Introduction

The health care safety net refers to the providers and payers that ensure people who do not have access to traditional coverage options—such as employer-sponsored insurance or an insurance product sold on the individual market—are able to access the health care they need. Medicaid plays multiple roles in the health care safety net, including as an important source of financing for safety-net providers, a coverage option for vulnerable populations, and as a mechanism for policymakers to develop new payment and delivery system models. Medicaid currently covers approximately 20 percent of Americans.

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 some of the nation’s poorest people. Its original focus was on recipients of cash assistance through welfare programs. Today, however, most beneficiaries do not receive cash assistance. Medicaid has since become the nation’s largest source of funding to provide health services to low-income people.

State participation in Medicaid is optional. However, the federal government’s financial share of Medicaid financing creates an incentive. To date, no state has declined to participate—not every state implemented a Medicaid program the first year it was available, however. All 50 states, American Samoa, the District of Columbia, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands participate and administer their own Medicaid plans. The federal government pays between 50 percent and 83 percent of the costs of medical services under Medicaid. The federal share is referred to as the Federal Medical Assistance Percentage (FMAP).

Within federal guidelines, each state designs and administers its own Medicaid program. Once certain minimum federal standards are met, each
state determines how its program is administered, who to cover, what services to cover, and how providers are paid. Because states have so much autonomy in program design, it is often said that no two state Medicaid programs are alike.

As an entitlement program, Medicaid must provide assistance to all individuals who meet eligibility criteria and enroll. Enrollment caps and waiting lists are not allowed for beneficiaries whose eligibility is mandated by federal law—unless permitted under a waiver. These populations include children; pregnant women; and aged, blind, or disabled individuals whose incomes are below specified thresholds. States may choose to expand coverage to certain populations with incomes above the minimum required by federal law, which leads to wide variation in eligibility levels among states.

The Affordable Care Act (ACA) included many mandatory changes to Medicaid as well as new challenges, opportunities and flexibility for states. One of the most significant changes is a requirement that states expand Medicaid to all citizens between the ages of 19 and 64 whose family income is at or below 133 percent of the federal poverty level (FPL) on Jan. 1, 2014. This group is commonly referred as the childless adult group. However, on June 28, 2012, the Supreme Court ruled that Congress may not make a state’s entire federal Medicaid funding contingent upon the state’s compliance with the ACA Medicaid expansion. In practice, this ruling makes the Medicaid expansion a voluntary action by states. The Supreme Court decision affects coverage only of this adult group and no other requirements of the Affordable Care Act that impact Medicaid.

Who Is Eligible for Medicaid: A Snapshot

The federal statute defines more than 50 distinct population groups that are potentially eligible for Medicaid. Historically, Medicaid eligibility was subject to income and categorical restrictions that generally limited coverage to specific low-income people such as children, pregnant women, people with disabilities and the elderly. Medicaid also covers certain low-income parents, uninsured women with breast or cervical cancer, uninsured individuals with tuberculosis, some foster children, and parents and children in welfare-to-work families. States have the option to cover individuals in these categories above the minimum income levels provided that they also meet non-financial requirements such as citizenship and state residency. States may also extend coverage to low-income childless adults through section 1115 waiver authority or, starting January 2014, through the optional Affordable Care Act Medicaid expansion.
Who is eligible for Medicaid?

Before the ACA was passed, other low-income adults such as childless adults were not eligible for Medicaid unless a state chose to cover them under a section 1115 waiver approved by the Centers for Medicare and Medicaid Services (CMS). The ACA authorizes states to cover adults ages 19 to 64 with incomes up to 133 percent of the FPL (adult group) beginning in 2014. States also can cover this group 1) prior to 2014 and 2) above the 133 percent income standard beginning in 2014. The federal funding share for people newly eligible for the optional ACA Medicaid expansion is 100 percent for the first three years; it then decreases to 90 percent over time. The Supreme Court’s ruling did not make all ACA-related eligibility expansions optional for states. For example, the ACA also requires states to extend coverage for children ages 6 to 18 from 100 percent to 133 percent of FPL and to cover former foster care children up to age 26.

