CHAPTER 2

Overview of Medicaid

Section 1900(b) of the Social Security Act directs the Commission to review policies of the Medicaid program and the State Children's Health Insurance Program (CHIP) affecting access to covered items and services, including payment policies, eligibility policies, enrollment and retention processes, coverage policies, quality of care, the interaction of Medicaid and CHIP payment policies with health care delivery generally, interactions with Medicare and Medicaid, and other access policies.

Chapter Summary

The Medicaid program was enacted to allow states, at their option with federal financial support, to provide medical assistance to certain low-income families and individuals who could not afford the costs of necessary health care. Today, the program finances health coverage for an estimated 68 million people, about half of whom are children.

Medicaid pays for routine health care services, as well as benefits that are limited or not typically covered under Medicare or traditional health insurance, such as long-term services and supports. Low-income seniors, people with physical or mental disabilities, and children with special health care needs may rely the most on these Medicaid services. The breadth of Medicaid coverage varies by state because benefits are a combination of federal mandatory and state optional benefits. While the majority of Medicaid benefit spending occurs under fee-for-service (FFS) arrangements, many states contract with managed care plans to administer benefits and pay providers. In addition, states have been granted waivers to test changes in eligibility and care delivery.

Medicaid spending has grown in recent decades. Economic downturns compound the fiscal challenge since loss of jobs and income result in more people eligible for Medicaid. Today, many states face budget shortfalls, elevating Medicaid policy issues. This chapter highlights Medicaid eligibility, benefits and cost-sharing, state program flexibility, and the federal-state financing structure. In addition, the impacts of recent legislative changes on the current program are explained and future program issues are identified.

CHAPTER 2

Overview of Medicaid

Medicaid was established in 1965 under Title XIX of the Social Security Act (the Act). Its statutory purpose is to enable states, at their option, to furnish medical assistance, as well as rehabilitative and other services, for certain families and individuals whose income and resources (assets) are insufficient to meet the costs of necessary medical services (Section 1901 of the Act). It has evolved from a program that primarily served welfare recipients to one that finances health coverage for a substantial number of low-income people—an estimated 68 million in FY 2010, about half of whom are children under age 19. Each state operates its Medicaid program in accordance with a state plan submitted to and approved by the Centers for Medicare & Medicaid Services (CMS) that describes the nature and scope of the program (e.g., administrative structure and operations, eligibility, covered benefits, payment methods). Most of the discussion in this chapter reflects policies and operational approaches within Medicaid's federal framework for state plans. Major sections separately address eligibility, benefits, and financing and administration. The chapter also describes several authorities in the Act that provide states additional flexibility in operating their Medicaid programs under waivers of certain federal requirements.

Eligibility for Medicaid

People eligible for Medicaid coverage have historically included low-income children and their parents, pregnant women, individuals with disabilities, and individuals age 65 and older. Under the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended), low-income adults who do not fall into one of these groups will also be eligible for Medicaid beginning in 2014, or earlier at state option. However, as described in this section, additional eligibility criteria apply and not all low-income people are covered. Minimum income and other eligibility criteria are set by the federal government; states may opt to cover additional people beyond these federal minimums. All individuals

who meet these federal and state criteria are entitled to enroll in the program and receive Medicaid benefits.

For many people eligible for Medicaid, other coverage may be unavailable or unaffordable. In 2008, for example, among people working full time, less than one-third of those with family incomes at or below the federal poverty level (FPL, currently $18,530 for a family of three) and less than half of those at or below 200 percent FPL ($37,060 for that same family) were offered health insurance through their job.[1] In comparison, more than three-quarters of full-time workers with family incomes above 200 percent FPL received an offer.[2]

Some individuals who are eligible for Medicaid as a result of their low incomes—and in some cases, high medical expenses—may have other coverage, such as Medicare (among individuals age 65 and older and certain persons with disabilities) or private insurance (e.g., from a child's non-custodial parent). In these cases, Medicaid is generally the payer of last resort—that is, the other insurance pays for the expenses it covers and Medicaid then "wraps around" to provide additional services that are covered by Medicaid but not the primary insurance. Medicaid also pays for certain cost-sharing amounts charged to enrollees by their primary insurance (as noted later, state Medicaid programs may charge their own cost-sharing amounts). This is particularly important for "dual eligibles," the one of every six Medicare beneficiaries who are also enrolled in Medicaid, which helps to pay for their Medicare premiums and, in most cases, deductible and coinsurance amounts. For most dual eligibles, Medicaid also provides benefits not covered by Medicare (MedPAC 2010).

History

At the time of enactment, states that chose to participate in Medicaid were required to provide coverage to all "categorically needy" individuals who received cash payments under federal assistance programs for aged, blind, and disabled individuals, as well as families with dependent children.[3] Each federal assistance program was administered by the states, which often set their income eligibility thresholds below the FPL. In addition to covering these mandatory categorically needy individuals under Medicaid, states could choose to cover optional "medically needy" individuals who fell within one of the federal assistance categories (aged, blind, disabled, families with dependent children)—but whose higher incomes made them ineligible for cash payments and whose medical expenses (if any) would be deducted when determining countable income for eligibility purposes.

Until the mid-1980s, eligibility for Medicaid continued to be closely tied to the receipt of cash payments under states' Aid to Families with

[1] See Table 19 in MACStats for dollar amounts that reflect various FPL percentages for different family sizes, as well as for Alaska and Hawaii, whose FPLs differ.

[2] Agency for Healthcare Research and Quality (AHRQ) analysis for MACPAC of 2008 Medical Expenditure Panel Survey, Household Component (MEPS-HC), 2011.

[3] For an overview of Medicaid enrollment and spending growth as the program evolved from enactment through 1999, see Klemm 2000.

Dependent Children (AFDC) programs and the federal Supplemental Security Income (SSI) program.[4]

For SSI recipients, a federal income eligibility standard with annual cost-of-living increases meant that Medicaid eligibility generally kept pace with inflation. For AFDC recipients, however, the income eligibility standards set by states varied significantly and had been declining in real (inflation-adjusted) terms since the 1970s (Burwell and Rymer 1987).

