaid coverage to seniors and to individuals with disabilities with incomes between 76 percent and 100 percent of the FPL.

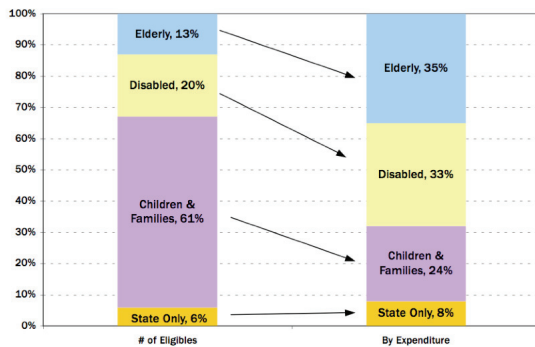
**Figure 3: Pennsylvania Medicaid Recipients from 1997–2005**



Note. Data provided by PA DPW.<sup>19</sup>

Figure 4 shows the distribution of Medicaid recipients and expenditures by broad eligibility category. (We include the “State Only” data because the Department of Public Welfare traditionally includes information on these individuals when it is reporting on the Medicaid program.)

**Figure 4: Distribution of Pennsylvania Medicaid Recipients and Expenditures by Broad Eligibility Category in 2005**



Note. Data provided by PA DPW.<sup>20</sup>

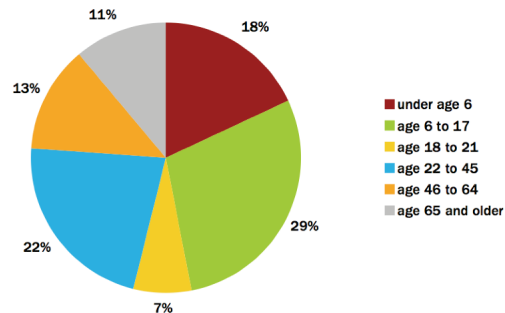
In this figure, all nondisabled children, pregnant women, and families who are recipients of the cash welfare assistance program TANF are allocated to the children and families category. Disabled children and the women enrolled in the Breast and Cervical Cancer Prevention and Treatment program are allocated to the disabled group. Although children and families make up the largest proportion of Medicaid recipients (61 percent), they do not account for the largest

proportion of expenditures (only 24 percent). Disabled individuals are the second largest enrollment group (20 percent) and they account for 33 percent of expenditures. The elderly account for only 13 percent of recipients, but 35 percent of expenditures. The elderly account for such a disproportionate share of expenditures because of their heavy use of long-term care services and prescription drugs. Per recipient, children and families spend 40 percent of the average, state spend 130 percent of the average, the disabled spend 165 percent of the average, and the elderly spend 270 percent of the average.

In the average month in 2006, there were 38,808 disabled children (10.3 percent of the total disabled population), 907 women with breast or cervical cancer (.2 percent of the total disabled population), and 6,871 disabled and working disabled individuals (1.8 percent of the total disabled population).