In addition, the ACA changed the way financial eligibility for Medicaid will be determined for many individuals. Before passage of ACA, states determined income multiple ways; some states factored in income disregards and some states conducted asset testing. The ACA requires that all states use Modified Adjusted Gross Income (MAGI) to determine eligibility for most beneficiaries, except for the elderly and disabled. This means states can no longer require an asset test or apply additional income disregards when determining eligibility for non-elderly, non-disabled populations.

Who is covered by Medicaid?

Medicaid covers about one in every five Americans. However, a person’s eligibility can change frequently over time, a process known as “churning.” As family income fluctuates, so does eligibility for Medicaid; for low-income populations, changes in job status and income are not uncommon and often are affected by larger economic conditions, resulting in changes in their Medicaid eligibility. For example, if the economy goes into recession, producing less consumer demand for low-wage trades, these individuals may see cuts to their hours and pay. Job loss or pay cuts result in increased numbers of people who qualify for Medicaid. Conversely, if there is an uptick in economic activity, families may earn too much to qualify for Medicaid. In addition to fluctuations in income, changes in categorical eligibility can alter one’s Medicaid eligibility, such as when a pregnant woman gives birth. Below is aggregate information about the role of Medicaid for specific populations.

**Children:** Medicaid is the largest source of health insurance for children in the United States. Between Medicaid and the Children’s Health Insurance Program (CHIP*), one in three children is covered by taxpayer-sponsored programs.

**Pregnant Women:** Medicaid is a key source of coverage for pregnant women, and many states serve more women than required by federal law. Medicaid paid for 40 percent of all births in the United States in 2011.

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*The Children’s Health Insurance Program (CHIP, formerly the State Children’s Health Insurance Program (SCHIP)) was created by the Balanced Budget Act of 1997, enacted Title XXI of the Social Security Act, and has allocated about $20 billion over 10 years to help states insure low-income children who are ineligible for Medicaid but cannot afford private insurance. States receive an enhanced federal match (greater than the state’s Medicaid match) to provide this coverage.*
People with Disabilities and the Elderly: In 2010, 9.3 million non-elderly people with disabilities, including 1.5 million children, were covered by Medicaid. The program not only covers medical services, but also long-term care services for people with severe physical and mental health conditions and disabilities (e.g., cerebral palsy, Down Syndrome, AIDS). In 2010, Medicaid paid for roughly 55 percent of long-term institutional care nationally—or about $68.1 billion.8

One in five Medicare beneficiaries also qualify for Medicaid coverage based on their income.9 These individuals, known as “dually eligible” beneficiaries, are much poorer and in worse health than other Medicare enrollees. For dually eligible people, Medicare covers acute care services and hospital care, while Medicaid covers Medicare premiums, cost-sharing and services that Medicare limits or does not cover, such as long-term services and supports. Dually eligible beneficiaries are a costly population. They accounted for only 15 percent of Medicaid enrollees but 38 percent of all Medicaid spending in 2009.10

Racial and Ethnic Minorities: Medicaid plays a large role for certain racial and ethnic populations.11 In 2009, the program covered 27 percent of black Americans.12 It is an especially important source of coverage for black children, half of whom are enrolled in Medicaid. Many Americans were affected by the recent recession, but minority groups were particularly hard-hit. Twenty-eight percent of black Americans reported losing a job during the downturn. Between 2007 and 2009, Medicaid covered an additional 1.4 million black people.13

Twenty-five percent of Medicaid enrollees are Hispanic, and the program covers nearly half of the nation’s Hispanic children.14 Hispanics are the fastest growing minority group in the United States15 and were also hit hard during the recession; 38 percent reported losing a job, and Medicaid covered an additional 2.5 million Hispanic Americans between 2007 and 2009.16

Nineteen percent of Asian Americans are on public insurance.17 Compared to black or Hispanic Americans, fewer Asians are on Medicaid, but a greater percentage of them are uninsured.18

Many Native Americans and Alaska Natives who are part of a federally recognized tribe are eligible for health care services though the Indian Health Service, which is not Medicaid. However, about 37 percent of the Native American population receive Medicaid benefits.

What services does Medicaid cover?

Like eligibility, federal law requires states to provide certain Medicaid benefits and allows states to offer additional or optional benefits. Table 1 lists both mandatory and optional categories of services. All services are subject to a determination of medical necessity by the state Medicaid program or a managed care plan under contract with the state.

