



# Medicaid: A Primer

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## Summary

In existence for 45 years, Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term care to more than 68 million people in FY2010. The estimated annual cost to the federal and state governments was roughly \$381 billion in FY2009. In comparison, the Medicare program, which provided health care benefits to 46 million seniors and certain persons with disabilities cost nearly \$511 billion in FY2009.

Each state designs and administers its own version of Medicaid under broad federal rules. State variability is the rule rather than the exception in terms of eligibility levels, covered services, and how those services are reimbursed and delivered. The new health reform law makes both mandatory and optional changes along these dimensions for the Medicaid program.

This report describes the basic elements of Medicaid, focusing on federal rules governing who is eligible, what services are covered, how the program is financed and how beneficiaries share in the cost of care, how providers are paid, and the role of special waivers in expanding eligibility and modifying benefits. Basic program statistics are also provided. Finally, recent legislative changes at the federal level that affect Medicaid in significant ways are also described.

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**M**edicaid was enacted in 1965 in the same legislation that created the Medicare program (i.e., the Social Security Amendments of 1965; P.L. 89-97). It grew out of and replaced two earlier programs of federal grants to states that provided medical care to welfare recipients and the elderly. It has expanded in additional directions since that time, most recently with the enactment of the Patient Protection and Affordable Care Act (PPACA).<sup>1</sup>

In the federal budget, Medicaid is an entitlement program that constitutes a large share of mandatory spending. Two other federally supported health programs—Medicare and the Children’s Health Insurance Program (CHIP)—are also entitlements,<sup>2</sup> and are also components of mandatory spending in the federal budget. All three programs finance the delivery of certain health care services to specific populations. While Medicare is financed by the federal government and premiums paid by beneficiaries, both Medicaid and CHIP are jointly financed by the federal and state governments. Federal Medicaid spending is open-ended, with total outlays dependent on the generosity of state Medicaid programs. In contrast, CHIP is a capped federal grant to states.

Even though Medicaid is an entitlement program in federal budget terms, states choose whether to participate, and all 50 states do so. If they choose to participate, states must follow federal rules in order to receive federal reimbursement that offsets most of their Medicaid costs. Although this report describes federal Medicaid requirements, a number of these requirements can be waived, with approval from the Secretary of Health and Human Services (HHS), as discussed in the subsection on research and demonstration waivers.

## Who Is Eligible for Medicaid?

The federal Medicaid statute (Title XIX of the Social Security Act) defines more than 50 distinct population groups as being potentially eligible. Historically, Medicaid eligibility was subject to *categorical restrictions* that generally limited coverage to the elderly, persons with disabilities (as generally defined under the federal Supplemental Security Income Program, or SSI<sup>3</sup>), members of families with dependent children, certain other pregnant women and children, certain women with breast or cervical cancer, and uninsured individuals with tuberculosis. Recent changes in law (described below) provide eligibility for nonelderly, childless adults who do not fit into these traditional categories.

In addition, to qualify for Medicaid coverage, applicants’ income (e.g., wages, Social Security benefits) and sometimes their resources, or assets (e.g., value of a car, savings accounts), must meet program *financial requirements*. Medicaid began with eligibility based on receipt of cash assistance under other programs such as Aid to Families with Dependent Children (AFDC), or the SSI program, as noted above. In recent years, Medicaid has shifted largely to eligibility based on

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<sup>1</sup> For more information on the Medicaid changes under PPACA, see CRS Report R41210, *Medicaid and the State Children’s Health Insurance Program (CHIP) Provisions in PPACA*, coordinated by Julie Stone.

<sup>2</sup> The term “entitlement” has two meanings in this context. Individuals who meet state eligibility requirements, which must also meet federal minimum requirements, are entitled to Medicaid. Similarly, individuals who meet federal eligibility requirements are entitled to Medicare. In contrast, states that meet certain federal requirements are entitled, or have access to, federal CHIP grants. All states have qualified for CHIP. There is no individual entitlement under CHIP.

<sup>3</sup> SSI provides cash assistance to the elderly and adults with certain disabilities that significantly restrict their ability to be gainfully employed. In the case of children, disabilities must result in marked and severe functional limitations.

income, and most enrollees do not receive cash assistance. However, states are still required to apply rules used by their former AFDC programs<sup>4</sup> or the federal SSI program when determining countable income for Medicaid. Generally, SSI rules are applicable to the elderly and those with disabilities, while AFDC rules are applicable to other groups. These programs differ on what counts as income and how much is disregarded (ignored) for determining financial eligibility for Medicaid. States have the option to apply additional disregards in order to reduce countable income.