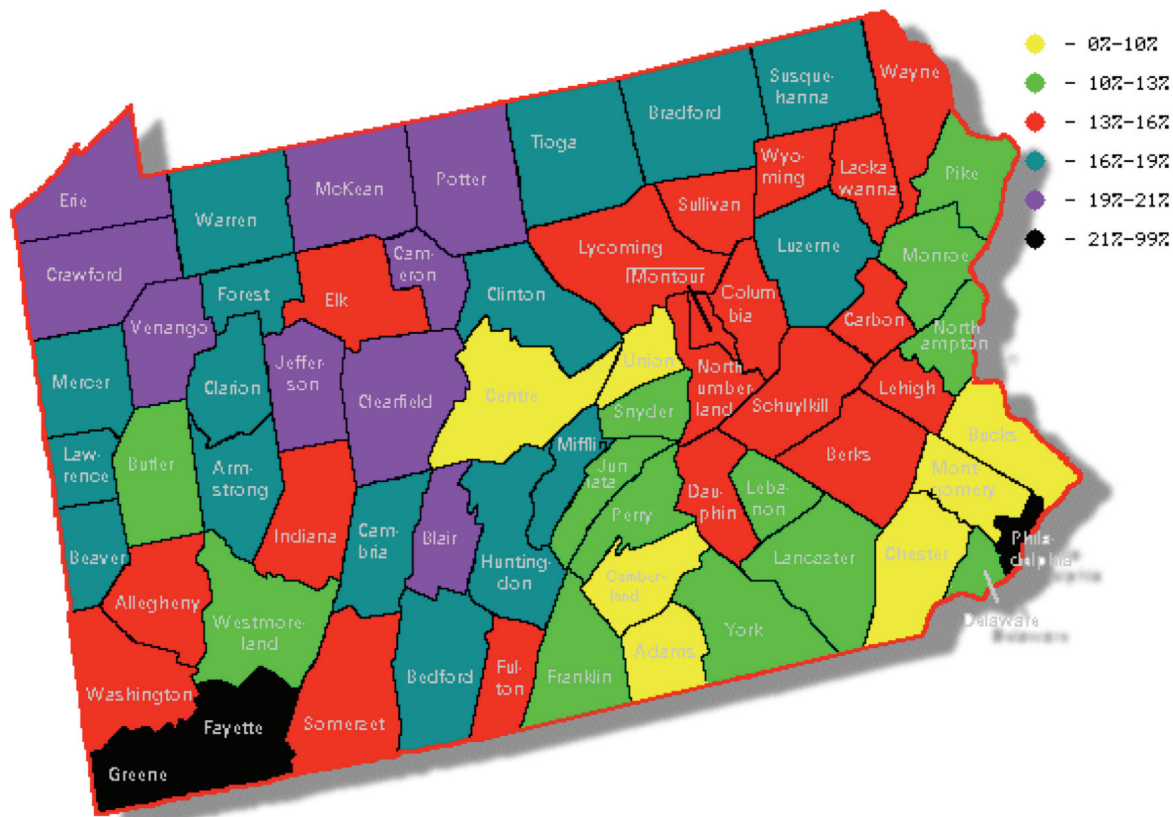
Figure 5 shows the distribution of Pennsylvania Medicaid recipients by age. (In this graph, children with disabilities are identified as children.) Individuals under the age of 18 are the largest proportion of Medicaid recipients, because the Pennsylvania Medicaid eligibility criteria are relatively broad. Adults are only eligible for Medicaid if they are aged, disabled or in households with children. As noted in Figure 2, adults in families with children are only eligible for Medicaid if their family income is less than or equal to 25 percent of the FPL; most of the adults between ages 18 and 65 are disabled. Many of the elderly on Medicaid are eligible because they are residents of long-term care facilities and have “spent down” their assets to Medicaid requirements.

**Figure 5: September 2006 Percent of Pennsylvania Citizens Enrolled in Medicaid by Age**



Note. Data provided by PA DPW.<sup>21</sup>

**Figure 6: The Proportion of Medicaid Recipients to Pennsylvania County Populations in 2006**

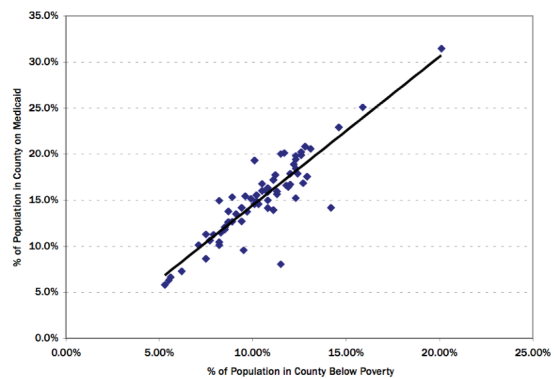


*Note.* Data Provided by PA DPW. Other information from U.S. Census Bureau, 2006.<sup>22</sup> Pennsylvania map provided via 'Do It Yourself' Color-Coded State Maps, <http://monarch.tamu.edu/~maps2/>, Texas A&M University System.

