THE HENRY J. KAISER FAMILY FOUNDATION

# MEDICAID IN THE DISTRICT OF COLUMBIA

January 2017

Medicaid and the Children's Health Insurance Program (CHIP) provide health and long-term care coverage to more than 262,000 low-income children, pregnant women, adults, seniors, and people with disabilities in DC. Medicaid is a major source of funding for safety-net hospitals and nursing homes. Federal policy proposals could fundamentally change the scope and financing of the program.

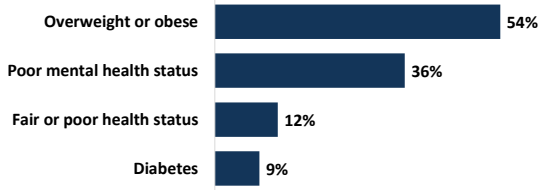
## Snapshot of DC's population

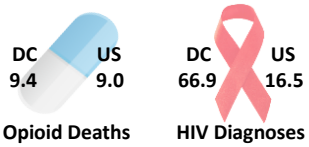
**676,800** people live in DC

**31% of DC's population is low-income**

Low-income: <200% FPL or $40,320 for a family of 3 in 2016

**Adults in DC reporting:**

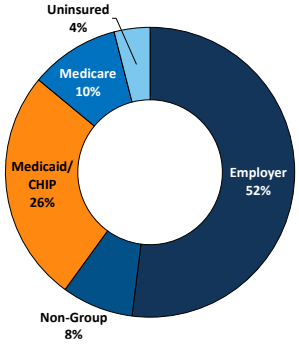


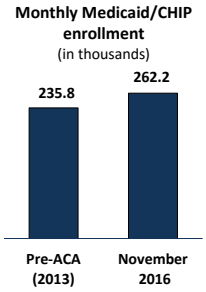

Per 100,000 population in 2014

## How has Medicaid affected coverage and access?

**In 2015, 26% of people in DC were covered by Medicaid/CHIP.**




**Since implementation of the Affordable Care Act (ACA), Medicaid/ CHIP enrollment has increased in DC.**

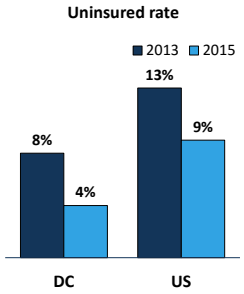



**Did DC expand Medicaid through the ACA?**

☑ Yes ☐ No

**62,600 adults**
in the expansion group in Q1 of 2016

**The uninsured rate in DC has decreased.**



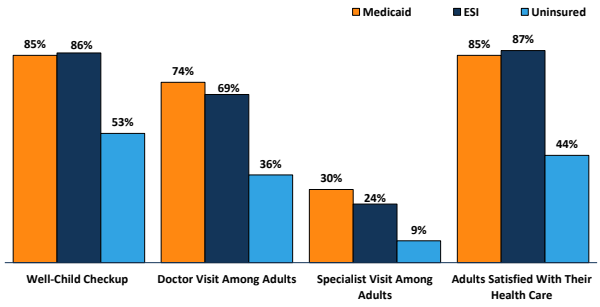

**In DC, Medicaid/CHIP covers:**

- 1 in 5 adults <65
- 3 in 5 low-income individuals
- 1 in 2 children
- 4 in 5 nursing home residents
- 3 in 5 people with disabilities

**67%**
of adult and child Medicaid enrollees in DC are in families with a worker.

**Nationally, Medicaid is comparable to private insurance for access and satisfaction – the uninsured fare far less well.**

Percent reporting in the last year:




**Medicaid coverage contributes to positive outcomes:**

- Declines in infant and child mortality rates
- Long-term health and educational gains for children
- Improvements in health and financial security

**And…**

**>85%**
of the public would enroll themselves or a child in Medicaid if uninsured.

## How does Medicaid work and who is eligible?

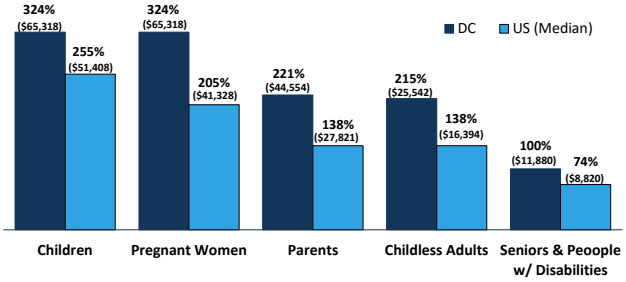
**Each Medicaid program is unique:**

**Federal government sets core requirements, but states have flexibility regarding:**

- **Eligibility** - All states have taken up options to expand coverage for children; many have opted to expand coverage for other groups.
- **Benefits** – All states offer optional benefits, including prescription drugs and long-term care in the community.
- **Delivery system & provider payment**– States choose what type of delivery system to use and how they will pay providers; many are testing new payment models to better integrate and coordinate care to improve health outcomes.
- **Long-term care** – States have expanded eligibility for people who need long-term care and are increasingly shifting spending away from institutions and towards community-based care.
- **State health priorities** – States can use Medicaid to address issues such as the opioid epidemic, HIV, Zika, autism, dementia, environmental health emergencies, etc.

