Medicaid in a Nutshell

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Medicaid is an optional program, but all states choose to participate because of the large share of costs underwritten by the federal government—58.3% of Medicaid costs in Wisconsin. Medicaid is difficult to budget for because it is an entitlement program that cannot exclude anyone who qualifies for coverage. Some groups have particularly high medical and long-term care needs. For example, in Wisconsin, the low-income elderly and disabled make up only 33% of Medicaid clients, but account for 76% of program costs. In contrast, children and adults (mostly poor parents and pregnant women) account for 67% of clients, but only 24% of costs

Medicaid has become the nation's largest source of funding to provide health services to low-income people, amounting to about $270 billion in 2003. The program accounts for about 20% of the average state's budget and nearly 70% of state spending on health services and programs. As Medicaid costs rise faster than state revenues, states struggle to rein in costs, while preserving services to their most vulnerable citizens. This chapter summarizes key elements of the program, including what Medicaid is, why legislators should care about it, which people it covers, what services it includes, why the program costs so much, how some states control their Medicaid costs, and new developments in the program.

What is Medicaid?

A federal-state partnership program created by Congress in 1965 (Title XIX of the Social Security Act), Medicaid was designed to finance health care services for the nation's poor people. Its original focus was on recipients of cash assistance through welfare programs. The program expanded to fund health services for approximately 52 million low-income Americans during the 2003 calendar year, according to the Congressional Budget Office.

Although Medicaid is an optional program in which states may choose to participate, the federal government's large financial share provides an incentive. All 50 states participate and administer their own Medicaid plans. The federal government pays at least 50% of the costs of medical services under Medicaid, ranging as high as 80% in the poorest states. In FY 2005, the federal government paid 58.3% of Wisconsin's cost of Medicaid medical services.

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Medicaid is sometimes confused with Medicare, a federal program that serves the elderly and certain people with long-term disabilities. Nonetheless, Medicare relies on Medicaid to help it cover certain services for low-income elderly people, such as nursing home care and pharmaceuticals. Approximately 7 million people qualify for dual coverage—under both Medicare and Medicaid—as discussed later.

Medicaid has evolved to become three programs in one:

1. A health financing program for low-income parents (mostly women) and children.
2. A health financing program for people with significant disabilities.
3. A long-term care financing program for low-income elderly people.

Why Should We Care About Medicaid?

We should care about Medicaid for several reasons, including that Medicaid:

- ➤ Accounts for nearly 20% of the average state's budget and nearly 70% of all state health expenditures. In FY 2003, Wisconsin spent 12.3% of its total budget and 73.1% of its health care budget on Medicaid.[1]
- ➤ Serves as the largest health financing source for low-income Americans.
- ➤ Accounts for about 43% of federal assistance to states.
- ➤ Funds about one-third of all U.S. births.
- ➤ Funds long-term care services for nearly one-third of all people age 85 and over.
- ➤ Subsidizes state health services for uninsured people.
- ➤ Subsidizes graduate medical education in states.

Medicaid has become a vital funding source for health care in this country; it paid for nearly one-half of nursing home care, 17% of hospital services, 17.2% of prescription drug costs, and 16.7% of all personal health services in 2001. Hospitals and clinics that serve a large share of both Medicaid-eligible and uninsured patients receive extra payments through Medicaid's "disproportionate share hospital" (DSH) provisions to help pay for such care.

With most state budgets in financial trouble, Medicaid programs and costs have come under increased scrutiny. Although average state revenues grew only 1.2% in 2002, Medicaid costs soared 12.8% - similar to the increases in the private insurance market. Medicaid costs rose another 9.3% in 2003, and the Congressional Budget Office predicts annual increases of 8% or higher during the next several years. In Wisconsin from FY 2002 to FY 2003, Medicaid expenditures increased 12.6%, an increase of more than $438 million.[2]

Which People Does Medicaid Cover?

Medicaid budgeting is difficult because the number of eligible people fluctuates with the economy and other variables.