Although 14.8 percent of Pennsylvania’s population was covered by Medicaid in the average month in 2006, the proportion of the population covered varied by county. *Figure 6* shows the distribution of the Medicaid population across the counties. The county population coverage proportions ranged from 5.8 percent in Chester County to 31.5 percent in Philadelphia County.

The main factor influencing the proportion of a county’s population that is covered by Medicaid is the proportion with income below the FPL. *Figure 7* shows the association between the percent of a county’s population that is enrolled in the Medicaid program and the percentage of people in the county below the poverty line. The graph shows that an increase in the proportion of a county’s population below the poverty line from 5 to 20 percent is associated with

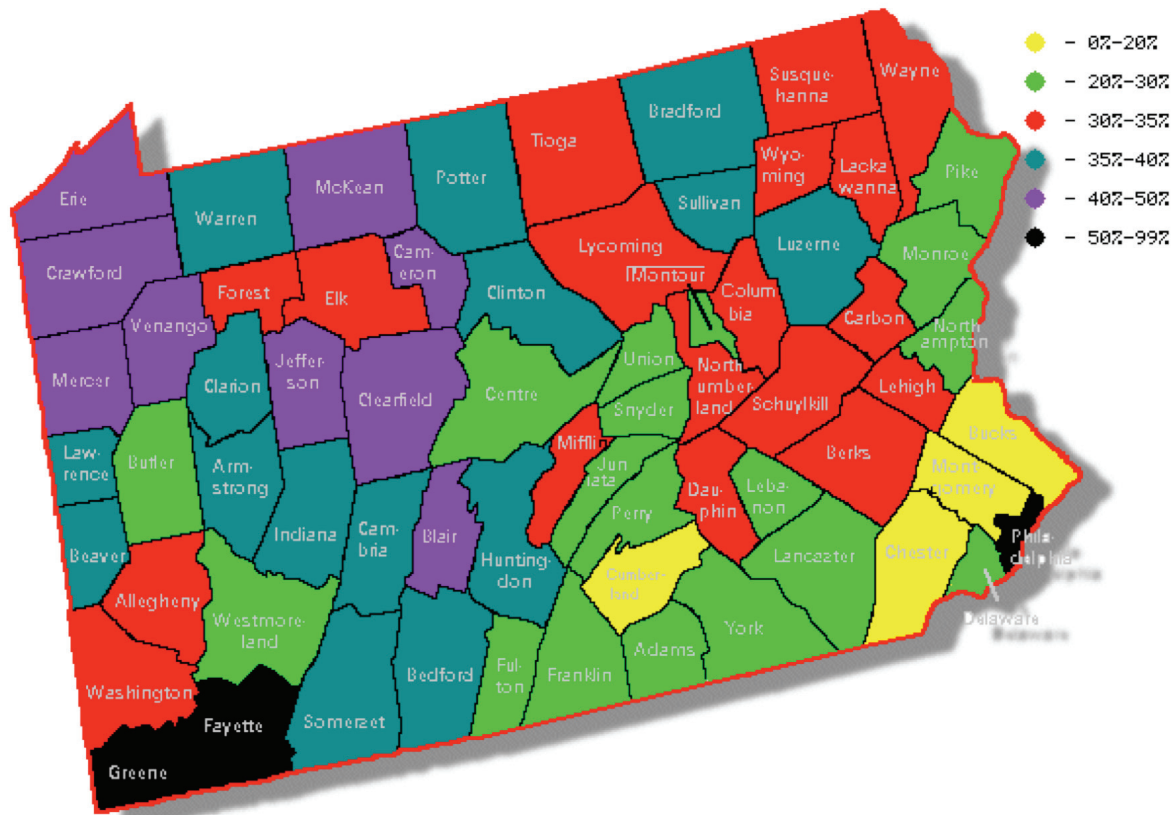
**Figure 7: 2006 Percentage of County Population on Medicaid Against 2003 Percentage of People in County Below the Poverty Income Level<sup>††</sup>**



*Note.* Data provided by PA DPW. Other information from U.S. Census Bureau, 2006.<sup>23</sup>

<sup>††</sup> We do not have 2006 data on the percent of the population in each county that falls below the poverty level.