States have the option to cover additional benefits for Medicaid enrollees, and every state takes advantage of this option. For example, prescription drugs are an optional benefit covered by all states and territories. Other optional services include, but are not limited to, routine dental care, podiatrist services, optometrist services and eyeglasses,
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<tr>
<th>Mandatory Benefits</th>
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<td>Inpatient hospital services</td>
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<td>EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services</td>
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<td>Rural health clinic services</td>
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<td>Certified pediatric and family nurse practitioner services</td>
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<td>Freestanding birth center services (when licensed or otherwise recognized by the state)</td>
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<td>Services for individuals age 65 or older in an institution for mental disease</td>
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<td>TB-related services</td>
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<td>Inpatient psychiatric services for individuals under age 21</td>
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<td>Other services approved by the secretary*</td>
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*This includes services furnished in a religious nonmedical health care institution, emergency hospital services by a non-Medicare certified hospital, and critical access hospital (CAH).*
hospice services, inpatient psychiatric care for the elderly and for individuals under age 21, physical therapy and prosthetic devices.

Federal law places constraints and directives on Medicaid services. Covered services must be available statewide (with certain exceptions), must be comparable (equal for all in a group), and must be sufficient in “amount, duration, and scope” to reasonably achieve its purpose.\(^1\) Beneficiaries must also have “freedom of choice” among health care providers or managed care entities participating in Medicaid. Coverage specifics can vary from state to state, even for mandatory services. For example, states may place different limits on the amount of inpatient hospital services a beneficiary can receive in a year.\(^2\)

The law also includes specific benefits or rules for targeted populations. For example, children under age 21 are entitled to EPSDT services.\(^3\) Under EPSDT, children receive well-child visits, immunizations, laboratory tests, other screening services at regular intervals, and any service deemed “medically necessary” even if a state does not cover the services under its Medicaid plan. State Medicaid programs also must pay Medicare cost-sharing expenses (e.g., Medicare premiums and, in some cases, deductibles and co-insurance) for certain low-income individuals who are eligible for both programs.\(^4\)

States may seek waivers from the federal government that allow them more flexibility related to providing services. For example, a waiver of the “statewide” requirement may allow states to implement managed care in only one county of the state. Since more than 30 states have obtained waivers in the last few years, a great deal of variation in benefits and program design exists among states.

### Benchmark Benefit Packages

The Deficit Reduction Act of 2005 gave states the option to enroll specified groups in new benchmark and benchmark-equivalent benefit packages. These benefit packages are commonly referred to as alternative benefit plans. In general, benchmark benefit packages cover fewer benefits than traditional Medicaid, but some requirements—such as coverage of EPSDT services for children and transportation to and from medical providers—might make such coverage more generous than most private insurance. A state that elects an alternative benchmark plan must ensure that the benefits meet the following requirements.

1. The state must ensure that Medicaid beneficiaries have access to services provided by federally qualified health centers (FQHCs) and rural health centers (RHCs). States are required to reimburse the FQHCs and RHCs according to the prospective payment system.

2. A state that elects to enroll children under age 21 into an alternative benefit plan must also ensure that these children have EPSDT services.

3. Beginning Jan. 1, 2014, any alternative benefit plan must cover at least the 10 categories of services listed as essential health benefits outlined in the ACA. In addition, the Mental Health Parity and Addiction Equity Act (MHPAEA) applies to the alternative benefit plans.
With exceptions, states are required to enroll non-elderly adults with incomes at or below 133 percent of the FPL in an alternative benefit plan.

**Premium Assistance and Medicaid**

Federal law allows states the flexibility to use Medicaid funds to purchase private health insurance plans for beneficiaries if the cost is equal to or less than traditional Medicaid. These programs, called premium assistance, subsidize the purchase of private health coverage, mostly employer-sponsored health plans, using Medicaid and CHIP funding. However, limited access to employer-sponsored coverage for Medicaid-eligible, low-income families creates challenges for premium assistance programs. When CHIP was reauthorized, the law included new provisions designed to improve the viability of premium assistance programs, but there has been little time for implementation. Thus, it is difficult to assess whether these new provisions are working effectively. Currently, premium assistance plays a small role in state Medicaid programs; state spending on premium assistance programs accounted for about 1 percent of total Medicaid spending in 2009.