Between 1984 and 1990, the Congress made significant changes to Medicaid for pregnant women and children. It created new mandatory and optional eligibility groups for them that were based on income relative to the FPL rather than to receipt of cash payments under AFDC. This shift was significant; not only did the FPL represent a national amount that was much higher than most states' income eligibility standards for AFDC, it also is increased annually to account for inflation. Mandatory and optional eligibility was also extended to, among others, additional individuals ages 65 and older and persons with disabilities, as well as families transitioning from welfare to work.[5]

The program also saw changes under the welfare reform law of 1996, which severed the link between Medicaid and cash assistance for families with children. As a result, Medicaid eligibility for these families is now based on specified income and asset standards and methodologies—generally those that were in effect for AFDC as of July 16, 1996, with state options to be more or less restrictive—rather than receipt of benefits under the Temporary Assistance for Needy Families (TANF) program that replaced AFDC. Other major changes in Medicaid eligibility to date include the creation of CHIP (which has been implemented as a Medicaid expansion in many states; see Chapter 3) in 1997 and the expansion of Medicaid eligibility for non-elderly adults under PPACA.

The Medicaid Program Today

Although a detailed discussion of all eligibility pathways contained in the Medicaid statute is not provided here, Medicaid eligibility groups are typically defined by the populations they cover and the financial (i.e., income and asset) criteria that apply. Some eligibility groups are mandated by federal law and some may be covered at state option. Figure 2-1 provides summary information on Medicaid and CHIP income eligibility by major populations covered. For state-level detail on income thresholds for major eligibility groups, see Tables 9 through 11 in MACStats.

As noted earlier, populations covered under Medicaid have historically included low-income children and their parents, pregnant women, persons with disabilities, and individuals over the age of 65. As a result of PPACA, however, adults under age 65 with incomes at or below 133 percent FPL (currently $14,484 for a single person) who are not pregnant and do not have Medicare coverage may be covered at state option through 2013 and must be covered starting in 2014.

Some people, including most individuals age 65 and older and persons with disabilities who receive

[4] SSI was enacted in 1972 to replace federal assistance programs for aged, blind, and disabled individuals that had previously been administered by the states.

[5] For a legislative history through this period, see U.S. House of Representatives 1993.

SSI cash assistance payments and children who are in foster care, qualify for Medicaid automatically by virtue of their participation in those programs.[6] Others must meet financial (i.e., income and asset) criteria that vary both by group and among states (Figure 2-1). For example, pregnant women with incomes at or below 133 percent FPL ($24,645 for a family of three)—or higher in some states—are a mandatory eligibility group.[7] However, many states opt to cover additional pregnant women with incomes above mandatory levels. Most states have eliminated asset tests for children and pregnant women and about half have done so for parents (Heberlein et al. 2011). The treatment of both income and assets can be complex for individuals in need of long-term services and supports (LTSS) (Walker and Accius 2010).

Along with falling into a specified eligibility group, individuals must meet other criteria in order to qualify for Medicaid. For example, they must be citizens or nationals of the United States or qualified aliens in order to receive the full range of benefits offered under the program.[8] Non-qualified aliens (as well as qualified aliens subject to a five-year bar on full benefits) who meet income and all other eligibility criteria for the program can only receive limited emergency Medicaid coverage.[9] In addition, individuals in need of LTSS may be required to meet functional eligibility criteria that demonstrate difficulty performing activities necessary for self care and independent living.

For FY 2009, Figure 2-2 shows the estimated distribution of Medicaid enrollment and benefit spending by enrollees' basis of eligibility. (See Table 2 in MACStats for state-level enrollment for FY 2008 and national estimates for FY 2009-FY 2012). Although individuals age 65 and older and persons with disabilities account for less than one-third of enrollees, they account for about two-thirds of Medicaid spending on benefits.

These two groups account for a disproportionate share of Medicaid spending because they have substantially higher per-enrollee costs than others. For example, estimated average spending on a non-disabled child enrolled in Medicaid for the entire year was about $2,900 in FY 2009 (including federal and state dollars); the figure for a non-disabled adult under age 65 was about $4,100.[10] In comparison, estimated average spending on a person eligible on the basis of a disability who was enrolled for the entire year was about $16,600; for a person age 65 or older, it was about $15,700

[6] Eleven "209(b)" states (referring to a section of the Social Security Act) may use criteria that differ from SSI when determining Medicaid eligibility.

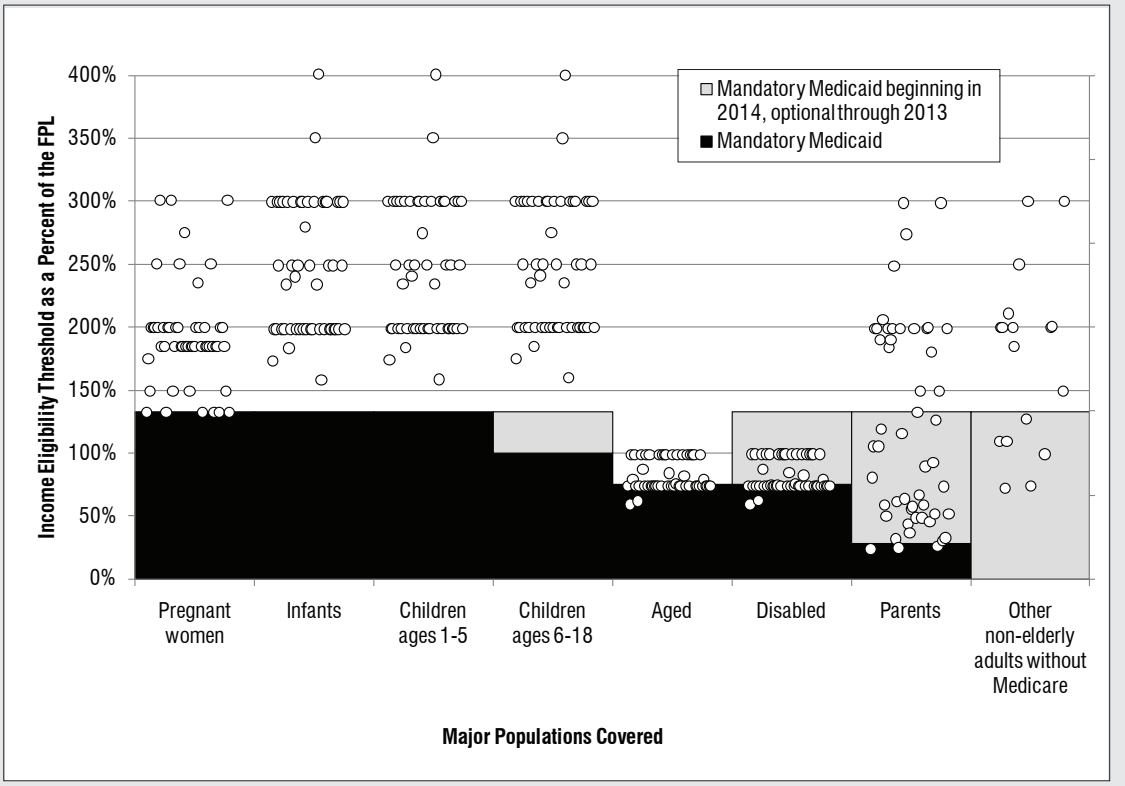
[7] The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) set a generally applicable mandatory income eligibility level of 133 percent FPL for pregnant women and infants. However, at the time of enactment, 15 states had already opted to cover them at higher levels—which ranged from 150 percent FPL to 185 percent FPL (Hill 1992)—and their mandatory levels were set at these higher amounts.