**Figure 8: The Proportion of Medicaid Children to Pennsylvania County Children Population in 2005**

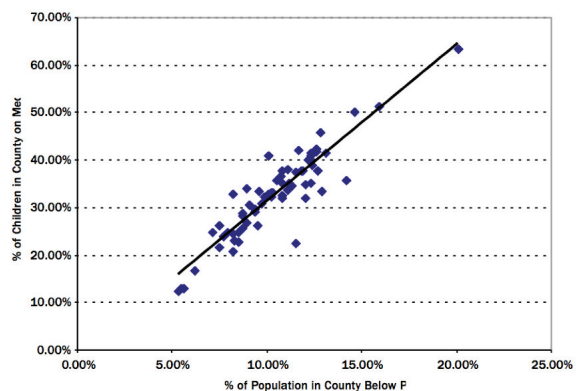


*Note.* Data provided by the PA DPW. Other information from U.S. Census Bureau, 2006.<sup>24</sup> Pennsylvania map provided via 'Do It Yourself' Color-Coded State Maps, <http://monarch.tamu.edu/~maps2/>, Texas A&M University System.

an increase in the county Medicaid population from 6 to 32 percent.<sup>§§</sup>

As previously noted, children are the largest proportion of Medicaid recipients in Pennsylvania and we will now examine this group separately to evaluate their impact on Pennsylvania Medicaid. During the average month in 2005, 33 percent of children in Pennsylvania were covered by the Medicaid program. However, there was considerable variation across the counties with respect to the proportion of children covered. *Figure 8* shows the proportion of children who are covered in each county for FY2006. The proportion of children covered by Medicaid ranges from 12.4 percent in Chester County to 63.4 percent in Philadelphia County. As with the overall Medicaid population, the major factor accounting for the

**Figure 9: 2005 Percentage of Children in Medicaid against 2003 Percentage of Persons below Poverty by County**



*Note.* Data provided by PA DPW. Other information from U.S. Census Bureau, 2006.<sup>25</sup>

<sup>§§</sup> The relationship is demonstrated by the fact that the  $R^2$ , which is a measure of the strength of the association between percent Medicaid and percent of the county that is poor, is .79.

proportion of children in a county that is covered by the Medicaid program is the county per-capita income.

*Figure 9* shows the relationship between the percent of children in a county that are covered by Medicaid and the percent of people in that county with incomes below the poverty level. This graph shows that as the proportion of a county population that is below the poverty line increases from 5 to 20 percent, the proportion of children covered by Medicaid increases from 15 to 65 percent. \*\*\*

### Summary

This report aims to provide policy makers and other key stakeholders in health care with an understanding of the structure and reach of the Medicaid program in Pennsylvania. The complexity of Medical Assistance (as it is known in the Commonwealth), its eligibility criteria, the type of services covered, governance and funding makes it impenetrable to many and hampers the debate about future reform.

Created by Congress in 1965, Medicaid has evolved significantly from its origins as a health care program primarily for individuals receiving cash welfare assistance. It could now be more accurately described as an insurance program that fills in key gaps in the health care financing system and pays for medical and long-term care for eligible low-income citizens, such as children, pregnant women, individuals with disabilities, and seniors. In 2005, approximately 42.5 million individuals, or about 14 percent of the population, were covered by Medicaid in the United States.

In Pennsylvania, more than 1.8 million people were covered by the program on an average month in 2006, representing close to 15 percent of the population. Across the counties in Pennsylvania, Medical Assistance coverage ranged from 5.8 percent in Chester County to 31.5 percent in Philadelphia County—a reflection of the number of low-income individuals resident there. More than one-third of the Commonwealth's children relied on Medical Assistance for their health care coverage in 2005: this ranged from 12.4 percent in Chester County to 63.4 percent in Philadelphia County. Although children and families comprised the largest proportion of Medicaid recipients in 2005 (61 percent), they

accounted for 24 percent of expenditure. Disabled individuals—the second largest enrollment group at 20 percent—accounted for 33 percent of program expenditure. The elderly represented 13 percent of Medicaid recipients, but 35 percent of expenditure.

