

FREQUENTLY ASKED QUESTIONS

Medicaid

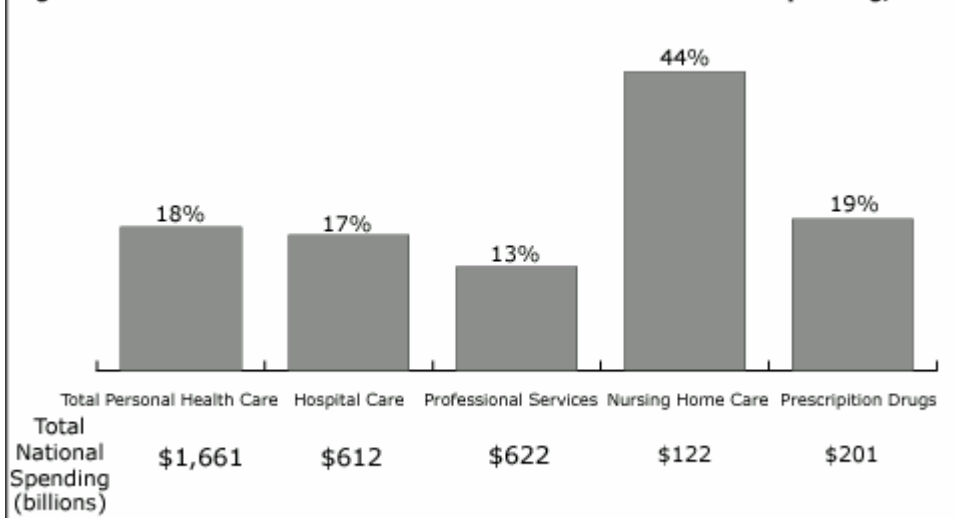
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What is Medicaid?

Authorized by Title XIX of the Social Security Act, Medicaid is a means-tested entitlement program, funded by state and federal dollars, that pays for health and long-term care services on behalf of eligible individuals. The program pays Medicare premiums and, in some cases, other cost-sharing requirements

Figure 1. Medicaid as a Share of National Personal Health Care Spending, 2005




Source: The Kaiser Commission on Medicaid and the Uninsured, 2007.

for low-income Medicare beneficiaries, who are known as dual eligibles. Total spending on Medicaid in FY 2005 was \$316.5 billion, accounting for 18 percent of total national spending on personal health care. Medicaid pays for a substantial share of the cost of many categories of




services as shown in Figure 1. The program, a major source of payment for providers that serve the uninsured, is the largest source of public funding for mental health and substance abuse services.

Medicaid, the largest source of health insurance for children in the United States, covered one in every four in 2005 (28 million). Medicaid funds more than one in three births and is the largest source of public funding for family planning. The program covers more than 7 million of Medicare's almost 44 million enrollees (about one of every six), and it provides long-term care coverage for 60 percent of nursing home residents, 44 percent of people living with HIV/AIDS, and 15 percent of Medicare beneficiaries.

- Medicaid does not provide assistance to all low-income people. Instead, Medicaid eligibility is based both on financial criteria and on being a member of a certain covered category, including children, pregnant women, the elderly, people with disabilities and certain parents. Medicaid is a partnership between the states and the federal government and can be characterized as a federally authorized program that is administered by states. States must operate their Medicaid programs in accordance with an approved state plan. 

Who pays for Medicaid?

States and the federal government share in the cost of Medicaid. The federal share of a state's Medicaid expenditures is determined by a formula—called the Federal Medical Assistance Percentages (FMAP)—that is outlined in federal statute and that allocates funds to pay a share of the cost of services delivered through the program. States with per capita incomes below the national average receive higher matching percentages, and those with per capita incomes above the national average receive lower matching percentages. Every state receives at least a 50 percent match. Some services, such as family planning, are reimbursed at a higher federal match rate. Federal matching rates for each state are updated annually, published in the *Federal Register*, and posted at <http://aspe.os.dhhs.gov/health/fmap.htm>. Most administrative expenditures are matched by the federal government at 50 percent. Certain administrative costs, however—such as those related to Medicaid management information systems (MMIS)—receive a higher federal matching rate.