[8] The term qualified alien was created by the welfare reform law of 1996 (P.L. 104-193). Examples include legal permanent residents (LPRs), refugees, and asylees. LPRs entering after August 22, 1996, are generally barred from receiving full Medicaid benefits for five years, after which coverage becomes a state option. However, children and pregnant women who are lawfully present may be covered during the five-year bar at state option.

[9] Examples of non-qualified aliens include those who are unauthorized or illegally present, as well as students and other nonimmigrants who are admitted for a temporary purpose.

[10] Not all enrollees are covered by Medicaid for a full year. As a result, spending per person enrolled for a full year shown here (annual spending divided by average monthly enrollment) will be higher than spending per person ever enrolled in Medicaid during the year (annual spending divided by the number of people who had at least one month of enrollment during the year).

FIGURE 2-1. Medicaid and CHIP Income Eligibility by Major Populations Covered



Note: Dots on the chart generally represent state Medicaid or CHIP upper income eligibility thresholds for each population and may include employer-sponsored premium assistance and limited benefit packages; however, individuals with high medical expenses or long-term care needs may be eligible at higher income levels than those shown. Excludes eligibility for aged and disabled dual eligibles who only receive assistance with Medicare premiums and cost-sharing. In addition to meeting income criteria, individuals may be subject to an asset test and must meet additional eligibility criteria as noted in the text of Chapters 2 and 3.

Bars on the chart do not reflect Medicaid mandatory thresholds in all states. Exceptions include parents (varies by state, bar reflects U.S. median); pregnant women and infants (higher in 15 states than the generally applicable 133 percent FPL shown here); and aged and disabled individuals (11 states may use a threshold that differs from the SSI level shown here).

The mandatory thresholds for parents and disabled individuals will not change as of 2014; however, individuals above the current thresholds will gain mandatory status up to 133 percent FPL under the new eligibility group for other non-elderly adults who are not pregnant and do not have Medicare coverage.

Source: Social Security Act and Tables 9 through 11 in MACStats.

(OACT 2010). These differences in Medicaid costs across groups are even more striking in light of the fact that most enrollees over age 65 and about a third of enrollees with disabilities also have Medicare coverage,[11] which is the primary payer for their hospital, physician, and other acute care services.

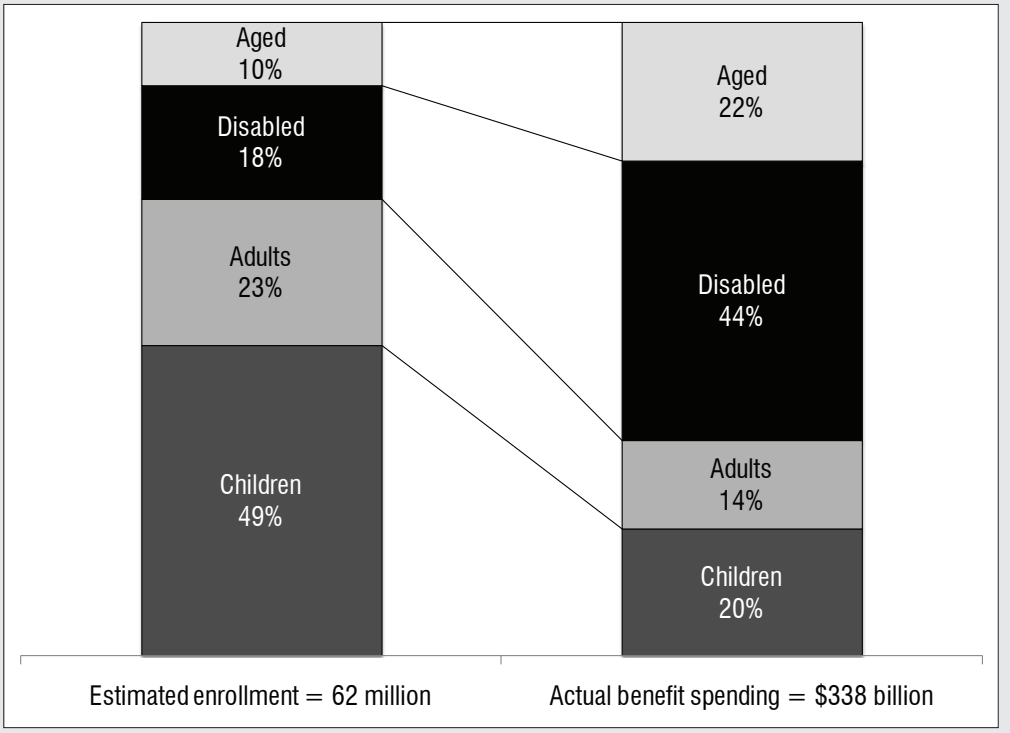
Eligibility: Future Issues

PPACA includes a maintenance of effort (MOE) provision that requires states to maintain the eligibility policies they had in place on the date of its enactment—until 2014 for adults and through FY 2019 for children—regardless of mandatory or optional status.[12] In addition, to coordinate determinations of eligibility with the subsidies for

[11] MACPAC analysis of FY 2008 Medicaid Statistical Information System (MSIS) data.

[12] For 2011-2013, there is an exception to the MOE for nonpregnant, nondisabled adults above 133 percent FPL if the state has a budget deficit. States are also subject to an MOE requirement through June 2011 as a condition of receiving a temporary increase in federal funds noted later in this chapter.

FIGURE 2-2. Distribution of Medicaid Enrollment and Benefit Spending by Basis of Eligibility, Estimated FY 2009



Note: Adults and children are non-disabled enrollees under age 65 and 19, respectively. Reflects people ever enrolled during the year and includes federal and state dollars. Excludes the territories, disproportionate share hospital (DSH) payments, and adjustments.