Through Medical Assistance, the state is the second largest health insurer in Pennsylvania after Blue Cross/Blue Shield affiliates, thus the program plays an important role in reducing the number of individuals who might otherwise be uninsured. Close to 68,000 providers (hospitals, long-term care facilities, dentists and physicians) participate in the Medicaid program. Medical Assistance is an important funding stream for health care institutions that serve a disproportionately large number of poor patients.

As the cost of health care rises and thus the impact of Medical Assistance on the state's budget becomes greater, attention has focused in Pennsylvania on how the program can most effectively meet its mission of providing health care coverage to some of the Commonwealth's most vulnerable citizens. This report and future analyses provided by the PMPC are intended to provide a nonpartisan, independent and fact-based context for these deliberations.

\*\*\* The relationship is demonstrated by the fact that the  $R^2$ , which is a measure of the strength of the association between percent of children on Medicaid and percent of the county that is poor, is .83.

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## Glossary<sup>26</sup>

### **Assets**

To qualify for Medicaid, applicants must meet both income and resource thresholds. The resource test counts the assets that applicants may have available to them beyond their earnings and other income. Assets usually include items such as savings accounts, but not the home in which the applicant lives. While most states have chosen to eliminate the asset test when determining Medicaid eligibility for children, they have been slower to lift the requirement for parents.

### **Categorically Needy**

As defined by the Centers for Medicare & Medicaid Services, categorically needy individuals are those who must be covered by Medicaid, which usually includes: low-income families with children; individuals receiving Supplemental Security Income (SSI); pregnant women, infants and children with incomes less than a specified percentage of the Federal Poverty Level (FPL); and qualified Medicare beneficiaries.

States can choose from a range of options as to how they define “categorically needy.” They may opt to include individuals receiving only a state supplementation of SSI, although their income would prohibit any SSI payment. Categorically needy individuals must be provided with the following services: physician services; inpatient hospital services; outpatient hospital services; rural health clinic services; laboratory and x-ray services; nursing facility services; home health care services for individuals age 21 or older; family planning services and supplies; early and periodic screening, diagnosis and treatment for individuals under age 21; certified mid-wife services and physician services; medical and surgical dental services; certified pediatric and family nurse practitioner services; and federally qualified ambulatory and health center services. In addition, there are many other services Pennsylvania chooses to provide, such as ambulatory surgical centers; birthing center services; chiropractic services; hospice services; intermediate care facilities for persons with mental retardation. For the medically needy, states have considerably more discretion in the services they provide.

### **Centers for Medicare and Medicaid Services (CMS)**

The federal agency within the United States Department of Health and Human Services that runs Medicare. CMS works with the states to run the Medicaid program and the State Children’s Health Insurance Program (SCHIP).

### **Children**

Under Medicaid, children are eligible based on one of several criteria: (1) they are dependent children who qualify under section 1931 provisions, which related to prior Aid to Families with Dependent Children cash assistance standards (including children of unemployed parents), (2) they are medically needy, (3) they qualify under poverty-related eligibility criteria, (4) they are foster care or adopted children, (5) they are eligible under a section 1115 demonstration, or (6) they qualify under other child eligibility provisions. States may elect to define the age cutoff for children at 19, 20, or 21 years. Children who have been granted Medicaid eligibility under disability provisions are usually identified as disabled beneficiaries. Some individuals under age 21, who are pregnant, or who are parents or caretaker relatives of dependant children, may be identified as adults. Federal law requires that all states extend Medicaid to children under age six with income less than 133 percent of the FPL and to children under age 19 with family income less than 100 percent of the FPL.

### **Chronically Ill**

A medical problem that will not improve, that lasts a lifetime, or recurs.



**Cost-Sharing**

The generic term that includes copayments, coinsurance, deductibles, and out-of-pocket payments for balanced billing on unassigned claims. Excludes monthly premiums for Supplementary Medical Insurance coverage, voluntary Hospital Insurance (HI) coverage, and supplemental insurance.