Some eligibility groups are mandatory, meaning that all states with a Medicaid program must cover them; others are optional. Examples of groups that states *must* provide Medicaid to include:

- poor families that meet the financial requirements (based on family size) of the former AFDC cash assistance program,<sup>5</sup>
- families losing Medicaid eligibility due to increased earnings from work who receive up to 12 months of Medicaid coverage,
- pregnant women and children through age 18 with family income below 133% of the federal poverty level (FPL),<sup>6</sup>
- poor individuals with disabilities or poor individuals over age 64 who qualify for cash assistance under the SSI program,<sup>7</sup>
- certain groups of legal permanent resident immigrants (e.g., refugees for the first seven years after entry into the U.S.; asylees for the first seven years after asylum is granted; lawful permanent aliens with 40 quarters of creditable coverage under Social Security; immigrants who are honorably discharged U.S. military veterans) who meet all other financial and categorical Medicaid eligibility requirements,
- beginning in 2014, certain individuals who age out of foster care, up to age 26, who do not qualify under one of the other mandatory groups noted above,
- beginning in 2014, or sooner at state option, all non-elderly, non-pregnant adults with modified adjusted gross income (MAGI) below 133% FPL who do not qualify under one of the other mandatory groups noted above.

Coverage of certain persons aging out of foster care and non-elderly, non-pregnant adults was added to the Medicaid statute by PPACA. In June 2010, Connecticut became the first state to receive approval to expand Medicaid coverage to non-elderly, non-pregnant individuals; the state extended Medicaid coverage to these individuals with income up to 56% FPL, as allowed under

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<sup>4</sup> Under the 1996 welfare reform law, AFDC was replaced with the Temporary Assistance for Needy Families (TANF) program.

<sup>5</sup> AFDC income standards are well below the federal poverty level, but states can modify (liberalize or potentially further restrict) these criteria. Although TANF recipients are not automatically eligible for Medicaid, some states have aligned income rules for TANF and Medicaid, thus facilitating Medicaid coverage for some TANF recipients.

<sup>6</sup> For example, in 2010, the FPL for a family of four is \$22,050—133% of FPL for such a family would equal \$29,326.50. See <http://aspe.hhs.gov/poverty/09extension.shtml>.

<sup>7</sup> Some states use income, resource and disability standards that differ from current SSI standards.

PPACA prior to 2014.<sup>8</sup> Later in June 2010, the District of Columbia also received approval to cover such individuals with income up to 133% FPL with no asset test.<sup>9</sup>

Examples of groups that states *may choose* to cover under Medicaid prior to 2014 include:

- parents with income above AFDC financial levels,
- pregnant women and infants with family income exceeding 133% FPL up to 185% FPL,
- individuals with disabilities and people over age 64 whose income exceeds the SSI level (about 75% FPL nationwide) up to 100% FPL,
- children with disabilities whose family income is above the financial standards for SSI but below 300% FPL,
- individuals who require institutional care (in a nursing facility or other medical institution) whose income exceeds the SSI level up to 300% of the applicable SSI payment standard (based on family size) or roughly 221% FPL,
- the “medically needy” are those individuals in categories selected by the state (e.g., over 64, disabled, families with dependent children) whose income is too high to qualify as categorically needy, but have countable income up to 133⅓% of the maximum payment amount applicable under states’ former AFDC programs.<sup>10</sup> For states that elect the medically needy option, coverage must be provided to certain pregnant women and children under age 18 who otherwise meet the applicable financial criteria. Medically needy coverage is particularly important for the elderly and persons with disabilities, since this pathway allows deductions for medical expenses that lower the amount of income counted in the determination of financial eligibility for Medicaid.
- legal immigrants after their first five years (or earlier for children and pregnant women) in this country; and
- beginning in 2014, all non-elderly, non-pregnant individuals with MAGI above 133% FPL,<sup>11</sup>

As of January 1, 2014, modified adjusted gross income (MAGI) rules will apply to most Medicaid enrollees. Also, no asset test will apply. MAGI is defined as the Internal Revenue Code’s Adjusted Gross Income (AGI, which reflects a number of deductions, including trade and business deductions, losses from sale of property, and alimony payments), *increased* (if applicable) by tax-exempt interest and income earned by U.S. citizens or residents living abroad. Income thresholds for determining Medicaid eligibility must be adjusted to account for the fact that some individuals could lose eligibility under these new rules. These implementation details are still to be worked out. In addition, for certain eligibility groups, states must disregard dollar amounts equal to 5% FPL, and states are prohibited from applying additional income disregards.