Source: OACT 2010

health insurance coverage that PPACA authorizes, starting in 2014 the way in which income and assets are counted for purposes of Medicaid and CHIP eligibility will change. Countable income for most Medicaid and CHIP enrollees, primarily those who are under age 65 and not disabled, will be based on modified adjusted gross income (MAGI) rules.[13] In addition, no asset test will apply to these individuals. In order to accommodate these changes and others made by PPACA, including the expansion of coverage for non-elderly adults, most states will need to make substantial modifications to their eligibility determination systems and processes.

Medicaid Benefits

In addition to covering routine services, Medicaid provides certain benefits that are limited or not typically covered under traditional health insurance. For example, it provides LTSS for individuals with physical and mental disabilities, including those

[13] Despite the fact that Medicaid eligibility has shifted away from the receipt of cash assistance payments, states are generally required to apply state-specific AFDC or federal SSI rules regarding exclusions and disregards (e.g., a portion of earned income, certain child care expenses) that reduce the amount of income and assets that are counted for Medicaid eligibility purposes. MAGI has its own rules for counting income (e.g., it excludes some or all Social Security benefits). For individuals whose eligibility is determined using MAGI starting in 2014, the only income disregard that will apply is a dollar amount equal to five percent of the FPL. This means, for example, that an individual whose total income equals 138 percent FPL will only have 133 percent FPL counted when his or her Medicaid eligibility is determined. In the transition to MAGI, states will be required to ensure that individuals do not lose eligibility based on the new method for counting income.

TABLE 2-1. Mandatory and Optional Medicaid Benefits

Mandatory

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals under age 21 (screening, vision, dental, and hearing services and any medically necessary service listed in the Medicaid statute, including optional services that are not otherwise covered by a state)
- Family planning services and supplies
- Federally qualified health center services
- Freestanding birth center services
- Home health services
- Laboratory and X-ray services
- Nursing facility services (for ages 21 and over)
- Nurse midwife services (to the extent authorized to practice under state law or regulation)
- Nurse practitioner services (to the extent authorized to practice under state law or regulation)
- Rural heath clinic services
- Tobacco cessation counseling and pharmacotherapy for pregnant women
- Non-emergency transportation[14]

Optional (number of states covering benefit)

- Medical or remedial care provided by licensed practitioners under state law. (Specific provider types, as well as all optional benefits states cover, are listed in Table 12 in MACStats.)
- Intermediate care facility services for individuals with mental retardation (51)
- Clinic services (50)
- Skilled nursing facility services for individuals under age 21 (50)
- Occupational therapy services (50)
- Optometry services (50)
- Physical therapy services (50)
- Prescribed drugs (50)
- Targeted case management services (50)
- Prosthetic devices (49)
- Hospice services (48)
- Inpatient psychiatric services for individuals under age 21 (48)
- Dental services (46)
- Eyeglasses (45)
- Services for individuals with speech, hearing, and language disorders (45)
- Audiology services (43)
- Inpatient hospital services, nursing facility services, and intermediate care services for individuals age 65 or older in institutions for mental diseases (42)
- Emergency hospital services[15] (40)
- Dentures (37)
- Preventive services (37)
- Personal care services (35)
- Private duty nursing services (33)
- Rehabilitative services (33)
- Diagnostic services (32)
- Program for All-Inclusive Care for the Elderly (PACE) services (31)
- Screening services (30)
- Chiropractic services (29)
- Critical hospital services (22)
- Respiratory care for ventilator-dependent individuals (22)
- Primary care case management services (14)
- Services furnished in a religious nonmedical health care institution (13)
- Tuberculosis-related services (13)
- Home and community-based services (HCBS)[16](4)
- Sickle cell disease-related services (2)
- Health homes for enrollees with chronic conditions (new benefit as of January 1, 2011)

Note: This table provides a list of mandatory and optional state plan benefits for the 50 states and the District of Columbia. It does not include services provided under a Medicaid waiver; for example, while four states provide HCBS under the state plan option, all states offer home and community-based services through waivers.

Source: See Table 12 in MACStats

[14] Federal regulations require states to provide transportation services; they may do so as an administrative function or as part of the Medicaid benefit package.

[15] Federal regulations define these services as being those that are necessary to prevent the death or serious impairment of the health of the recipient and, because of the threat to life, necessitates the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet Medicare's participation requirements or the definition of inpatient or outpatient hospital services under Medicaid rules.

[16] While only four states provide HCBS under the state plan option, all states offer HCBS through waivers.

BOX 2-1. Medicaid's Role in Long-term Services and Supports

People who have a chronic illness or a physical or mental disability may use long-term services and supports (LTSS) to assist them with basic daily activities (such as bathing, dressing, and moving in and out of a bed or chair). Their need for assistance can change over time. With many of these services not covered by Medicare or private insurance, Medicaid is the de facto payer of LTSS for many people, paying about half of these costs nationally (Figure 1-3). The people who use these services span all ages and often have significant acute care needs as well. For example, services such as inpatient hospital, physician, and prescription drugs accounted for about a quarter of Medicaid spending among enrollees receiving LTSS in FY 2002 (Sommers et al. 2006).[17]

The Supreme Court, in *Olmstead v. L.C.,* 119 S. Ct. 2176 (June 22, 1999), ruled that people with disabilities who are capable of living in the community should have the option to reside in the most integrated setting appropriate to their needs, and that to deny these services constitutes discrimination under the Americans with Disabilities Act (ADA). As communicated by CMS in a letter to state Medicaid directors, states are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional care if: the state's treatment professionals reasonably determine that care in the community is appropriate; the enrollee does not decline such treatment; and the community placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state-supported disability services (CMS 2000).

enrolled in Medicare, which does not cover these services (Wenzlow et al. 2008). Under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, it provides a broad range of therapies and services for children, including those with special health care needs (Peters 2006). It also provides translation, interpretation, and non-emergency transportation services that may not be covered under private plans.

States can require enrollees to share in the costs of their Medicaid coverage (such as through copayments for services and premiums to enroll), but certain exemptions and limits apply. Although the majority of Medicaid spending occurs under fee-for-service arrangements whereby states pay providers directly for care received by enrollees, many states also contract with managed care plans to administer benefits and pay providers.

Covered Services

Under Medicaid, states are required to cover "mandatory" benefits and may choose to cover "optional" benefits. These benefits are defined in federal statute and regulations and cover specific items, provider types, and service types; however, the breadth of coverage (i.e., amount, duration,

[17] A more current estimate might differ somewhat due to the transfer of most prescription drug costs for dual eligibles from Medicaid to Medicare Part D beginning in 2006.

and scope) varies by state. For example, one state may elect to cap the number of inpatient hospital days an enrollee might receive each year, while another state may allow an unlimited number of inpatient hospital days.