*Copayments:* A specified dollar amount, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a prescription.

*Coinsurance:* A percentage share of medical bills which a beneficiary must pay.

*Deductibles:* Specified amounts of spending which an individual or a family must incur before insurance begins to make payments.

**Covered Services**

Services and supplies for which Medicare, Medicaid, or SCHIP will reimburse.

**Deficit Reduction Act of 2006 (DRA 2006)**

On February 8, 2006 the President signed the Deficit Reduction Act (DRA). The DRA calls for decreasing Medicaid expenditures by enacting new strategies. It allows states to adjust premiums and cost-sharing rates within certain eligibility groups and for certain services. The DRA also allows states to supplement the existing mandatory benefit packages with “benchmark” packages. However, some mandatory services were retained and mandatory benefit packages for certain eligibility categories (pregnant women, parents, individuals with disabilities or special medical needs, dual eligibles and people with long-term care needs) were also retained. The DRA also instituted changes in asset transfer penalties, instituted a longer look-back period, and added home equity into the asset equation. This legislation decreases reimbursement for prescription medication, and allows states to impose increased cost-sharing for prescription medication. In addition, all beneficiaries are required to show documentation of US citizenship to avail Medicaid services.

**Department of Public Welfare**

This is the public agency in Pennsylvania that is responsible for administering Medicaid. It includes the following offices: Office of Administration, Office of Child Development, Office of Children, Youth and Families, Office of Income Maintenance, Office of Medical Assistance Programs, Office of Mental Health and Substance Abuse Services, Office of Mental Retardation and Office of Social Programs.

**Disabled**

One of the categories used for classifying Medicaid eligibles and Medicare enrollees. Under Medicare, disabled refers to individuals under age 65 receiving Social Security or Railroad Retirement Benefit (RRB) disability insurance benefits for 24 months. Individuals under age 65 who are diagnosed with end-stage renal disease (ESRD) are also eligible to receive Medicare benefits and are included with the disabled unless otherwise noted. Under Medicaid, “disabled” refers to low-income individuals of any age who are eligible as individuals meeting the Social Security Administration’s programmatic definition of disability. This includes individuals receiving Supplemental Security Income (SSI) as well as those whose incomes are too high for SSI, but qualify under separate Medicaid income standards.

**Disproportionate Share Hospitals (DSHs)**

Hospitals that serve a disproportionately large volume of low-income persons. Hospitals that meet DSH criteria may receive supplemental payments for Medicaid.

**Dual Eligible**

An individual having entitlement to more than one program or plan. An individual who is eligible for both Medicare and Medicaid coverage, depending on the services and limitation placed by the state, as well as payments of Medicare, monthly premiums, deductibles, and coinsurance. More broadly used to include Medicare beneficiaries eligible for some or all of the Medicare cost-sharing, but not full Medicaid benefits.

**Earned Income**

Earned income may include wages, tips, salaries, or net earnings from self-employment. It may also include other compensation received from performing work activity.

**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)**

A screening, diagnostic, and treatment program under Medicaid with a specific focus on recipients under age 21, which reviews any physical or mental problems and the associated medical requirements to address these problems.

**Eligibility**

Meeting the requirements for coverage under Medicare, Medicaid, or SCHIP. In Medicaid data, the term eligible is often used to refer to individuals who qualify and have actually enrolled in the program.

**Federal Benefit Rate (FBR)**

The national benefit amount, established by the Social Security Administration (SSA), for Supplemental Security Income (SSI) recipients. The Federal Benefit Rate (FBR) is administered by SSA for all states and Commonwealths annually. For 2007, the FBR is \$623 for an individual and \$934 for a couple.

**Federal Medical Assistance Percentage (FMAP)**

The percentage of Medicaid benefit payments reimbursed by the federal government. FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income and by law, may range from a minimum of 50 percent and to a maximum of 83 percent.

**Federal Poverty Level (FPL)**

Low-income guidelines established annually by the federal government. Public assistance programs, including Medicaid and SCHIP, often define income limits in relation to the FPL.