<sup>8</sup> For additional details, see <http://www.hhs.gov/news/press/2010pres/06/20100618h.html>. States can choose an income level up to 133% FPL.

<sup>9</sup> For additional details, see <http://www.cms.gov/MedicaidGenInfo/downloads/DC-10-03-Ltr.pdf>

<sup>10</sup> This limit can be raised or lowered based on specific provisions in the 1996 welfare reform legislation.

<sup>11</sup> It is unclear how many states will elect this option given that, beginning in 2014, these individuals will be eligible for coverage through state-based exchanges.

MAGI will *not* apply for specific exempted populations (e.g., those eligible for Medicaid based on their eligibility through another federal or state program such as SSI or foster care, the elderly, certain disabled individuals, and medically needy populations). For such exempted populations, AFDC and SSI income counting rules will continue to apply.

## What Benefits Does Medicaid Cover?

Prior to 2006, in general, states provided mandatory and state-selected optional benefits to their Medicaid beneficiaries. In this report, these are referred to as “traditional” benefits. Beginning in 2006, as an alternative to traditional benefits, states were given the option to provide what are called “benchmark” benefit packages to certain Medicaid subpopulations. These plans can also be limited to substate areas. When certain conditions are met, states can also offer premium assistance for health insurance offered through employer-based plans for Medicaid children and their parents.

### Traditional Medicaid Benefits

Like eligibility, federal rules require states with Medicaid programs to cover certain benefits under the traditional Medicaid program. Certain other services may also be offered at state option. States define the specific features of each covered benefit within four broad federal guidelines:

- Each service must be sufficient in “amount, duration, and scope” to reasonably achieve its purpose. States may place appropriate limits on a service based on such criteria as medical necessity.
- Within a state, services available to the various categorically needy groups<sup>12</sup> must be equal in amount, duration, and scope. These requirements are called the “comparability” rule.
- With certain exceptions, the amount, duration, and scope of benefits must be the same statewide, referred to as the “statewideness” rule.
- With certain exceptions, beneficiaries must have “freedom of choice” among health care providers or managed care entities participating in Medicaid.

Standard benefits identified in the federal statute and regulations include a wide range of medical care and services. Some benefits are specific items, such as eyeglasses and prosthetic devices. Other benefits are defined in terms of specific types of providers (e.g., physicians, hospitals) whose array of services are designated as coverable under Medicaid. Still other benefits define specific types of service (e.g., family planning services and supplies, pregnancy-related services) that may be delivered by any qualified medical provider that participates in Medicaid.

Examples of benefits that are *mandatory* for most Medicaid groups include:

- inpatient hospital services (excluding services for mental disease),

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<sup>12</sup> Categorically needy groups include families with children, the elderly, persons with disabilities, and certain other pregnant women and children who meet former AFDC- and SSI-related financial standards, or have income below specified percentages of the FPL. Beginning in 2014, or earlier at state option, this group will also include non-elderly, non-pregnant adults.

- services provided by federally qualified health centers,
- beginning in March of 2010, services provided by free-standing birthing centers,
- laboratory and x-ray services,
- physician services,
- pregnancy-related services,
- beginning in October 2011, smoking cessation services for pregnant women (i.e., counseling and pharmacotherapy) with no beneficiary cost-sharing,
- nursing facility services for individuals age 21 and over, and
- home health care for those entitled to nursing home care.

Examples of *optional* benefits for most Medicaid groups include:

- prescribed drugs (covered by all states),
- routine dental care,
- physician-directed clinic services,
- other licensed practitioners (e.g., optometrists, podiatrists, psychologists),
- beginning in 2013, certain preventive care services recommended by the U.S. Preventive Services Task Force and adult immunizations recommended by the Advisory Committee on Immunization Practices,
- inpatient psychiatric care for the elderly and for individuals under age 21,
- nursing facility services for individuals under age 21,
- beginning in 2011, consumer-directed personal care attendant services for persons with income up to 150% FPL, or higher when certain conditions are met,
- physical therapy, and
- prosthetic devices.