States are not required to participate in Medicaid, although a large financial incentive exists to do so. If a state chooses to participate, Medicaid is an entitlement to the state as well as to individuals as long as covered services are provided to eligible people in accordance with federal statute and an approved state plan or waiver. In other words, the federal government will pay its share of the Medicaid costs as long as individuals covered, services provided, providers reimbursed, and rates paid are consistent with the state's Medicaid state plan or waivers approved by the federal government. 

Who is covered by Medicaid?

Medicaid provides three general types of health coverage:

- Health insurance for low-income families with children and people with disabilities who cannot obtain or afford private-sector coverage;
- Supplemental coverage for low-income Medicare recipients for Medicare premiums and for services not covered by Medicare; and
- Long-term care coverage for people of all ages with disabilities.

In general, Medicaid eligibility is based on a combination of financial and categorical eligibility requirements; some categories of coverage are mandatory under federal law and others are optional. Major categories of people for whom Medicaid coverage is mandatory are children up to age 5 with incomes at or below 133 percent of the poverty level, children between the ages of 6 and 18 with incomes at or below 100 percent of the poverty level, pregnant women up to 133 percent of poverty, people with disabilities and the elderly who receive Supplemental Security Income, those who live in institutions and who have monthly incomes up to 300 percent of the SSI level, and low-income Medicare beneficiaries for whom Medicaid pays all or some Medicare premiums and cost-sharing. For a list of mandatory coverage groups, see http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp.

States may choose to provide coverage to more than 25 optional eligibility groups. Among them are higher-income people within mandatory coverage categories, women with breast or cervical cancer, and those with disabilities who qualify for buy-in coverage. Some states also have expanded eligibility through Medicaid waivers that are focused on particular groups identified by the state. All states provide community-based, long-term care services to individuals who are Medicaid-eligible and who qualify for institutional care. Most states use financial eligibility requirements for such individuals that are more liberal than those normally used in the community.

Each state determines income thresholds and resource standards for its Medicaid program, following basic federal guidelines. A state may choose to set different standards for children, adults, the elderly and people with disabilities if those standards meet minimum federal requirements for each group. Differing state choices have led to wide variation in eligibility rules. 🏛️

What services does Medicaid cover?

Certain services are mandatory under federal law and must be covered by states in order for the state to receive federal matching funds. Mandatory services include the following:

- Inpatient and outpatient hospital services;
- Rural health clinic services;
- Federally qualified health center and rural health clinic services;
- Laboratory and x-ray services;
- Nursing facility care for individuals age 21 or older;
- Family planning services and supplies;
- Pregnancy-related services;
- Physician services;
- Nurse-midwife services;
- Home health care for individuals who are entitled to nursing facility services;
- Nurse practitioner services;
- Emergency care for non-citizens; and
- Early and Periodic Screening Diagnosis and Treatment (EPSDT).

The mandatory EPSDT benefit requires states to provide all medically necessary care to children on Medicaid regardless of whether the state offers the service under its state plan.

For a list of mandatory services, see http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp.

Examples of optional services that states may—but are not required to—provide include:

- Prescription drugs;
- Vision and dental services;
- Rehabilitation;
- Case management;
- Intermediate care;
- Personal care;
- Hospice services; and
- Prosthetic devices. 🏛️

How do Medicaid service providers receive payments?