2007 Poverty Guidelines for the 48 Contiguous States and the District of Columbia are as follows:

PERSONS IN FAMILY	GUIDELINE
1	\$10,210
2	\$13,690
3	\$17,170
4	\$20,650
5	\$24,130
6	\$27,610
7	\$31,090
8	\$34,570

For families with more than 8 persons, add \$3,480 for each additional person.

**Fiscal Year (FY)**

The 12-month period under which the federal government operates. Until 1976, the FY extended from July 1 of each year to June 30 of the following year. Beginning in 1976, the FY was changed to October 1–September 30. (The 3-month period July–September 1976—the so-called transition quarter—does not belong to any FY.) FY's are labeled by the year in which they end, e.g., October 1, 2000–September 30, 2001 is called FY 2001.

**Home and Community-Based Services**

A variety of supportive services delivered in community settings or in an older individual's home which are designed to help older individuals remain living at home and avoid institutionalization.

**Managed Care Organization**

Entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers. These include entities such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and point of service (POS) plans. In the Medicaid world, other organizations may set up programs to provide Medicaid managed care. These organizations include Federally Qualified Health Centers (FQHC's), integrated delivery systems, and public health clinics.

### **Mandated and Optional Services**

Mandatory services are a specific set of services that must be covered by any state participating in the Medicaid program (unless waived under section 1115 of the Social Security Act) as opposed to those, which a state may elect to include under its Medicaid plan or waivers.

### **Medicaid**

The joint federal/state program, enacted in 1965 as Title XIX of the Social Security Act, that pays for medical care on behalf of certain groups of low-income individuals.

### **Medical Assistance**

The Medicaid program in Pennsylvania.

### **Medically Needy (MN) Eligibles**

An optional Medicaid eligibility group consisting of individuals who qualify under an income standard- the MN income level- that is separated from the standards used for categorically needy coverage. MN enrollees must meet Medicaid's categorical requirements (aged, disabled, adults with children, children) and may meet the MN income level by incurring high medical expenses, usually from hospital or nursing home care, which are deducted from their incomes in the process known as "spend-down."

### **Medicare**

Medicare is medical insurance for the elderly (age 65 or older) and/or for individuals with disabilities who receive Social Security Disability Insurance (SSDI). Individuals with disabilities must complete a five month waiting period from their disability onset before their Social Security benefits begin. There is an additional 24 month waiting period (Medicare Qualifying Period) before individuals are entitled to Medicare benefits. Cash benefits will begin before individuals are eligible for Medicare benefits.

There are two parts to Medicare. Medicare Part A pays for hospital in-patient and certain follow-up care. Medicare Part B is an elective coverage and is paid for through monthly premiums. If an individual is eligible for both Medicare and Medicaid, Medicaid will pay for the Medicare Part B premium (these individuals are also known as 'dual eligibles.')

In 2006, a new program called Medicare Part D (The Medicare Prescription Drug Program) was made available for low-income Medicare beneficiaries to help pay for prescription drugs.

### **Office of Medical Assistance Programs**

This is one of Pennsylvania's state agencies within the Department of Public Welfare. The Office of Medical Assistance Programs administers the joint state/federal Medical Assistance program that purchases health care for close to 1.7 million Pennsylvania residents. Based upon an individual's eligibility category, covered services may include physician and clinic visits; inpatient hospital care; home health care; medical supplies and equipment; nursing facility care; inpatient and outpatient psychiatric and drug and alcohol services; prescription drugs; dental and other medically necessary services. This Office of Medical Assistance Programs is also responsible for enrolling providers, processing provider claims, establishing rates and fees, contracting and monitoring of managed care organizations, and detecting and deterring provider and recipient fraud and abuse.

**Office of Income Maintenance**

An office within the Pennsylvania Department of Public Welfare. The Office of Income Maintenance is responsible for the administration of cash assistance, Medicaid, food stamps, and employment and training services. These programs are provided through county assistance offices, which are located across the Commonwealth.