Interest in premium assistance programs is rising as states consider ACA implementation and explore using Medicaid funds to purchase private coverage through the Health Insurance Marketplaces (also known as Exchanges.) This option is appealing to states that are looking for alternatives to traditional Medicaid expansion. Premium assistance programs may also be a method for improving the continuity of coverage for people in higher income ranges who will move between Medicaid, the exchange and employer-sponsored insurance as their income and job status change.

On March 29, 2013, the Centers for Medicare and Medicaid Services released information about Medicaid premium assistance programs for the newly eligible adult population beginning in 2014. The guidance confirms that states may implement certain premium assistance programs using a Medicaid state plan amendment and clarifies that these enrollees will remain Medicaid beneficiaries. Therefore, to the extent that private coverage offers fewer benefits and higher cost-sharing requirements than Medicaid, states must have mechanisms in place to “wrap-around” private coverage in order to ensure that the Medicaid requirements are met; it also must be cost-neutral.

Notably, CMS opened the door for a limited number of states to pursue a premium assistance program that purchases coverage for Medicaid beneficiaries through ACA’s new health insurance marketplaces. States must apply for and receive approval for a waiver to implement this type of program.

**Who provides Medicaid services?**

Medicaid is not a direct provider of health care. States contract with and pay providers—such as hospitals, managed care plans, nursing homes and physicians—to deliver Medicaid services at state-determined rates. Providers are not required to participate in the Medicaid program, but it is a significant source of revenue for some.

The Balanced Budget Act of 1997 repealed much of the federal law that required states to pay rates sufficient to attract enough providers for “reasonable access” to services, which gave states more flexibility to set their own payment rates; however, there was some concern that states cut rates
too much in subsequent years, which made the program less attractive to providers. From Jan. 1, 2013, through Dec. 31, 2014, the ACA requires states to reimburse qualified primary care providers at Medicare rates, which will increase payments in most states. While the federal government will pay the full amount of this increase over the two-year period, states are responsible for ensuring only qualified providers receive the enhanced payment. In addition, a 2012 proposed rule, Methods for Assuring Access to Covered Medicaid Services, proposes to once again require states to ensure payment is enough to ensure access.

States must cover services provided by FQHCs and RHCs. These providers are discussed in more detail later in this primer.

**Disproportionate Share Hospitals (DSH)**

States are required to make additional Medicaid payments to hospitals that treat a “disproportionate share” (DSH) of low-income patients. These allotments, known as DSH payments, are used to offset the costs of uncompensated care, that is, services that are not paid for by the patient or a third-party payer. States have limited flexibility to classify hospitals as DSH facilities and must develop a system to identify them and to make payment adjustments to these facilities. In 2011, total Medicaid DSH payments were $11.3 billion nationally. The ACA reduces the annual Medicaid DSH allotments by $500 million in 2014; $600 million in 2015; $600 million in 2016; $1.8 billion in 2017; $5 billion in 2018; $5.6 billion in 2019; and $4 billion in 2020. The law does not specify a formula for achieving these overall reductions in federal DSH allotments to states. Instead, the secretary of Health and Human Services must use certain general parameters to develop a methodology to achieve these dollar reductions. On May 13, 2013, CMS released a proposal for how the reductions would be implemented across states in 2014 and 2015; the proposed rule also contains a procedure for protecting allotments that support Medicaid 1115 demonstration coverage expansions. It also encourages states to target payments to hospitals that serve high numbers of Medicaid beneficiaries and have high levels of uncompensated care. The assumption behind the ACA-related DSH reduction is that, as more people access coverage through the health insurance marketplaces or the Medicaid expansion, hospitals should see a reduction in their uncompensated or charity care. With the Medicaid expansion effectively being optional for states, many safety-net providers have voiced concern about the planned DSH cuts.