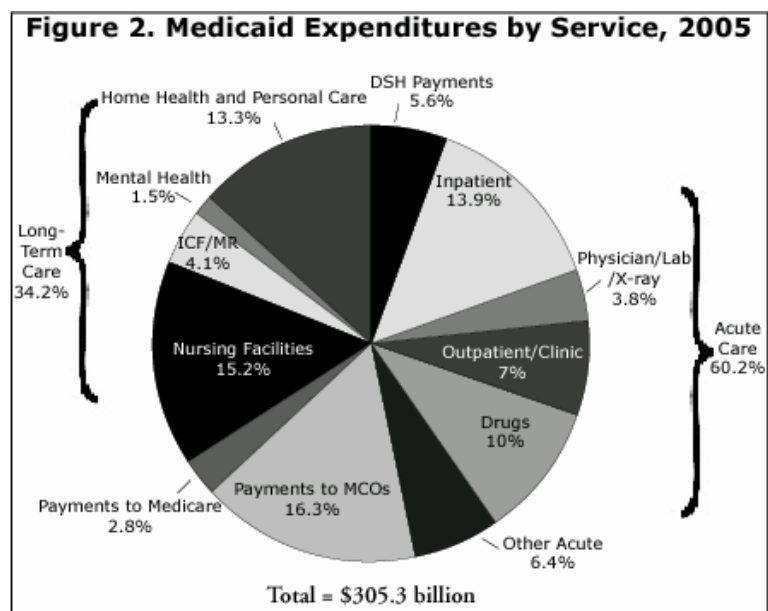
Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis or states may pay for Medicaid services through prepaid, capitated payments to health plans or other entities. Within federally imposed upper limits for certain services, each state has broad discretion to determine the payment method and payment rate for services. Federal law requires that provider reimbursement rates be sufficient to enlist enough providers to make covered services available to the covered population within a geographic area. Participating providers must agree to accept Medicaid payment rates.

States may require cost-sharing from Medicaid beneficiaries with family income at or above the poverty level, but they not permitted to require it of pregnant women, most children, or those who live in institutions. Cost-sharing may not exceed 5 percent of a family's income. States have the option to allow providers to deny services for lack of payment, and they may require enrollees to prepay premiums before they receive benefits. 🏛️

How are expenditures distributed within Medicaid? What does Medicaid pay for?

Medicaid is distributed across an array of acute, long-term care and supportive services (including support for the Medicare costs incurred by low-income people); supplemental payments to hospitals that serve a disproportionate share of low-income or uninsured patients; and administrative expenses. About 60 percent of expenditures are attributable to acute care, 35 percent to long-term care, and 6 percent to payments to disproportionate share hospitals (see Figure 2).

Medicaid spending per capita varies considerably by eligibility group. Children and their parents make up



the majority of the Medicaid population, but the bulk of Medicaid funds are used to pay for services for the elderly and people with disabilities. Children and parents make up three-quarters of the Medicaid population but account for 30 percent of expenditures. Services for the elderly and those with disabilities account for about 70 percent of Medicaid spending.

A significant share is attributable to “dual eligibles”—those low-income elderly or people with disabilities who are enrolled in both Medicare and Medicaid. Dual-eligibles pose a particular challenge for Medicaid agencies due to their high levels of need and the lack of any other continuous funding source for long-term support services. As states consider new strategies for managing diseases and costs associated with dual-eligibles, they are challenged by the heterogeneity of the growing elderly and disabled population, the difficulties of coordinating with Medicare, and the prevalence and severity of chronic disease. ¹¹

What are the roles of the federal and state governments in setting Medicaid policy?

Broad federal mandates govern Medicaid, but eligibility rules, covered services and provider reimbursement policies vary considerably among states. Essentially, 56 different Medicaid programs are in operation—one for each state, territory and the District of Columbia. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration or scope from the services provided in a similar or neighboring state.

It often is difficult to compare payment rates for services across states due to diverse state approaches for gathering baseline data, and for calculating and updating rates.


The federal framework for Medicaid requires statewide coverage, mandates comparable services for all eligible people, guarantees free choice of provider, covers only medically necessary services, requires that Medicaid serve as the payer of last resort, and mandates that each state designate a single state agency to administer the program. Within guidelines established by federal statutes, regulations and policies, each state establishes its own financial and categorical eligibility standards; determines the type, amount, duration and scope of services; sets the rate of payment for services; and administers its own program. States convey these decisions through a Medicaid state plan and state plan amendments that are submitted to the federal government for approval. States also exercise their policy options through various waiver authorities that are available under federal law.