The optional traditional benefits offered vary across states. In addition, the breadth of coverage for a given benefit can and does 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 (e.g., up to 15 inpatient days per year in one state versus unlimited inpatient days in another state)—again, as long as applicable requirements are met regarding comparability, statewideness and sufficiency of amount, duration and scope within the state. Exceptions to stated limits may be permitted under circumstances defined by the state.

The federal Medicaid statute also specifies special benefits or special rules regarding certain benefits for targeted populations. For example:

- Most Medicaid children under age 21 are entitled to *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services*. Under EPSDT, children receive well-child visits, immunizations, laboratory tests, and other screening services at regular intervals. In addition, medical care that is necessary to correct



or ameliorate identified defects, physical and mental illness, and other conditions must be provided, including optional services that states do not otherwise cover in their Medicaid programs.

- *Unauthorized aliens* (i.e., illegal aliens, foreign nationals who are not lawfully present in the United States) are ineligible for Medicaid. Such individuals who meet the eligibility requirements for Medicaid, but are ineligible due to immigration status, may receive Medicaid coverage for emergency conditions (i.e., emergency Medicaid) only, which includes costs associated with emergency labor and delivery for pregnant women and excludes costs for organ transplants.
- Special benefit rules apply to optional *medically needy populations*. States may offer a more restrictive benefit package than is provided to categorically needy populations, but at a minimum, must offer (1) prenatal, delivery and postpartum services for pregnant women, (2) ambulatory services as defined in the state Medicaid plan for individuals under 18 and those entitled to institutional services, and (3) home health services for individuals entitled to nursing facility care.<sup>13</sup>
- State Medicaid programs must pay *Medicare cost-sharing expenses* (e.g., Medicare premiums and, in some cases, deductibles and co-insurance) for certain low-income individuals eligible for both programs, often called “dual eligibles.”
- Under section 1915(c) of Medicaid law, the Secretary may waive certain statutory requirements to allow states to offer comprehensive long-term care (LTC) service packages to people living in home and community-based (HCB) settings who would otherwise require an institutional level of care. Medicaid law also gives states the authority, under section 1915(i), to offer LTC services to persons residing in HCB settings with a lower level-of-care need. Further, a variety of other state plan benefit options are available to states to cover personal care attendant services (e.g., sections 1915(j) and 1915(k)). Such benefits are designed to help maximize independence, avoid unnecessary hospitalizations, and delay or even prevent the need for institutional care.

## Benchmark Benefit Packages

As an alternative to providing all of the mandatory and selected optional benefits under traditional Medicaid, the Deficit Reduction Act of 2005 (DRA) gave states the option to enroll state-specified groups in new benchmark and benchmark-equivalent benefit packages. The new mandatory eligibility group for non-elderly adults with income under 133% FPL will be enrolled in these plans instead of traditional Medicaid, but certain subpopulations will be exempt from mandatory enrollment in benchmark plans (e.g., those with special health care needs).

In general, benchmark benefit packages may cover fewer benefits than traditional Medicaid, but there are some requirements, such as coverage of EPSDT services and transportation to and from medical providers (as per a recent regulation<sup>14</sup>), that might make them more generous than private insurance. The benchmark options include:

<sup>13</sup> Broader requirements apply if a state has chosen to provide coverage for medically needy persons in institutions for mental disease and intermediate care facilities for the mentally retarded.

<sup>14</sup> Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicaid Program: States (continued...)

- the Blue Cross/Blue Shield standard provider plan under the Federal Employees Health Benefits Program (FEHBP),
- a plan offered to state employees,
- the largest commercial HMO in the state, and
- other Secretary-approved coverage appropriate for the targeted population.

Benchmark-equivalent coverage must have the same actuarial value as one of the benchmark plans identified above. Such coverage must include (1) inpatient and outpatient hospital services, (2) physician services, (3) lab and x-ray services, (4) emergency care, (5) well-child care, including immunizations, (6) prescribed drugs, and (7) other appropriate preventive care (designated by the Secretary). Such coverage must also include at least 75% of the actuarial value of coverage under the benchmark plan for vision care and hearing services (if any).

For any child under age 21 in one of the major mandatory and optional Medicaid eligibility groups, benchmark and benchmark-equivalent coverage must include EPSDT. Also, Medicaid beneficiaries enrolled in such coverage must have access to services provided by rural health clinics and federally qualified health centers.

Some states have experience with benchmark benefits under Medicaid. According to a recent regulation, CMS has approved 10 benchmark packages, eight of which are classified as Secretary-approved coverage.<sup>15</sup> Most offer traditional state plan benefits plus additional services, such as personal care, personal assistance, and disease management services even though benchmark coverage is generally associated with fewer benefits.