**How is Medicaid financed?**

The Medicaid program is jointly funded by the federal government and states. The federal government pays states for a specified percentage of Medicaid medical expenditures—the Federal Medical Assistance Percentage (FMAP). The FMAP varies by state based on criteria including per capita income; therefore, the lower the per capita income in a state, the higher the FMAP. The state FMAP rate ranges from 50 percent in wealthier states (the minimum regular FMAP percent) up to about 75 percent in states with lower per capita incomes (the maximum regular FMAP is 83 percent). Federal funding for individuals who will become newly eligible under the adult group in 2014 is provided at 100 percent for the first three years, phasing down to 90 percent by 2020 and beyond. It is important to note that the federal match for administrative expenditures does not vary by state and is generally 50 percent, but certain admin-
Medicaid and the Safety Net

Administrative functions—such as operation of a state Medicaid fraud control unit, health information technology systems, or certification of nursing home—have a higher federal matching rate.

Because Medicaid is an entitlement, there is no cap on the total amount of federal funds a state may receive or on the cost of the program to the state. While the federal government has increased FMAP rates for states during economic downturns in the past, these enhanced FMAPs are not required.

States must ensure they can fund their share of Medicaid. Recognized sources of funding for the state share of Medicaid payments include legislative appropriations; inter-governmental transfers (IGTs); certified public expenditures (CPEs); and permissible taxes and provider donations.

State policies affect the amount the federal government spends on Medicaid. States are guaranteed federal Medicaid matching funds for the costs of covered services for eligible individuals, and once they have met federal minimums, they have broad discretion to determine who is eligible, what services they will cover, and what they pay for covered services.

What does Medicaid cost?
In 2011, federal and state Medicaid spending totaled about $435 billion, including payments for Medicare premiums and DSH payments. A large portion of those funds—30 percent—are directed to nursing homes, home and community-based care, and other long-term services and supports. Administrative costs accounted for about 5 percent of total Medicaid spending—a relatively small amount when compared to the private market.

Children and their parents make up the majority of Medicaid enrollees, but they do not account for the bulk of the cost. Children and non-elderly adults, including pregnant women, make up three-quarters of the Medicaid population but account for only about 34 percent of Medicaid spending. Most Medicaid spending is attributable to the elderly and people with disabilities, who use high-cost, long-term care services. The elderly and people with disabilities make up one-quarter of the Medicaid population, but account for about 65 percent of spending. This disparity—a small group of people accounting for a disproportionate share of spending—occurs across all coverage options, public and private. In Medicaid, only 5 percent of the enrollees account for more than half of all Medicaid spending.

What drives Medicaid cost growth?
Medicaid costs are sensitive to costs in the overall health system. Many factors contribute to cost growth in the health system; not all of them are well understood. One driver of cost is the increasing number of people with chronic conditions, complex health needs or multiple health needs. For example, an individual with dementia and diabetes requires additional and more expensive care than someone suffering from only one condition. Medicaid costs, like those in the overall health system, are sensitive to health care inflation, the health status of enrollees and economic forces, such as unemployment.

Enrollment in the program affects Medicaid costs. During economic downturns, Medicaid spending often grows faster than the rate of increase in national health spending, but much of this is due to increased enrollment that—excluding an eligibility expansion—is largely driven by underlying
Medicaid and Federally Qualified Health Centers

Federally qualified health centers (FQHCs), also known as “health centers,” are community-based, nonprofit or public organizations that provide services to people who lack other access to health care, including those without insurance, residents of rural and underserved areas, and Medicaid patients. These services are available to all people, regardless of their ability to pay, and are provided on a sliding fee scale based on income. Health centers include community health centers, migrant health centers, health care for the homeless programs and public housing primary care centers.

Health centers serve a unique patient population, which often presents funding challenges. In 2011, the incomes of approximately 72 percent of health center patients were at or below the federal poverty level. In addition, 36 percent were uninsured, and 39 percent were enrolled in Medicaid or the Children’s Health Insurance Program. Although uninsured patients are the largest group served by health centers, out-of-pocket patient payments account for only about 6 percent of total revenue. Due to this revenue gap, many FQHCs rely upon federal grants to help subsidize care for the uninsured. Medicaid payments make up 37 percent of an average health center’s funding, and federal government grants account for approximately 22 percent. Funding from state and local governments averages about 10 percent, nationwide. Other support is provided by Medicare, private foundation grants, private insurance and other public programs. Due to this mix of funding sources, health centers are affected by changes to state Medicaid programs.