States use waivers authorized under several sections of the Social Security Act to achieve objectives that they cannot achieve through their state plans. Waivers are diverse among and within states, with each waiver expressly designed for specific groups of people or to meet specific goals. The three major types of waivers that are authorized by law and in use by states are:

- **Section 1115 Research and Demonstration Projects** that test policy innovations related to coverage, service delivery or other program elements;
- **Section 1915(b) Managed Care/Freedom of Choice Waivers**, which allow states to implement managed care delivery systems or otherwise limit individuals' choice of provider under Medicaid; and
- **Section 1915 (c) Home and Community-Based Services Waivers**, which allow long-term care services that are not included in the state plan to be delivered in community settings.


The 1115 waivers are the most complex. States have used these waivers to redesign delivery systems, add new beneficiaries and change the scope of services. All Section 1115 waivers must be budget-neutral over the life of the project (generally five years). In other words, the proposed demonstration cannot be expected to cost the federal government more than it would have spent without the waiver.

The Henry J. Kaiser Family Foundation provides information about state Medicaid eligibility levels, benefits and payment approaches at <http://www.kff.org/mfs/index.jsp> and <http://www.kff.org/medicaid/benefits/index.jsp>.

For information about waivers in each state, see <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGL/>. 

What are Medicaid spending trends?

Medicaid spending is influenced by the number of individuals who enroll, the price of services, and the volume of services used. Between 1975 and 2002, according to the Congressional Budget Office, the average real rate of growth for federal and state Medicaid benefit payments was 7.1 percent annually. Expenditures grew especially rapidly between 1999 and 2004, due to increased enrollment, the recession that occurred during that period, state-level expansions of coverage, and enrollment outreach efforts. The Congressional Budget Office projects that federal spending on Medicaid will grow at an average annual rate of 8.1 percent for the period between 2007 and 2016, due to increased enrollment of the aged and those with disabilities and to projected cost growth per enrollee.

Many of the factors that shape Medicaid costs are the same as those that affect health spending in general, including the increasing use of new medical technologies and the aging of the population. In addition, Medicaid faces more intense cost pressures due to the services it covers and the needs of its covered population. Medicaid has a unique role as a payer for extended nursing home care or other long-term support services and as a financing source for community health centers, public hospitals, and other providers serving low-income persons. Because many of the factors that influence cost are beyond a state's control, a state's capacity to make its costs more predictable is likely to depend on developing service delivery mechanisms and management strategies that promote high-quality care and improve accountability. 


What new options are available to states under the Deficit Reduction Act?

The Deficit Reduction Act of 2005 (DRA) created a number of new options for state Medicaid programs. Before DRA was enacted, states were required to use federal waiver authority to achieve some of these goals. Some of those options have been tried by states under waivers, but they now can be implemented by amending the state Medicaid plan.

One set of provisions gives states the authority to offer population-specific coverage arrangements through benchmark benefit packages. This option permits states to create "customized coverage" for specific groups of people in various coverage categories. The provisions may support state efforts to provide certain Medicaid beneficiaries with additional preventive or supportive services that usually are not found in

traditional Medicaid. The law also allows implementation of disease management services, as well as incentive-based approaches or premium assistance for private insurance or other experiments.

Other important provisions allow states to vary the premiums and cost-sharing they charge certain beneficiaries; to enter into long-term care partnerships to allow purchasers of private long-term care insurance to retain a greater portion of their assets if they qualify for Medicaid coverage; and to offer home- and community-based services and consumer-directed home care services under their state plans rather than through waivers.

For additional information about DRA options, see www.cms.hhs.gov/deficitreductionact. 

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Other Sources

The official government web site for information about Medicaid is www.cms.hhs.gov. The site includes links to regulations, manuals and studies about Medicaid. For additional information about Medicaid eligibility and coverage, see publications by the **Henry J. Kaiser Commission on Medicaid and the Uninsured** at <http://www.kff.org/>

- The **National Academy for State Health Policy** at <http://www.nashp.org/>
- The **State Medicaid Directors' Association** at http://www.nasmd.org/Home/home_news.asp

Good sources for research studies about state Medicaid programs include:

- **Center for Health Care Strategies** at <http://www.chcs.org/>
- **The Commonwealth Fund** at <http://www.cmwf.org/>
- **Mathematica Policy Research** at <http://www.mathematica-mpr.com/>