Cash assistance includes Temporary Assistance for Needy Families (TANF), General Assistance (GA), and State Blind Pension. Pennsylvania also supplements the basic Supplemental Security Income (SSI) grants, administered by the Federal Social Security Administration, for individuals who are elderly, blind or disabled.

**Optional Services**

Optional services are a specific set of services, which a state may elect to include under its Medicaid plan or waivers.

**Participating Physician and Supplier**

Under Medicaid, participating providers agree to accept Medicaid reimbursement as payment in full.

**Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996**

This federal legislation created the Temporary Assistance to Needy Families (TANF) program to replace the earlier AFDC program. This legislation also introduced new rules relating to receipt of public benefits by immigrants. No immigrant who entered the United States after the PRWORA was passed (August 22, 1996) was eligible for federal means-tested public benefit for 5 years. After five years of residence, they can apply for Medicaid and TANF benefits, to be given at the discretion of each state. Legal permanent residents (LPRs) who were residing in the US prior to August 22, 1996 are barred from receiving food stamps and Supplemental Security Income (SSI). Each state is still allowed to offer Medicaid and TANF benefits to new immigrants. All states are mandated to cover all immigrant children by the State Children's Health Insurance Program (SCHIP). Refugees and asylees are eligible for benefits seven years after entering the US. Nonimmigrants and undocumented aliens are barred from receiving any benefits, with the exception of emergency and public health services. The Farm Security and Rural Investment Act of 2002 restored immigrants' access to food stamps.

**Physician Services**

Physicians' services are services provided by an individual licensed under state law to practice medicine or osteopathy. Services covered by hospital bills are not included.

**Premium**

A monthly fee that may be paid by Medicare, Medicaid, and SCHIP enrollees. Aged individuals who are not eligible for automatic Hospital Insurance (HI) enrollment may pay a monthly premium to obtain HI coverage. Supplemental Medical Insurance (SMI) enrollees pay a monthly premium that is updated annually to reflect changes in program costs.

**Recipient**

A Medicaid enrollee who receives a Medicaid-covered service. An alternate reference to beneficiary.

**Specified Low-Income Medicare Beneficiaries (SLMB)**

A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.

**State Children's Health Insurance Program (SCHIP)**

Free or low-cost health insurance that is available in each state for uninsured children under age 19. SCHIP provides health insurance for uninsured children whose families earn too much to qualify for Medicaid, but not enough to get private coverage.

**Spend Down**

For Medicaid, if a person's income is above the Medicaid income standards, he/she may be required to pay out-of-pocket for some of the medical services (the spend-down amount) before receiving Medicaid coverage each month. Each month when the individual's medical expenses equal or exceed the spend-down amount, Medicaid can help pay the remaining medical expenses. This is similar to a deductible for private insurance.

**Social Security Administration (SSA)**

The federal agency responsible for administering the Old Age, Survivors, and Disability Insurance (OASDI) program as well as the Supplemental Security Income (SSI) program of the Social Security Act.

**Supplemental Security Income (SSI)**

A program of income support for low-income, aged, blind, and disabled persons established in Title XVI of the Social Security Act.

**Temporary Assistance for Needy Families (TANF)**

Created by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, TANF provides assistance and work opportunities to needy families. This program replaced the earlier AFDC program.

**Waiver**

An exception to the usual requirements of Medicare or the usual requirements of Medicaid granted to a state by CMS, authorized through the following sections of the Social Security Act or Social Security Amendments:

*1115 of the Social Security Act:* Allows states to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid program. Radical, system wide changes are possible under this provision.

*1915(b) of the Social Security Act:* Allows states to waive freedom of choice. States may require that beneficiaries enroll in HMOs or other managed care programs, or select a physician to serve as their primary care case manager.

*1915(c) of the Social Security Act:* Allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify for services in an ICF/MR, nursing facility, institution for mental disease, or inpatient hospital.

*1929 of the Social Security Act:* Allows states to provide a broad range of home and community-based services to functionally disabled individuals as an optional state plan benefit. In all states except Texas, the option can serve only people age 65 or over.

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