Federal law requires Medicaid programs to cover certain populations and allows states the option of covering others. Medicaid is an "entitlement" program, which means that states may not exclude anyone who applies for coverage if he or she meets specified eligibility criteria. This provision makes budgeting for Medicaid somewhat difficult because enrollment may not be limited and the number of eligible people fluctuates with the economy and other variables. Although 52 million people were covered by Medicaid at some point during 2003, month-by-month variations exist as people move in and out of the program. For example, 41.2 million people were enrolled in Medicaid during December 2002. In Wisconsin in June 2003, 631,400 people were enrolled in Medicaid.[3]

Mandatory Populations

Although state participation in Medicaid is optional, states that have Medicaid programs must provide coverage to certain groups or "categories" of people (sometimes referred to as "categorically eligible"). Mandatory groups include the following:

- AFDC-related populations (certain parents and children).
- People who receive Supplemental Security Income (SSI), a federal cash assistance program for low-income people with disabilities who meet specified eligibility criteria.
- Pregnant women with incomes up to 133% of federal poverty guidelines ($12,382 for a single woman in 2004).
- Infants of women enrolled in Medicaid at the time of birth, or those in families with income up to 133% of poverty guidelines.
- Children under age 6 in families with income up to 133% of poverty guidelines.
- Children ages 6 through 18 in families with incomes at or below the poverty level.
- Children in adoption or foster care.
- Some low-income Medicare recipients (for services not covered by Medicare).

Optional Populations

For many years, states had little discretion about covering additional people under Medicaid. The program was mainly designed to assist very low-income, welfare-related populations. However, the program expanded over time, most notably for children and pregnant women. A few of Wisconsin's optional groups include low-income infants and pregnant women, other low-income children, and certain aged, blind, or disabled adults with income less than 100% of the poverty level. The most common additional populations that states may choose to cover in their Medicaid programs include the following.

- Infants and pregnant women with family incomes up to 185% of the federal poverty guidelines.
- Additional families, by disregarding a portion of family income, eliminating asset tests, raising income levels to adjust for inflation, or extending benefits to two-parent working families.
- Additional Medicare recipients by increasing income eligibility levels.
- "Medically needy" people (specified low-income people who do not meet income criteria, but who have large medical expenses in proportion to their income).
- People with disabilities who would lose eligibility because of higher income, who may buy Medicaid coverage under a sliding-scale premium (the "Ticket to Work" initiative).
- Low-income uninsured women with breast or cervical cancer who have been diagnosed through the National Breast and Cervical Cancer Early Detection Program, for their cancer treatment (see www.ncsl.org/programs/health/bcsnapshot.htm or www.cms.hhs.gov/bccpt/default.asp?).

- Children under the State Children's Health Insurance Program (SCHIP). Under the federal SCHIP legislation passed in 1997, states may extend Medicaid coverage to children through age 18 with family incomes of up to 200% of the federal poverty guidelines (or they may create a non-Medicaid insurance option). For background on Wisconsin's family-based SCHIP program, see the June 2003 Family Matters newsletter at http://familyimpactseminars.org/fisnews3-1.pdf.

Figure 1. 2004 Federal Poverty Guidelines for a Family of Three

Income as a Percent of Poverty	48 Contiguous States and D.C.
100%	$15,670.00
133%	20,841.10
185%	28,989.50
200%	31,340.00

Source: Federal Register, February 13, 2004.

In general, states cover people who meet the eligibility criteria for each of the listed categories, as determined in each state's program plan. With the exceptions described below, unless people fit one of the categories, they may not receive Medicaid assistance no matter how poor they are. For example, an adult with no income may not qualify for Medicaid assistance unless he or she meets the criteria for one of the listed categories (e.g., welfare-related parent, SSI recipient, pregnant woman).

According to the Kaiser Commission on Medicaid and the Uninsured, Medicaid covered about 40% of nonelderly Americans with incomes below poverty guidelines in 2001, and 23% of Americans with incomes between 100% and 200% of federal poverty guidelines. Of the people enrolled in Medicaid in 2001, about 29% were covered under optional categories, including 21% of children, 41% of parents, 22% of people with disabilities, and 48% of the elderly.[4]

"Waiver" Populations

Some states have received "waivers" from the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers both programs, to expand their Medicaid programs to include other uninsured residents who do not fit into the regular optional eligibility categories. The "1115 waiver," the most common waiver that allows states to expand eligibility, was created by section 1115 of the Social Security Act. As a "research and demonstration" program, it gives the secretary of the Department of Health and Human Services broad discretion to waive certain federal requirements so that states can test new and innovative ideas. Some examples follow.