Waivers and State Flexibility

Sections 1115 and 1915 of the Social Security Act give the secretary of Health and Human Services authority to waive provisions of the law to encourage state innovation and experimental demonstrations in Medicaid. Waivers are vehicles states can use to test new or existing ways to deliver, expand coverage or pay for health care services in Medicaid and the Children’s Health Insurance Program. A state must apply for and receive approval from CMS in order to operate a waiver. There are four primary types of waivers and demonstration projects.

- Section 1115 Research & Demonstration Projects provide states with flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP, and may allow for coverage to be expanded to populations who are not generally eligible. This is the broadest category of waiver; states must demonstrate that their proposal is “budget
neutral,” meaning that it will not result in increased costs to the federal government.

- **Section 1915(b) Managed Care Waivers** permit states to provide services through managed care delivery systems or otherwise limit peoples’ choice of providers.

- **Section 1915(c) Home and Community-Based Services Waivers** permit states to provide long-term services and supports in home and community settings, rather than institutional settings.

- **Concurrent Section 1915(b) and 1915(c) Waivers** can be used by states to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all federal requirements for both programs are met.

States have long used the waiver process to have more flexibility to reform and improve the value of the Medicaid program. The 1115 waiver process has been criticized by states for a lack of transparency, due to the subjective nature of waiver approval. The ACA requires states applying to CMS for a waiver to provide an opportunity for public comment and greater transparency of the section 1115 demonstration projects. A final rule, effective on April 27, 2012, establishes a process for ensuring public input on the development and approval of new section 1115 demonstrations as well as extensions of existing demonstrations. This final rule sets standards for making information about Medicaid and CHIP demonstration applications and approved demonstration projects publicly available at the state and federal levels.41

**State Innovations**

Funding Medicaid programs is one of the greatest challenges for states. The states’ share of the joint state-federal program accounts for an average of 16 percent of state general funds and about 21 percent of total state spending when federal funds are added to the mix. Cutting benefits, limiting eligibility and reducing provider reimbursements have been the three “usual suspects” used by states for short-term Medicaid cost containment. Many policymakers think these short-term fixes to Medicaid are not the answer for creating a sustainable Medicaid program. Lawmakers are focusing on how to bring down the costs of Medicaid for the long-term. For more information about Medicaid cost containment efforts, visit http://www.ncsl.org/default.aspx?tabid=25353.

Some states are redesigning how health care is delivered and how Medicaid pays for services. For more information about payment reform, visit NCSL’s website at www.ncsl.org/default.aspx?tabid=25420.

Other states are looking to strengthen partnerships with managed care organizations and expanding mandatory participation in managed care for the elderly and people with disabilities. For more information about Medicaid managed care, visit www.ncsl.org/default.aspx?tabid=25352.
Reducing fraud and abuse within the Medicaid program is a priority for both the federal government and states. States are increasingly moving away from identifying fraud after it happens and toward proactive fraud and abuse prevention. For more information about state efforts to reduce fraud, visit www.ncsl.org/default.aspx?tabid=23827.

Leveraging the strength of community providers—such as community health centers and rural health centers—has become a central point for some states’ efforts to redesign their Medicaid programs. For more information about Medicaid and health centers, visit www.ncsl.org/default.aspx?tabid=25249.

Conclusion

Medicaid plays multiple important roles in the health care safety net in this country. Providers rely on Medicaid to finance the care for many of their patients and, therefore, Medicaid is important part of a safety-net provider’s business model. Medicaid is, sometimes, the only coverage option for vulnerable populations—covering many of the nation’s children and people with disabilities. As a mechanism for policymakers to develop new payment and delivery system models, states can leverage federal resources to improve this program. Policymakers who aim to contain their state’s health costs and, at the same time, expand quality medical coverage may want to investigate ways to increase the value of their Medicaid program.

Getting to Know Medicaid in Your State: The Questions You Should Ask

- Who is eligible for Medicaid in your state?
- What benefits are covered in your state’s Medicaid program?
- How much of your state’s Medicaid population is enrolled in managed care?
- What are the top three cost drivers in your state’s program?
- How does your state’s provider reimbursement rates compare to neighboring states?
- Are there enough providers accepting Medicaid to ensure adequate access?
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This brief was written by Melissa K. Hansen.

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