**Medicaid/CHIP eligibility levels are highest for children and pregnant women.**

**Eligibility Level as a Percent of FPL, as of January 1, 2017**




Eligibility levels are based on the FPL for a family of three for children, pregnant women, and parents, and for an individual for childless adults and seniors & people w/ disabilities. Seniors & people w/ disabilities eligibility may include an asset limit.

# How are Medicaid funds spent and how is the program financed?

**Medicaid plays a key role in the U.S. health care system, accounting for:**

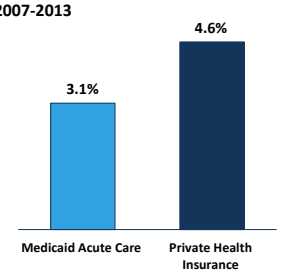
**$1 in $6 dollars spent overall in the health care system**

**More than $1 in $3 dollars provided to safety-net hospitals and health centers**

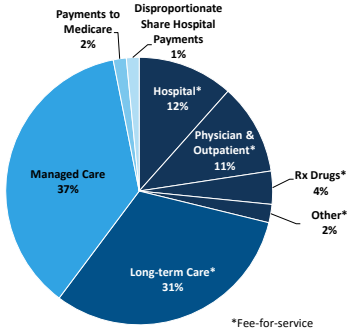
**$1 in $2 dollars spent on long-term care**

**On a per enrollee basis, Medicaid spending growth is slower than private health care spending, in part due to lower provider payments.**

**Per enrollee spending growth in the US, 2007-2013**




**In FY 2015, Medicaid spending in DC was $2.4 billion.**

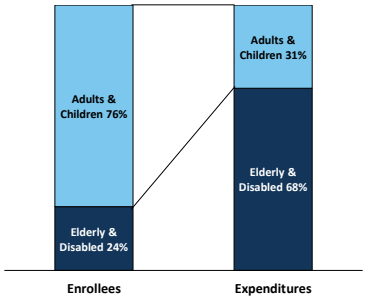



**0.80**
is the Medicaid-to-Medicare physician fee ratio in DC.

**53%**
of long-term care spending in DC is for home and community-based care.

**76%**
of beneficiaries in DC are in managed care.

**In 2011, most Medicaid beneficiaries in DC were children and adults, but most spending was for the elderly and people with disabilities.**



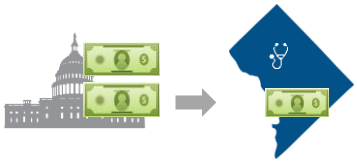

**23,400**
Medicare beneficiaries (33%) in DC rely on Medicaid for assistance with Medicare premiums and cost-sharing and services not covered by Medicare, particularly long-term care.

**25%**
of Medicaid spending in DC is for Medicare beneficiaries.

**Federal funding to states is guaranteed with no cap and fluctuates depending on program needs.**

In DC the federal share (FMAP) is 70.0%. For every **$1** spent by the state, the Federal government matches **$2.33**.

Expansion states receive an increased FMAP for the expansion population. DC received **$557.2 million** in federal funds for expansion adults from Jan 2014 – Sept 2015.



**8%**
of state general fund spending in DC is for Medicaid.

**65%**
of all federal funds received by DC is for Medicaid.

# What are the implications of reduced federal financing in a Medicaid block grant or a per capita cap?

**Congress may soon debate proposals to reduce federal Medicaid funding through ACA repeal and federal caps.**

The March 2016 Budget Resolution would reduce federal Medicaid spending by **41%** nationally over the 2017-2026 period.

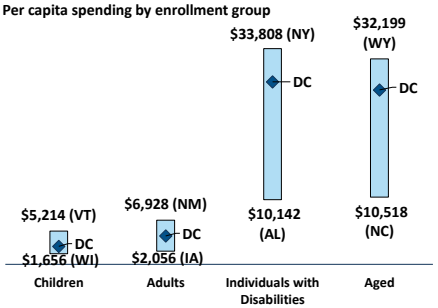
**Total reduction in federal funds:**
$2.1 trillion

**The impact of a block grant or per capita cap will depend on funding levels, but could include:**

- Increases in the number of uninsured
- Reduced access and service utilization, decreased provider revenues (to hospitals, nursing homes, etc.), and increased uncompensated care costs
- Increased pressure on state budgets
- Decreased economic activity

**A per capita cap could lock in historical state differences or redistribute federal funds across states.**

**Per capita spending by enrollment group**

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