Minnesota covers children under age 2 in families with incomes up to 280% of poverty guidelines, pregnant women with incomes up to 275%, and other children through age 18 in families with incomes up to 170% of federal poverty guidelines, and several other categories of people with incomes up to 100% of poverty guidelines.

Oregon covers children and pregnant women in families with incomes of up to 185% of federal poverty guidelines, and parents and childless adults with incomes up to poverty guidelines. Childless adults, covered by a less comprehensive benefits package, pay both monthly premiums and service copayments. In addition, Oregon subsidizes employer-sponsored insurance or individual insurance coverage for certain low-income populations through its Family Health Insurance Assistance Program. The state received a Medicaid waiver in October 2002, which allows it to receive federal Medicaid matching funds for the program.

Such waivers, usually five-year demonstration projects, must be "cost neutral" over the life of the waiver, meaning states must achieve savings in some program areas in order to cover additional people. Early waiver programs achieved savings by enrolling their populations into managed care plans and assessing premiums or copayments. Oregon developed a list of "prioritized" services to achieve savings and cover additional people. Utah's new 1115 waiver, which covers about 25,000 previously uninsured adults, limits benefits to preventive and primary care. In an effort to save costs, the state reduced benefits for some optional populations and hopes to save money through reduced hospital and emergency room use.

In 2002, the Bush administration announced a new 1115 waiver initiative, the "Health Insurance Flexibility and Accountability" (HIFA) waiver, which allows states additional flexibility to expand Medicaid to their uninsured populations. For more information about 1115 waivers, visit www.cms.hhs.gov/medicaid/1115/default.asp. For more information about HIFA, see www.ncsl.org/programs/health/hifa.htm or www.cms.hhs.gov/hifa.

What are the Pros and Cons of Expanding Medicaid?

Several states have used Medicaid to anchor major health reforms that are designed to reduce their uninsured populations. The key advantages to expanding Medicaid coverage to achieve insurance coverage for low-income people include the following.

- The federal government pays at least half the costs for medical services under Medicaid.
- States already have administrative and provider networks in place under their Medicaid programs.
- With new flexibility, states have more options to create programs that are designed to meet their unique needs.
- Expanding Medicaid has proven successful in lowering the number of uninsured residents, which also helps reduce the burden of cost-shifting to employers, other purchasers of private coverage, and health care providers.

Expanding Medicaid lowers the number of uninsured residents and reduces cost shifting.

Concerns about expanding Medicaid eligibility include the following.

- Some people prefer private sector solutions to cover the uninsured and object to expanding the government's role.
- State financing constraints – many states cannot afford the matching funds necessary for expanding their programs.

- Federal requirements limit state options in choosing which people to cover and which benefits to offer.
- Congress has occasionally imposed a "maintenance of effort" requirement on states that have expanded eligibility, which removes the state's option to reduce eligibility in the future.

For state-by-state Medicaid enrollment information, see *Medicaid Enrollment in 50 States: June 2003 Update.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2004, http://kff.org/medicaid/7237.cfm.

What Services Does Medicaid Cover?

Similar to mandatory and optional populations for Medicaid eligibility, federal Medicaid law requires states to cover certain services and allows states to select from a menu of other optional services. Because Medicaid covers so many low-income elderly people and people with serious disabilities who cannot obtain private sector coverage, its benefits package reflects these special needs. For example, Medicaid covers some services that most private insurance plans do not cover, such as nursing home and other long-term care services, and that can be especially expensive.