Starting in 2014, both benchmark and benchmark-equivalent packages must cover at least essential health benefits that will also apply to plans in the private individual and small group markets. There are 10 such essential health benefits: (1) ambulatory services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance abuse services, (6) prescribed drugs, (7) rehabilitative and habilitative services and devices, (8) lab services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. Many of these essential health benefits are already coverable under benchmark packages. All benchmark packages must also cover family planning services.

Mental health parity, as defined in the Public Health Service Act, generally means that, under a given insurance plan, coverage of mental health services (if offered) should be on par with coverage of medical and surgical services in terms of the treatment limitations (e.g., amount, duration and scope of benefits), financial requirements (e.g., beneficiary co-payments), in- and out-of-network covered benefits, and annual and lifetime dollar limits. Managed care plans under both traditional Medicaid and benchmark packages must comply with all federal mental health parity requirements. Benchmark packages that are not managed care plans are only required to comply with federal requirements for parity in treatment limitations and financial requirements.

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(...continued)

Flexibility for Medicaid Benefit Packages, Final Rule, 75 *Federal Register* 23068 (April 30, 2010).

<sup>15</sup> Ibid.

However, these plans are deemed to comply with federal mental health parity requirements if they offer EPSDT, which they are statutorily required to cover.<sup>16</sup>

## How Is Medicaid Financed?

The federal and state governments share the cost of Medicaid. States are reimbursed by the federal government for a portion (the “federal share”) of a state’s Medicaid program costs. Because Medicaid is an open-ended entitlement, there is no upper limit or cap on the amount of federal funds a state may receive. Medicaid costs in a given state and year are primarily determined by the expansiveness of eligibility rules and beneficiary participation, the breadth of benefits offered, the generosity of provider reimbursement rates, and other supplemental payments.

The state-specific federal share for benefit costs is determined by a formula set in law that establishes higher federal shares for states with per capita personal income levels lower than the national average (and vice versa for states with per capita personal income levels that are higher than the national average).<sup>17</sup> The federal share, called the federal medical assistance percentage (FMAP), is at least 50% and can be as high as 83% (statutory maximum). For FY2011 (excluding the temporary increase in FMAP currently in effect through December 2010), the federal share for benefit costs ranges from 50% (in 13 states) up to 74.73% (in one state, Mississippi).

The federal match for administrative expenditures does not vary by state and is generally 50%, but certain administrative functions have a higher federal matching rate. Functions with a 75% federal match include, for example, survey and certification of nursing facilities, operation of a state Medicaid fraud control unit (MFCU), and operation of an approved Medicaid management information system (MMIS) for claims and information processing. Overall, administrative costs represent about 5% of total Medicaid spending in a given year.

PPACA included provisions that changed certain payments to states under Medicaid. One such provision affects disproportionate share hospital (DSH) payments. States make DSH payments to hospitals that treat large numbers of low-income and Medicaid patients. The main purpose of these payments is to compensate hospitals for otherwise low Medicaid payments and uncompensated care. For FY2009 forward, state DSH allotments equal the prior year amount increased by the change in the consumer price index for all urban consumers. For FY2010, such allotments were estimated to total about \$12 billion.<sup>18</sup> That overall amount will increase over time under the current formula until FY2014, when there should be fewer uninsured individuals as a result of a number of changes in insurance coverage via PPACA. Thus, in theory there may

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<sup>16</sup> For more detailed information on mental health parity under Medicaid, see CRS Report R41249, *Mental Health Parity and the Patient Protection and Affordable Care Act of 2010*, by Amanda K. Sarata.

<sup>17</sup> There are a number of exceptions to the FMAP. For example, for family planning services and supplies, the federal share is 90% for all states. In addition, the federal share is 100% for Medicaid services provided by an Indian Health Service facility (whether operated by the IHS or certain Indian tribes or tribal organizations) to Medicaid beneficiaries. For additional information on FMAP, see CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by April Grady and Chris L. Peterson.