Within a state, each service provided must be adequate in amount, duration, and scope to reasonably achieve its purpose, although the state may limit coverage of a service based on criteria such as medical necessity or through utilization control measures. In addition, benefits for most enrollees must be equivalent in amount, duration, and scope (known as the comparability rule); benefits must be the same throughout the state (the statewideness rule); and enrollees must have freedom of choice among health care providers and practitioners or managed care plans participating in Medicaid.

As an alternative to traditional Medicaid benefits, states may enroll state-specified groups (excluding individuals with special medical needs and certain others) in benchmark and benchmark-equivalent benefit packages.[18] States that elect to use this benefit design can provide coverage that is equal to the Blue Cross and Blue Shield standard provider plan under the Federal Employees Health Benefits Program; a plan offered to state employees; the largest commercial health maintenance organization (HMO) in the state; or other coverage approved by the Secretary of HHS appropriate for the targeted population. A benchmark-equivalent benefit package must be actuarially equivalent to the benchmark to which it is being compared and must include certain benefits.[19]

Benchmark and benchmark-equivalent packages allow states to bypass requirements that have traditionally applied to Medicaid, such as statewideness, comparability, and freedom of choice. States must assure access to EPSDT services for children under age 21 either through these packages or as additional benefits provided by the state.

States also have the option to use premium assistance programs to help eligible individuals purchase private insurance through their employer and 39 do so with Medicaid funds (GAO 2010). However, less than one percent of enrollees are enrolled in these programs (Shirk 2010).

Enrollee Cost-Sharing

States can require that certain groups of Medicaid enrollees pay enrollment fees, premiums, deductibles, coinsurance, copayments, or similar cost-sharing amounts. There are, however, specific guidelines regarding who may be charged these fees, the services for which they may be charged, and the amount allowed (Table 13 in MACStats).

Enrollees exempt from cost-sharing include: children under age 18, enrollees receiving hospice care, those in nursing facilities and intermediate care facilities for the mentally retarded (ICFs-MR),

[18] Groups that are exempt from mandatory enrollment in these benefit packages include pregnant women, dual eligibles, those who qualify for Medicaid on the basis of blindness or disability, enrollees receiving hospice care, and those who are medically frail or have special medical needs.

[19] A benchmark-equivalent benefit package must include inpatient and outpatient hospital services, physician services, laboratory and X-ray services, emergency care, well-baby and well-child care, family planning services and supplies, and other appropriate preventive care. It must also include at least 75 percent of the actuarial value of coverage under the benchmark package for prescription drugs, mental health services, vision care, and hearing services, if these services are included in the comparison package.

and certain enrollees in hospitals and other medical institutions. Pregnancy-related services, emergency services, family planning services and supplies, and items and services provided to an Indian are also excluded from cost-sharing.

Adults with family incomes at or below 100 percent FPL (currently $18,530 for a family of three) may only be charged nominal amounts for certain services and premiums may not be imposed at or below 150 percent FPL ($27,795 for a family of three). For adults with family incomes above 100 percent FPL, states may impose nominal or higher cost-sharing for some services; in addition, those with incomes above 150 percent FPL may be charged premiums. Regardless of income level, states must ensure that the aggregate amount paid by individuals subject to cost-sharing above nominal amounts does not exceed five percent of a family's monthly or quarterly income.

Service Delivery and Payment Mechanisms

The majority of Medicaid spending occurs under FFS arrangements whereby states pay providers directly for care provided to enrollees. Many states, however, also contract with managed care plans to administer benefits and pay providers (Box 2-2). Section 1902(a)(30)(A) of the Social Security Act is the foundational statutory provision that governs payment for all Medicaid-covered services, requiring that they are consistent with efficiency, economy, and quality of care and are sufficient to provide access equivalent to the general population. In Chapter 5 we discuss payment policies and issues in greater depth.

In addition to or in lieu of standard payments, some providers with special roles in delivering care receive enhanced support from Medicaid. For example, federally qualified health centers (FQHCs), which are located in high-need areas and provide care to more than 7 million Medicaid and CHIP enrollees, receive cost-based payments for these patients.[20] Hospitals that serve large numbers of low-income and uninsured individuals may receive disproportionate share hospital (DSH) payments. In addition, states may make non-DSH supplemental payments to increase reimbursement above standard rates for certain providers, including hospitals and nursing homes. In general, DSH and non-DSH supplemental payments are made in aggregate amounts that are not tied to individual Medicaid enrollees and the services they receive.

As noted earlier, Medicaid is a dominant payer of LTSS. In recent decades there has been a significant shift in the delivery of care for people with mental and physical disabilities away from nursing homes, ICFs-MR, and other institutional settings to community-based alternatives (Vladeck 2003). For both institutional and community providers of LTSS, Medicaid accounts for a significant share of revenues (Quinn and Kitchener 2007).

Benefits: Future Issues

PPACA brings a variety of mandatory and optional changes to Medicaid benefits in the years to come. These changes include the coverage of services provided in free-standing birthing centers, expansion of preventive care for adults,

[20] These 7 million Medicaid and CHIP enrollees accounted for nearly 40 percent of FQHC patient volume in 2009; figures exclude FQHC "look-alikes" that also receive cost-based payments (HRSA 2009).

BOX 2-2. Fee for Service and Managed Care Arrangements

States may offer Medicaid benefits on a fee-for-service (FFS) basis, through managed care plans, or both. Under a FFS model, the state pays providers directly for each covered service received by a Medicaid enrollee. Under managed care, the state pays a fee to a managed care plan for each person enrolled in the plan; in turn, the plan pays providers for all of the Medicaid services an enrollee may require that are included in the plan's contract. Under primary care case management (PCCM) programs, providers are typically paid a small monthly case management fee for coordinating and monitoring care that is in addition to FFS reimbursement for providing primary care services.