Mandatory Services

States that participate in Medicaid must cover the following services, if needed, for all who qualify for the program: (1) inpatient and outpatient hospital services, (2) physician services, (3) dental services (medical and surgical), (4) nursing facility services, (5) home health care (for people who meet the eligibility criteria for nursing facility services), (6) family planning services and supplies (but not abortion), (7) rural health clinic services, (8) laboratory and x-ray services, (9) pediatric and family nurse practitioner services, (10) federally qualified health center (FQHC) services, (11) nurse-midwife services, and (12) early periodic screening, diagnosis, treatment (EPSDT) services for children through age 20.

It should be noted that mandatory coverage of EPSDT includes any "medically necessary" services allowed for federal reimbursement. This means that states must cover all optional services available under the federal menu of services for children who need them, even if the state does not choose to cover those optional services for their other Medicaid-enrolled people.

Optional Services

States may choose to include more than a dozen optional services in their Medicaid programs. Commonly covered services across all states include: (1) prescription drugs, (2) optometrist services and eyeglasses, (3) intermediate care facilities for people with mental retardation (ICF/MR), (4) emergency hospital services, (5) clinic services, (6) nursing facility services for the aged in an institution for mental diseases (IMD), (7) dental services (unless for medical or surgical conditions), (8) prosthetic devices, (9) hospice services, (10) services performed by podiatrists, chiropractors, or other licensed professionals, (11) psychological services, (12) private duty nursing, (13) personal care services, (14) case management, (15) diagnostic, preventive and rehabilitative services, (16) inpatient psychiatric services (for those under age 21 or over age 64), (17) physical and occupational therapies, (18) speech/language/hearing therapies,

(19) dentures, (20) respiratory services for children who use a ventilator, and (21) primary care case management. Wisconsin offers a number of optional services, including dental services, physical therapy, eyeglasses, hospice care, and personal care services.

In addition to requiring states to cover certain services, federal law places certain other constraints on Medicaid services. Covered services must be available statewide, must be comparable (equal for all in a group), and must be sufficient in “amount, duration, and scope” to achieve their purpose. For example, although states may limit the number of physical therapy appointments the state will pay for, they should be “sufficient” to achieve the intended purpose. However, states retain considerable flexibility in defining certain services and setting coverage guidelines. As with the requirements concerning Medicaid eligibility, states may seek waivers from CMS to allow them some flexibility related to providing services.

Services Waivers

The most common services-related waiver, known as the “home and community-based services” (HCBS) waiver, allows states to cover certain health and support services to Medicaid-eligible people who otherwise would be served in an institutional setting, such as a nursing home or intermediate care facility. HCBS waivers allow states to target certain populations and to provide a special menu of services, such as home health aide, homemaker, or respite care services. With such a waiver, states can help certain people live more independently in the community without making such services available to all Medicaid clients around the state. This enables a state to assist defined populations while protecting the state’s ability to cap expenditures by limiting enrollment in a particular waiver program. For more information about HCBS waivers and a related Supreme Court decision (Olmstead vs. L.C.), see www.ncsl.org/programs/health/olmstead-home.htm.

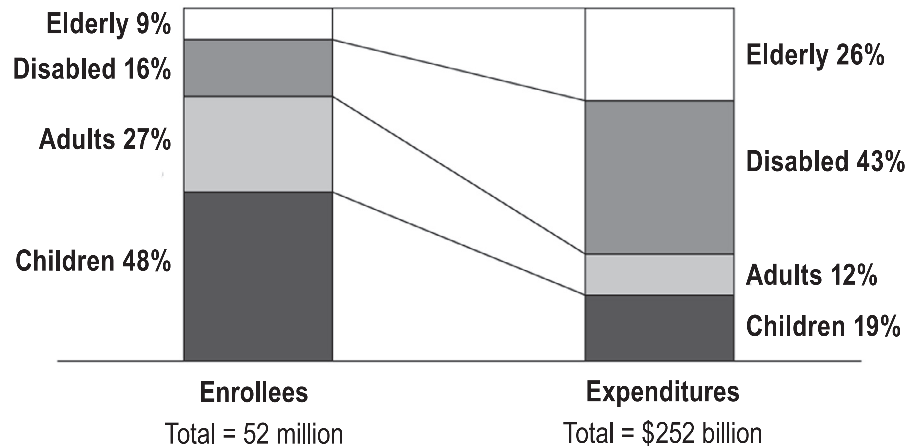
As described in the previous section, 1115 waivers allow flexibility in covering uninsured populations. For example, Utah’s 1115 waiver allows the state to cover only primary and preventive services to the new adults the program covers. For new populations covered under a Health Insurance Flexibility and Accountability (HIFA) 1115 waiver, for example, states may be able to offer only selected services and also reduce optional benefits to other Medicaid populations in the “optional” eligibility categories.