<sup>18</sup> Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicaid Program: Final FY2008, Revised Preliminary FY2009, and Preliminary FY 2010 Disproportionate Share Hospital Allotments and Final FY2008, Revised Preliminary FY2009, and Preliminary FY2010 Disproportionate Share Hospital Institutions for Mental Disease Limits, *75 Federal Register*, 21314 (April 23, 2010).

be less need for Medicaid DSH payments going forward. Under PPACA, there will be specific reductions in overall DSH allotments by fiscal year that must be implemented by the Secretary. These reductions will be \$500 million in FY2014, \$600 million for each of FY2015 and FY2016, \$1.8 billion for FY2017, \$5.0 billion for FY2018, \$5.6 billion for FY2019, and \$4.0 billion for FY2020.

PPACA did not specify a formula for achieving these overall reductions in federal DSH allotments to states. Instead, the Secretary must use certain general parameters to develop a methodology to achieve these dollar reductions.<sup>19</sup>

## Do Beneficiaries Pay for Medicaid Services?

Under traditional Medicaid, states are allowed to require certain beneficiaries to share in the cost of Medicaid services, although there are limits on (1) the amounts that states can impose, (2) the beneficiary groups that can be required to pay, and (3) the services for which cost-sharing can be charged. The rules for service-based cost-sharing (e.g., copayments paid to a provider at the time of service delivery) are different from those for participation-related cost-sharing (e.g., premiums paid by beneficiaries typically on a monthly basis independent of any services rendered).

### Service-Based Cost Sharing Under Traditional Medicaid

For some groups of beneficiaries, all service-related cost sharing is prohibited unless the prohibitions are lifted under a special waiver (see the subsection on waivers below). All service-related cost sharing is prohibited for children under 18 years of age. Service-related cost sharing is prohibited for pregnant women for any services that relate to the pregnancy or to any other medical condition that may complicate pregnancy. Other examples of prohibitions on cost-sharing include:

- services furnished to individuals who are inpatients in a hospital, or are residing in a long term care facility or in another medical institution if the individual is required to spend most of their income for medical care;
- services provided to Indians by an Indian health care provider or through referral under contract health services;
- emergency services; and
- family planning services and supplies.

For most other beneficiaries and services, Medicaid programs are allowed to establish “nominal” service-related cost sharing requirements. For example, for FY2009, the maximum permissible nominal amounts defined in regulations ranged from \$0.60 to \$3.40,<sup>20</sup> depending on the cost of the service provided. For working individuals with disabilities who qualify for Medicaid under

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<sup>19</sup> These parameters are described in more detail in CRS Report R41210, *Medicaid and the State Children’s Health Insurance Program (CHIP) Provisions in PPACA*, coordinated by Julie Stone.

<sup>20</sup> The effective date of the 2008 final rule for the DRA premium and cost-sharing provisions (73 *Federal Register* 71828; described in the next subsection) is July 1, 2010. This rule includes a medical inflation adjustment for nominal service-related cost-sharing maximums.

eligibility pathways established by the Balanced Budget Act of 1997 (BBA97) and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), service-related cost sharing charges may be required that exceed nominal amounts as long as they are set on a sliding scale based on income.

Under traditional Medicaid, providers cannot deny care or services based on an individual's ability to pay Medicaid cost-sharing amounts. In the past, some states allowed providers to refuse to provide services to Medicaid beneficiaries who failed to make copayments, but most states did not have specific policies on this issue.<sup>21</sup>

## **Participation-Related Cost Sharing Under Traditional Medicaid**

Premiums and enrollment fees are generally prohibited under traditional Medicaid. Examples of permitted exceptions include:

- For certain families losing eligibility due to increased earnings from work, states may charge premiums but only for the final six months of transitional Medicaid coverage.
- For pregnant women and infants with family income that exceeds 150% FPL, states are allowed to implement nominal premiums or enrollment fees between \$1 and \$19 per month, depending on family income.
- For individuals who qualify for Medicaid through the medically needy pathway, states may implement a monthly fee as an alternative to meeting the financial eligibility thresholds by deducting medical expenses from income (i.e., the “spend down” method).
- For individuals who qualify under pathways for working individuals with disabilities, states may charge premiums or enrollment fees. Fees for individuals with a disability who qualify under the provisions of BBA97 and whose family income does not exceed 250% FPL are charged on a sliding scale based on income (determined by the state). Premiums charged to those who qualify under TWWIIA, whose income is between 250% and 450% FPL, cannot exceed 7.5% of income. (When a state covers both groups, the same cost-sharing rules must apply.)

## **Beneficiary Cost Sharing Under DRA**

DRA (as modified by P.L. 109-432) provided states with an alternative for Medicaid premiums and service-related cost sharing. Under this option, states may impose premiums and cost sharing through Medicaid state plan amendments rather than through waiver authority, subject to specific restrictions.