Statistics from CMS often include managed care plans that provide comprehensive and limited benefits, as well as PCCMs, in the definition of Medicaid managed care. "Limited-benefit plans" are a diverse assortment of plans that typically manage a subset of benefits such as mental health and non-emergency transportation. Under a broad definition of managed care that includes comprehensive plans, limited-benefit plans, and PCCM programs, CMS reports that more than 70 percent of Medicaid enrollees nationally are in managed care (CMS 2010b). If the definition of managed care is restricted only to plans that provide comprehensive benefits, 47 percent of Medicaid enrollees were in managed care in FY 2008 (Table 2 in MACStats). In FY 2010, comprehensive managed care plans accounted for nearly 21 percent of Medicaid spending on benefits; limited-benefit plans and PCCM programs accounted for less than 3 percent (Table 7 in MACStats).

smoking cessation services for pregnant women, changes in the scope of coverage for children receiving hospice care, new statutory authority for consumer-directed personal care attendant services, "health homes" for people with chronic conditions, and new options for home and community-based services. In addition, beginning in 2014, benchmark and benchmark-equivalent packages must cover "essential health benefits" so that they align with plans offered through the individual and small group insurance markets.[21]

Under PPACA's 2014 eligibility expansion, most adults under age 65 who are new to Medicaid will be required to enroll in either benchmark or benchmark-equivalent benefit packages. However, as under existing rules for these packages, individuals with special medical needs are exempt and states have flexibility under a Secretary-approved benchmark or a benchmark-equivalent package to include additional Medicaid benefits. Since enrollees may experience shifts in their basis of eligibility (e.g., to a pregnancy category) as their income and health status changes, states must have systems for tracking changes in status to ensure that individuals are able to receive the services to which they are entitled.

Financing and Administration of Medicaid

Medicaid is a major source of federal financing for costs that might otherwise be borne by states and

[21] "Essential benefits" are defined as ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. For benchmark-equivalent benefit packages, prescription drugs and mental health services must be added to the basic services covered by the package.

local governments solely from their own revenues, individuals paying out of pocket, and providers supplying care for free or at reduced rates. Enrollment in Medicaid has grown steadily and particularly rapidly during economic downturns, a situation that places extra pressure on public budgets as tax revenues decline. With regard to spending growth in Medicaid, states are subject to the same underlying drivers of health care costs that other payers contend with, such as medical practice patterns and new, high-cost technologies.

Financing Medicaid

Financing for the Medicaid program is a shared responsibility of the federal government and the states. States that operate their Medicaid programs within federal guidelines are entitled to federal reimbursement for a share of their total program costs. States incur these costs by making payments to health care providers and managed care plans and by performing administrative tasks such as making eligibility determinations, enrolling and monitoring providers, and paying claims. They then submit quarterly expense reports in order to receive federal matching dollars. As shown in Table 6 in MACStats, FY 2010 Medicaid spending totaled $406 billion, with a federal share of $274 billion and a state share of $132 billion.

The federal share for Medicaid administrative costs is generally 50 percent. The federal share for most Medicaid service costs is determined by the federal medical assistance percentage (FMAP), which is based on a formula that provides higher reimbursement to states with lower per capita incomes—a measure of states' ability to fund Medicaid that was available at the time the formula was designed (GAO 2003)—relative to the national average (and vice versa). FMAPs have a statutory minimum of 50 percent and maximum of 83 percent. Certain exceptions apply, however, for the territories and the District of Columbia (whose FMAPs are set in statute); special situations (e.g., temporary state fiscal relief); and certain populations, providers, and services (e.g., services provided through Indian Health Service facilities). See Table 14 in MACStats for state-level information on FMAPs.

Unlike Medicare, an exclusively federal program for which a substantial portion of spending is financed by dedicated revenue sources that include payroll taxes and enrollee premiums, federal spending for Medicaid and CHIP is financed by general revenues (OACT 2010). Medicaid and CHIP represent a growing portion of the federal budget, having increased from 1.4 percent of federal outlays in FY 1970 to 8.1 percent in FY 2010; in comparison, Medicare increased from 3.0 percent of federal outlays to 12.3 percent over the same period (OMB 2011).

Funding for the nonfederal, or state, share of Medicaid comes from a variety of sources; at least 40 percent must be financed by the state and up to 60 percent may come from local governments. In state fiscal year (SFY) 2009, states reported that about 80 percent of the nonfederal share of their Medicaid costs was financed by state general funds, most of which are raised from personal income, sales, and corporate income taxes. The remaining 20 percent was financed by other state funds, including local funds and provider taxes, fees, donations, and assessments (NASBO 2010).

Medicaid is typically the largest or second-largest share of state budgets when they are viewed

BOX 2-3. Reductions in State Medicaid Spending Require Much Larger Reductions in Total Medicaid Spending

In most years, the federal share of Medicaid spending nationally is 57 percent. However, the FMAPs that determine the federal share of most Medicaid costs vary by state, with a statutory minimum of 50 percent and maximum of 83 percent. Thus, the non-federal, or state, share of Medicaid spending typically ranges from 20 percent to 50 percent. As result of this shared federal-state financing, obtaining a set level of savings in the *state* share of Medicaid spending requires much larger *overall* Medicaid spending reductions.

For example: A state with an FMAP of 70 percent expects total Medicaid spending of $60 million in the upcoming year; thus, the federal share of Medicaid spending is projected to be $42 million and the state's share $18 million. If the state wants to spend $6 million less in state dollars, it would have to reduce total Medicaid spending by $20 million. If the state's FMAP were lower, say 50 percent, obtaining state-share savings of $6 million would require that total Medicaid spending be reduced by just $12 million.

nationally; however, there is substantial variation both across states (when budgets are viewed individually) and within states (when distinctions are made between total and state-funded budgets). The program also accounts for more than two-thirds of state government health expenditures and more than 40 percent of state spending from federal funds (Milbank 2005, NASBO 2010).[22] Looking at *total* state budgets for SFY 2009 (including funds from all state and federal sources), Medicaid accounted for 21.1 percent of those budgets nationally. However, looking at the *state-funded portion* of state budgets for SFY 2009 (i.e., the portion that states must finance on their own through taxes and other means), Medicaid accounted for only 12.2 percent. For information on the variation across states under both of these measures, see Table 15 in MACStats.

When states seek to reduce the amount spent on Medicaid out of their own funds, they must reduce *total* Medicaid expenditures by substantially more than the reduction in state dollars that they seek. This is because the federal government matches at least half of states' Medicaid spending. (See Box 2-3.) The policy levers specific to Medicaid and CHIP over which states have some discretion include eligibility (as noted earlier, however, states are currently subject to an MOE requirement that applies to most populations); covered benefits; enrollee cost-sharing and premiums; and provider payments (discussed further in Chapter 5). Taking steps to address fraud, waste, and abuse also have potential for savings, but may require up-front spending to obtain longer-term results.

Medicaid spending has grown in recent decades, partly because of rising enrollment and partly because of rising costs per enrollee. Overall spending for Medicaid benefits grew at an annual average rate of 11.2 percent (7.1 percent after adjusting for inflation) between FY 1975

[22] In SFY 2003, the most recent year for which data are readily available, health expenditures accounted for 31.5 percent of state budgets; Medicaid accounted for more than two-thirds of that amount.

and FY 2002; about 40 percent of the growth during that period was due to a growing number of recipients and about 60 percent was due to increases in real (inflation-adjusted) treatment costs per recipient (CBO 2006). A more recent analysis indicates that, between FY 2000 and FY 2007, overall spending for Medicaid benefits has largely been driven by enrollment and—as with other payers—underlying health care inflation, meaning that increases in real treatment costs have played a smaller role (Holahan and Yemane 2009).