The primary reason Medicaid costs so much results from its coverage of low-income elderly and people with disabilities who have high medical needs.

Why Does Medicaid Cost So Much?

Health costs have skyrocketed in this country, and Medicaid is not immune to the same factors that drive up costs in the private sector. However, Medicaid is unique in other ways. The most notable reason Medicaid costs so much results from its coverage of low-income elderly and people with disabilities who have high medical needs, including long-term care. Although these two populations made up only 25% of Medicaid clients in 2003, they accounted for about 70% of program expenditures for medical care (see Figure 2). Not only do the elderly and people with disabilities account for nearly all of Medicaid’s institutional costs, they also account for about 85% of Medicaid spending for prescription drugs.

Figure 2. Medicaid Beneficiaries and Expenditures, 2003

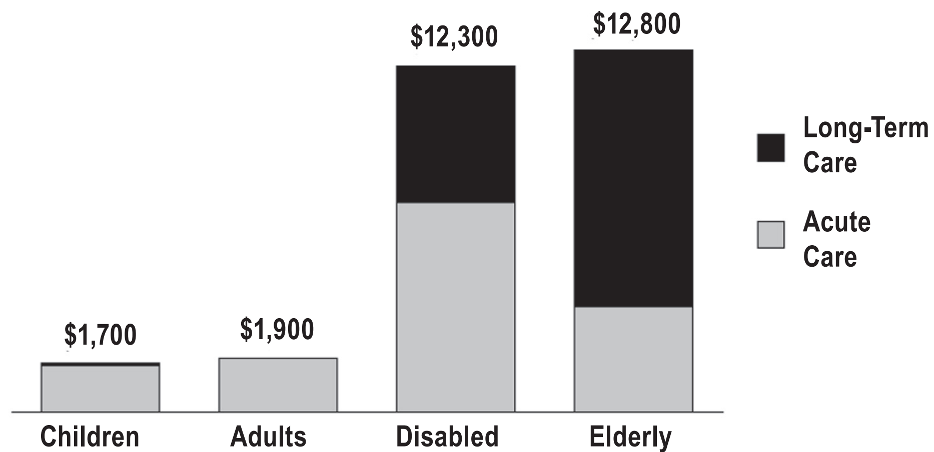


**Note: Expenditures excludes disproportionate share hospital payments*
Source: Kaiser Commission on Medicaid and the Uninsured, January 2005.
http://www.kff.org/medicaid/upload/The-Medicaid-Program-at-a-Glance-Fact-Sheet.pdf

In Wisconsin, children and adults (mostly poor parents and pregnant women) account for 67% of participants but only 24% of costs.

In contrast, children and adults (mostly welfare-related parents and pregnant women) made up 75% of the clientele in 2003, but accounted for just 31% of medical costs. In Wisconsin, these two groups account for about 67% of participants, but only 24% of costs. Many low-income people with significant disabilities or chronic diseases (such as AIDS) rely on Medicaid because they cannot obtain private sector health insurance and they do not qualify for Medicare. Many people in this category require intensive acute care services or long-term care services (see Figure 3).

Figure 3. Medicaid Expenditures Per Enrollee by Acute and Long-Term Care, 2003



Source: Kaiser Commission on Medicaid and the Uninsured estimates based on CBO and Urban Institute data, 2004.