In general, for individuals with income under 100% FPL:

- no premiums may be imposed,

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<sup>21</sup> U.S. Department of Health and Human Services, Office of Inspector General, *Medicaid Cost Sharing*, OEI-03-91-01800 (July 1993), available at <http://oig.hhs.gov/oei/reports/oei-03-91-01800.pdf>.

- service-related cost sharing cannot exceed nominal amounts, and
- the total aggregate amount of all cost sharing cannot exceed 5% of monthly or quarterly family income.

For individuals in families with income between 100 and 150% FPL:

- no premiums may be imposed,
- service-related cost sharing cannot exceed 10% of the cost of the item or service rendered, and
- the total aggregate amount of all cost-sharing cannot exceed 5% of monthly or quarterly family income.

For individuals in families with income above 150% FPL:

- service-related cost sharing cannot exceed 20% of the cost of the item or service rendered, and
- the total aggregate amount of all cost-sharing (including any applicable premiums) cannot exceed 5% of monthly or quarterly family income.

There are exemptions to DRA cost sharing for certain subgroups and services, which generally mirror those applicable under traditional Medicaid. For example, certain groups (e.g., some children, pregnant women, certain individuals with special needs) are exempt from paying premiums regardless of their income. Also, certain groups and services (e.g., preventive care for children, emergency care, family planning services) are exempt from the service-related cost sharing.

Under the DRA option, special rules apply to cost sharing for non-preferred prescription drugs and for emergency room copayments for non-emergency care, and as with traditional Medicaid, such cost sharing will also be adjusted for medical inflation over time. DRA also allowed states to condition continuing Medicaid eligibility on the payment of premiums. Providers may also deny care for failure to pay service-related cost sharing.

## **How Are Providers Paid Under Medicaid?**

For the most part, states establish their own payment rates for Medicaid providers. Federal statute requires that these rates be sufficient to enlist enough providers so that covered benefits will be available to Medicaid beneficiaries at least to the same extent they are available to the general population in the same geographic area. For CY2013 and CY2014 only, PPACA requires that Medicaid payment rates for certain primary care services be raised to what Medicare pays for these services. Also, for those two years only, the federal government will pick up the entire cost of that increase in payments (i.e., the difference between Medicare payment rates and the existing Medicaid payment rates as of July 1, 2009).

Medicaid regulations place restrictions on how Medicaid cost-sharing may be used in determining provider reimbursement. States are prohibited from increasing the payments they make to providers to offset uncollected amounts for deductibles, co-insurance, co-payments or similar

charges that the provider has waived or that are uncollectable (with the exception of providers reimbursed by the state under Medicare reasonable cost reimbursement principles<sup>22</sup>). In addition, if a state contracts with certain managed care organizations that do not impose the state's Medicaid cost-sharing requirements on their Medicaid members, the state must calculate payments to such organizations as if those cost-sharing amounts were collected.

## How Do Medicaid Research and Demonstration Waivers Work?

Section 1115 of the Social Security Act provides the Secretary of HHS with broad authority to conduct research and demonstration projects that further the goals of the Medicaid program (as well as other programs, such as CHIP). Some policymakers at both the federal and state level view Section 1115 authority as a means to restructure Medicaid coverage, control costs, and increase state flexibility in a variety of ways. To obtain such a waiver, a state must submit proposals outlining the terms and conditions of its waiver for approval by the federal agency that oversees and administers the Medicaid program, the Centers for Medicare and Medicaid Services (CMS).

Under this authority, the Secretary may waive any Medicaid requirements contained in Section 1902 of the federal Medicaid statute, including but not limited to, freedom of choice of provider, and comparability and statewideness of benefits (as described above in the benefits section). For example, states may obtain waivers that allow them to provide services to individuals who would not otherwise meet Medicaid eligibility rules, cover non-Medicaid services, limit benefit packages for certain groups, adapt programs to the special needs of particular geographic areas or groups of recipients, or accomplish a policy goal such as to temporarily extend Medicaid in the aftermath of a disaster (as was done in New York City after the September 11 terrorist attacks and in Gulf Coast states after Hurricane Katrina).