In addition to affecting state and federal budgets, the Medicaid and CHIP programs affect the U.S. economy through spending that generates health sector jobs, income, and tax receipts—as well as through labor market and other incentive effects.[23] At the state level, spending on Medicaid and CHIP draws down federal matching funds that might not otherwise flow into a state's economy; spending on programs funded solely with state dollars is not multiplied in this manner. At the federal level, the economic effects of Medicaid and CHIP spending may depend on the extent to which that spending contributes to deficits.

Administration

Although CMS is responsible for Medicaid program administration at the federal level, individual state Medicaid agencies establish many policies and manage their own programs on a day-to-day basis. Federal law requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. This agency will often contract with other public or private entities to perform various program functions. For example, most states contract with the private sector to operate their Medicaid Management Information Systems (MMISs) (CMS 2011), which are used to process claims for payment from providers and perform a variety of other tasks (e.g., monitor service utilization and provide data to meet federal reporting requirements). In addition, state—and often local—agencies that are responsible for eligibility determinations may be separate from those that deal with provider and payment issues.

CMS oversees the approval of state plan amendments, waivers, and demonstrations and provides guidance to states through State Medicaid Director (SMD) and State Health Official (SHO) letters. As a condition of receiving federal Medicaid funds, Section 1902 of the Social Security Act requires states to have a state plan on file with CMS that demonstrates an understanding of all federal Medicaid requirements. States are required to submit state plan amendments (SPAs) to CMS for review and approval prior to making program modifications. In addition to SPAs, CMS works with state Medicaid agencies to review and approve waivers (discussed later in this chapter).

Once states opt to participate in Medicaid, as all currently do, they are obligated to administer their programs within federal guidelines and requirements. The federal share for Medicaid administrative costs is generally 50 percent, but certain administrative functions receive a higher federal share. For example, upgrades to computer and data systems may be eligible for a 75 percent or

[23] For a discussion of the potential multiplier effects of federal transfers to states for Medicaid and other purposes in the context of stimulus funding, see CBO 2009. For a discussion of the potential labor market and other incentive effects of Medicaid, see Box 2-1 in CBO 2010.

90 percent federal match if certain criteria are met, a key issue for states as they implement eligibility and other changes related to PPACA.[24] In recent years, state Medicaid program administration costs have grown at about the same rate as service costs and thus have remained a relatively constant share of total Medicaid spending, about five percent.[25] Funding for Medicaid-related administrative activities at CMS generally comes from annual appropriations.

Compliance with federal and state Medicaid program policies is monitored in a number of ways. For example, under the Payment Error Rate Measurement (PERM) program for Medicaid and CHIP, a sample of claims and eligibility determinations are reviewed in a rotating subset of states each year (GAO 2011a). States also undertake their own efforts to address program integrity issues. Although discussions of such issues are often limited to fraud and abuse by Medicaid providers, as well as enrollees, a broader view encompasses program management issues. These issues include policy development and execution, which affect the ability of states and the federal government to ensure that enrollees receive quality care and that taxpayer dollars are spent appropriately (Wachino 2007). Partly in response to concerns about Medicaid's vulnerability to significant financial losses and previously low levels of resources devoted to program integrity, the Congress has provided new requirements and funding for these activities in recent years (GAO 2011b, Brice-Smith 2010).

Financing and Administration: Future Issues

In an economic downturn, state Medicaid and CHIP programs face dual pressures. First, enrollment increases at a faster rate than would otherwise be expected, because job and income losses lead more people to become eligible (Holahan and Garrett 2009). Second, it can be more difficult to finance the state share of Medicaid and CHIP costs, because state revenues fall below expected levels (Brinner et al. 2008). States are currently facing severe budget pressures as a result of the recent recession (NGA 2010) and are receiving a temporary increase in the share of their Medicaid costs paid by the federal government (GAO 2010b). The increase began in FY 2009 and will run through the third quarter of FY 2011, which corresponds with the end of SFY 2011 for most states. As a result, many are facing difficult budget choices as they plan for SFY 2012.

For individuals who meet the definition of "newly eligible" under the Medicaid expansion for non-elderly adults beginning in 2014, PPACA provides an increased FMAP (100 percent in 2014 and 2015, phasing down to 90 percent in 2020 and subsequent years). The newly eligible include those who would not have been eligible for Medicaid in the state as of December 1, 2009, or who were eligible under a waiver but not enrolled because of limits or caps on waiver enrollment. An increased FMAP is also available for states that had expanded eligibility prior to PPACA and thus would have few or no individuals who qualify as newly eligible.

[24] A recent proposed rule from CMS describes the availability of federal reimbursement for Medicaid data systems under current law. See CMS 2010c.

[25] Excludes administrative activities that are exclusively federal (e.g., program oversight by CMS staff).

Waivers

The overview provided in this chapter generally reflects the operation of Medicaid programs under "state plan" rules. However, as discussed in this section, the Social Security Act (the Act) contains multiple waiver authorities that provide states flexibility in certain areas by allowing them to operate their programs without regard to federal requirements that would otherwise apply. For example, the Act provides the authority to waive certain provisions of the Medicaid and CHIP statutes such as eligibility and benefits in order to explore new approaches to the delivery of and payment for health care and long-term services and supports. This flexibility has enabled states to make fundamental changes to their programs. All states operate one or more Medicaid waivers, which are generally referred to by the section of the Act granting the waiver authority. Those waivers are categorized as program waivers or research and demonstration projects. Regardless of the type of waiver, estimated federal spending over the period for which the waiver is in effect cannot be greater than they would have been without the waiver. Approval of states' waiver applications is at the discretion of the Secretary of HHS.

Medicaid Program Waivers

Enacted by the Congress in the Omnibus Reconciliation Act (OBRA) of 1981, Medicaid program waivers offer states additional targeted flexibility to test new approaches in service delivery. These waivers are specific to the Medicaid program and must not lead federal Medicaid expenditures over the waiver approval period to be higher than they would have been without the waiver.