In addition, Medicaid enrolls about 7 million people who are also covered under the federal Medicare program. These "dually eligible" people qualify for Medicaid based on their disability and low-income status. Virtually all elderly Medicaid recipients and about one-third of non-elderly enrollees with disabilities are also enrolled in Medicare. Medicare pays for any Medicare-covered services

(e.g., most acute care and hospital services) and Medicaid acts as a kind of supplemental policy. Medicare covers very limited nursing home care or prescription drugs, both of which have high costs. Medicaid pays for the bulk of long-term care services and prescription drugs for people enrolled in both programs. Nearly one-quarter of dually eligible people reside in long-term care facilities. (For more information, see www.kff.org/medicaid/4091-03.cfm.)

The new Medicare law, signed December 8, 2003, will begin covering prescription drugs in January 2006. However, it will not provide states with much fiscal relief. The federal law requires states to pay back 90% of the prescription drug costs associated with the new Medicare benefit in 2006 for dually eligible people, phasing down to 75% of such costs in 2015 and later years. Because of complexities in the new law and its other effects on state Medicaid programs, it is not yet clear how individual states will fare financially (see www.ncsl.org/programs/health/pharm.htm#new; or www.kff.org/medicaid/rxdrugs.cfm).

How Can States Control Medicaid Costs?

As Medicaid consumes a larger share of state budgets, policymakers seek ways to make the program as efficient and effective as possible. It is important to remember that program costs have risen in response to several factors, including rising health costs, a growing number of elderly people who need long-term care services, and the choice by states to cover millions of optional people under Medicaid who otherwise would not have health coverage. The most obvious ways for states to trim Medicaid costs involve cutting program eligibility, services, or payments to service providers. Each of these options has its drawbacks.

- Cutting eligibility may shift costs elsewhere, such as to other state or locally funded programs, to emergency rooms, to private insurance plans in the form of higher premiums, and to providers in the form of bad debt or charity care.
- Imposing overly stringent restrictions on services such as prescription drugs may result in higher costs associated with sicker patients, including expensive hospital or nursing home care.
- Freezing or reducing provider payments could result in fewer providers participating in the program, making it difficult to ensure that patients receive needed care.

States have undertaken a number of longer-term reforms to help control Medicaid costs, including reforming long-term care, focusing on disease management, emphasizing prevention, reducing prescription drug costs, investigating fraud and abuse, using electronic records, maximizing federal funding, leveraging federal flexibility, and conducting evaluations to identify potential cost savings.

Long-term care services consume about 40% of Medicaid budgets.

Reform long-term care. Long-term care services consume about 40% of Medicaid budgets. Maine cut the total per-person spending on Medicaid-funded long-term care by 12% by increasing community-based services, cutting the time that Medicaid clients stay in nursing homes, billing Medicare for appropriate services, and tightening medical eligibility standards. Promoting private long-term care insurance also may help lessen future burdens on state budgets.

Florida reports a $42.2 million savings over five years by providing intensive disease management services to certain chronically ill people.

Focus on the sickest people. At least 21 states attempt to "manage diseases" such as asthma and diabetes in their Medicaid programs. Florida reports a $42.2 million savings over five years by providing intensive services to certain chronically ill people. CMS announced support for disease management initiatives under Medicaid in a letter to state Medicaid directors on February 25, 2004 (see www.cms.hhs.gov/states/letters/smd022504.pdf).

Emphasize prevention. Children make up about half of Medicaid enrollees. By focusing on prevention and timely acute care services for Medicaid-enrolled children, a North Carolina pilot program cut emergency room visits by 20% and also reduced hospital stays.

Reduce prescription drug costs. States have saved millions of dollars by implementing prior authorization, preferred drug lists and supplemental rebates, and by requiring use of generic drugs. (For more information, see www.ncsl.org/programs/health/medicaidrx.htm.)

Investigate fraud and abuse. Florida discovered that a number of fake Miami clinics had billed Medicaid $25 million over a year's time. Strengthening investigative and enforcement policies have cut the state's estimated fraud in half.

Use electronic records. Arkansas saved an estimated $30 million over 17 months by creating an integrated electronic billing, eligibility verification, payment, data collection and analysis system.