Approved waivers are deemed to be part of a state's Medicaid plan, and thus, the federal share of the costs for such waivers is determined by the FMAP formula (described earlier). Unlike traditional Medicaid, waiver guidance<sup>23</sup> specifies that the costs of 1115 waivers must be *budget neutral* over the life of the program. To meet this requirement, estimated spending under the waiver cannot exceed the estimated cost of the state's existing Medicaid program under current law requirements (either on a per capita or aggregate basis). For example, states may move certain existing Medicaid populations into managed care arrangements and use the savings accrued from that action to finance coverage of otherwise ineligible individuals under an approved waiver.

There are specific limits and restrictions on how a state may operate a waiver program. For example, such waivers must not limit mandatory services for the mandatory pregnant women and children eligibility groups. Another provision specifies restrictions on cost-sharing that may be

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<sup>22</sup> For providers reimbursed under such principles, the state may increase its payment to offset uncollected Medicaid cost-sharing amounts that are bad debts for such providers. See 42 CFR 447.57 and 42 CFR 447.58.

<sup>23</sup> Medicaid Program; Demonstration Proposals Pursuant to Section 1115(a) of the Social Security Act; Policies and Procedures, 59 *Federal Register* 49249 (September 27, 1994).

imposed under waivers. PPACA included transparency requirements to facilitate public notice and input for such waivers.

## Some Medicaid Statistics

In FY2010, a total of 68.2 million people were estimated to be enrolled in Medicaid at some time during the year (excluding the territories). Nearly one-half of these beneficiaries (33.9 million) were children, and 18.2 million were adults in families with dependent children. There were also 10.3 million individuals with disabilities and 5.8 million people over the age of 65 enrolled in Medicaid that year.<sup>24</sup> The latest published estimate of total Medicaid spending available from CMS, including the costs of benefits and program administration for the federal and state governments combined, was \$381.3 billion for FY2009.<sup>25</sup>

Across the nation, traditional Medicaid covers a very diverse population and, compared to both Medicare and employer-sponsored health care plans, offers the broadest array of medical care and related services available in the United States today. Different groups under Medicaid have very different service utilization patterns. These patterns result in large differences in the proportion of total benefit expenditures by group.<sup>26</sup> For example, for FY2007:

- While the majority of enrollees were children without disabilities (nearly half), such children accounted for only about 18% of Medicaid's total expenditures on benefits. Most of the expenditures for such children are typically for primary and acute care in the fee-for-service setting, as well as for managed care premiums.
- The next-largest beneficiary group—adults without disabilities in families with dependent children—accounted for about 27% of all enrollees, but only about 13% of benefit expenditures. Like children, primary and acute fee-for-service care and managed care premiums account for the majority of these costs.
- In contrast, individuals with disabilities represented about 15% of Medicaid enrollees, but this group accounted for the largest share of Medicaid expenditures for benefits (about 40%) of all groups. Most of the costs for persons with disabilities are typically for institutional and non-institutional long-term care services, primary and acute fee-for-service care, and outpatient prescription drugs.
- Finally, the elderly represented about 9% of Medicaid enrollees, but about 23% of all expenditures for benefits. For the aged, the majority of costs are usually for long-term care and outpatient prescription drugs.

While these statistics vary somewhat from year to year and state to state, the patterns described above generally hold true.

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<sup>24</sup> Beneficiary statistics for FY2010 were taken from Table 1.16, *2010 CMS Statistics*, U.S. Department of Health and Human Services.

<sup>25</sup> Total Medicaid spending for FY2009 was taken from Table III.2, *2009 CMS Statistics*, U.S. Department of Health and Human Services.

<sup>26</sup> Medicaid payments by eligibility group for FY2007 were taken from Table III.10, *2010 CMS Statistics*, U.S. Department of Health and Human Services.



Since 2006, Medicaid beneficiaries who are also eligible for Medicare (i.e., the elderly and certain individuals with disabilities) receive their outpatient prescription drugs through the Medicare prescription drug benefit (known as Medicare Part D) instead of through Medicaid. As a result, Medicaid's drug costs for these populations have been considerably reduced.

## **Medicaid Resources**

For more information on Medicaid, there are several CRS reports listed below that may be of interest. This list will be updated as additional existing and new reports incorporate Medicaid changes made under health reform (PPACA).

CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA*

CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*

CRS Report R40144, *State Medicaid and CHIP Coverage of Noncitizens*

CRS Report RS22629, *Medicaid Citizenship Documentation*

CRS Report R40226, *P.L. 111-3: The Children's Health Insurance Program Reauthorization Act of 2009*

CRS Report R40223, *American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5): Title V, Medicaid Provisions*

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