- **Freedom of Choice: Section 1915(b) waivers.** The Medicaid statute generally guarantees beneficiaries freedom of choice of providers, but Section 1915(b) waivers permit states to implement service delivery models (e.g., those involving primary care case management programs or managed care plans) that restrict beneficiaries' choice of providers other than in emergency circumstances. States can also use Section 1915(b) to waive statewideness requirements (e.g., to provide managed care in a limited geographic area) and comparability requirements (e.g., to provide enhanced benefits to managed care enrollees).[26] Section 1915(b) waivers must be "cost effective" and show federal expenditures are not greater under the waiver. Section 1915(b) waivers are approved for two years with two-year renewal periods. There is no limit to how often a state can apply for or the Secretary can approve renewal of a 1915(b) waiver.[27]
- **Home and Community-Based Services (HCBS): Section 1915(c) waivers.** Section 1915(c) of the Medicaid statute authorizes states to provide home and community-based services as an alternative to institutional care in nursing homes, ICFs-MR, and hospitals. States use this authority to "rebalance" long term services and supports in their Medicaid

[26] The Secretary is precluded from restricting freedom of choice for Medicaid family planning services, waiving provisions that establish payments to rural health clinics and federally qualified health centers, and payments to disproportionate share hospitals for infants and young children.

[27] In addition to these waivers, a provision included in the Balanced Budget Act of 1997 (P.L. 105-33) allows states to require mandatory managed care enrollment for most groups under regular statutory rules through a state plan option.

programs from institutional settings to community settings. The statute identifies services that may be considered home and community-based services, including case management, homemaker/home health aide services, personal care services, adult day health, habilitation services, and respite care. The Secretary may also approve other services needed to avoid institutionalization. Under HCBS waivers, states can provide targeted sets of services to specific populations including, for example, seniors, people with physical disabilities or HIV/AIDS, individuals with developmental disabilities, and people with traumatic brain injuries.

HCBS waiver programs must be "cost neutral," meaning expenditures on behalf of enrollees in the waiver should be no greater than they would have been if the individual had resided in an institution. States are permitted to impose caps on waiver program enrollment and on the average costs per person to ensure that they do not exceed the cost-neutrality limit. HCBS waivers are approved for three years with an unlimited number of five-year renewals.[28]

Section 1115 Research and Demonstration Projects

Section 1115 of the Social Security Act gives broad authority to the Secretary to authorize "any experimental, pilot or demonstration project likely to assist in promoting the objectives of the programs" specified in that section of the Act. Under Section 1115 research and demonstration authority, states may waive certain provisions of the Medicaid and CHIP statutes related to state program design.[29] Section 1115 research and demonstration projects are generally broad in scope, operate statewide, and affect a large portion of the Medicaid population within a state; however, authority has also been used to focus on specific services or populations, such as family planning and people with HIV/AIDS. Provisions that may be waived under Section 1115 include Medicaid eligibility criteria, covered services, and service delivery and payment methods used by the state to administer the program.

Section 1115 demonstrations are required to be "budget neutral" (or "allotment neutral" for CHIP), meaning estimated federal spending over the waiver approval period must be no greater than they would have been without the waiver. To maintain budget neutrality, states identify savings in their proposed 1115 demonstrations that will offset the cost of any program expansion. The savings can include managed care savings, redirecting Medicaid DSH payments, and benefit and cost-sharing savings. Budget neutrality is a federal

[28] A provision included in the Deficit Reduction Act of 2005 (P.L. 109-171) allows states to convert their HCBS waivers into state plan options. PPACA also made changes to waiver and state plan options for HCBS.

[29] The Secretary does not have the authority to waive certain program elements such as the federal matching payment system for states. Waiver authority for CHIP is by reference in Sections 2107(e)(2)(A) and (f) of the Act.

TABLE 2-2. Medicaid Waivers and Research Demonstrations

Authority	Waiver Period	Renewal Period	Number Active	Number of States with waiver/demonstration
1915(b)	2	2	44 (as of 2009)	25
1915(c)	3	5	287 (as of 2008)	all
1115	5	3	66 (as of 2011)	41

Note: Section 1115 numbers include comprehensive statewide health care reform demonstrations, as well as those that are more limited in scope such as family planning.
Sources: CMS 2010a, 2010d.

regulatory policy, not a statutory requirement like cost effectiveness under 1915(b) waivers and cost neutrality under 1915(c) waivers. Section 1115 demonstrations include a research or evaluation component and usually are approved for a five-year period, with a possible three-year renewal period after the first five years.[30]

The ability to waive certain aspects of the Medicaid statute gives states flexibility to experiment with different approaches to program operation, service delivery, and financing in terms of both program expansion and contraction. Section 1115 authority has been used in a variety of ways and for an array of purposes. Such authority is not needed to expand or contract (within federal requirements) Medicaid coverage for low-income children, parents of dependent children, pregnant women, and elderly or disabled populations because states can do so under regular program options. However, Section 1115 authority is currently needed to:

- cap enrollment in Medicaid;
- reduce benefits below federal standards;
- increase premiums or cost-sharing beyond federal standards;
- cover adults not eligible under the new PPACA option; and
- implement different benefits and cost-sharing for different enrollee groups.

States have used 1115 research and demonstration authority for broad, structural changes to their Medicaid programs that affect both coverage and costs. Section 1115 research and demonstration projects for Medicaid and CHIP have included fundamental program alterations including:

- expanding coverage to uninsured populations such as adults not otherwise eligible under Medicaid and parents and pregnant women under CHIP;
- mandating managed care enrollment;
- using managed long-term care programs for service coordination and cost containment;
- providing tiered benefit packages and cost-sharing for different groups of enrollees across a state;

[30] In the early to mid 1990s there were several large federally funded, multi-state evaluations. As the volume of research and demonstration projects increased and federal research budgets diminished, efforts shifted toward state-specific, state-funded evaluations.

- implementing premium assistance programs for enrollees that are not subject to federal benefit or cost-sharing rules;
- creating defined contribution programs establishing a specific level of funding for each enrollee;
- capping federal Medicaid funding; and
- capping Medicaid enrollment for optional population groups.

Looking Forward

Medicaid serves a substantial number of low-income people—an estimated 68 million in FY 2010. In addition to covering routine services, it provides a range of benefits that are limited or not typically covered under traditional health insurance. Despite its unique role, however, the program is still subject to the same underlying medical cost drivers that other payers struggle to control, such as medical practice patterns and new, high-cost technologies. Although Medicaid is a major source of federal financing for states and the coverage they provide to low-income people, difficult choices are being made in the current budget environment. Future Commission reports will continue to support the work of the Congress, the executive branch, and the states in their consideration of specific policy issues and the broader role of Medicaid in the U.S. health care system.

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