Maximize federal funding. By identifying programs paid for by the state that could qualify for federal matching funds under Medicaid, states could reap significant benefits. For example, certain special education, foster care and substance abuse services may qualify for Medicaid reimbursement. In addition, states that sponsor pharmacy assistance programs for low-income residents may qualify for federal Medicaid assistance under a new Medicaid Pharmacy Plus waiver (see www.ncsl.org/programs/health/pharmplus.htm).

Leverage federal flexibility. Medicaid's 1115 waivers give states more flexibility to craft Medicaid demonstration projects. For example, Utah expanded its program to cover up to 25,000 additional low-income adults for primary and preventive services. The state projects savings in hospital and emergency room costs for previously uninsured adults. Missouri estimated savings of $11.4 million in 2002 through its premium assistance program, which subsidizes employer-sponsored insurance for eligible Medicaid workers (instead of enrolling individuals in the state's regular Medicaid plan).

Evaluate the program. A number of states have achieved savings in their Medicaid programs by conducting studies or audits to identify areas where the program could be refined or improved. For example, South Carolina's Legislative Audit Council recommended a preferred drug list to save $12.8 million and an enrollment fee to save an estimated $1.4 million.

What's New in Medicaid?

The Medicaid program has evolved over time from one that covers specific categories of very low-income people – mostly people associated with cash assistance programs – to one that allows states to cover virtually any groups they desire, as long as they receive a waiver from the Department of Health and Human Services. Major changes include:

Expanded coverage. The average income threshold for Medicaid eligibility for children and their single parents in the mid-1980s was about 40% of federal poverty guidelines. Today, states must cover young children and pregnant women with incomes up to 133% of poverty guidelines and older children up to 100% of poverty; they may set levels even higher.

Creation of the State Children's Health Insurance Program (SCHIP) in 1997 allows states to expand their Medicaid programs to cover additional children in Medicaid with an enhanced federal match. The program targets children in families with incomes up to 200% of federal poverty guidelines and also allows states to cover such children in non-Medicaid insurance plans. A number of states have expanded their SCHIP programs to cover additional children, pregnant women, parents of SCHIP-eligible children, and even childless adults (see www.ncsl.org/programs/health/chiphome.htm.)

Flexibility. Through the flexibility allowed under various waivers, states may extend eligibility to populations never allowed before, including single adults and working poor and near-poor populations. For example, Arizona, Delaware, Hawaii, Massachusetts, Minnesota, New York, Oregon, Utah and Vermont have used 1115 waivers to cover broad populations of low-income people, including single adults who would not otherwise be eligible for Medicaid. (see www.cms.hss.gov/medicaid/1115/default.asp?). Under the new Health Insurance Flexibility and Accountability waiver, states may cover additional people under a reduced benefits package and increase their cost-sharing requirements (see www.cms.hhs.gov/hifa/ or www.ncsl.org/programs/health/hifa.htm).

New flexibility under Medicaid and SCHIP also allows states to create "premium assistance" programs that subsidize employer-sponsored insurance for employees who cannot afford their share of the premium. By partnering with employers, states can save money by leveraging the employers' share of the premiums and also can help prevent erosion of the employer-based insurance system when expanding Medicaid or SCHIP to cover working poor people. At least 14 states including Wisconsin sponsor such premium assistance (see www.cms.hhs.gov/schip/snapshot.pdf and www.ncsl.org/programs/health/buyin03.htm).

The "Pharmacy Plus" waiver allows states that sponsor pharmaceutical subsidy programs to gain federal matching funds for people age 65 or older with incomes between 100% and 200% of federal poverty guidelines (see www.ncsl.org/programs/health/pharmplus.htm and www.ncsl.org/legis/pubs/203cure.htm).

Medicare changes. As described earlier (under "Why Does Medicaid Cost So Much?") the new Medicare law's prescription drug benefit will affect state Medicaid programs.

Fiscal relief. The Jobs and Growth Tax Relief Reconciliation Act of 2003 provided $20 billion in temporary fiscal relief to states, $10 billion specifically for Medicaid and $10 billion for unfunded federal mandates or other governmental priorities. The Medicaid funds temporarily increased the FMAP (federal share of Medicaid).

This chapter is based on the following publication.

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