Medicaid

Title XIX of the Social Security Act (part of the Social Security Amendments of 1965) established the Medicaid program to provide medical and health related services for individuals and families with low incomes through direct payment to suppliers of the program. Medicaid is the largest source of funds for medical care and related services to our Nation's poorest people.

Participation is optional; but all States and the District of Columbia have Medicaid programs. Puerto Rico, Guam, the Northern Mariana Islands, American Samoa, and the Virgin Islands also have some participation in Medicaid. (These other jurisdictions are included when the word "States" is used.)

Medicaid is a cooperative endeavor between each State and the Federal Government, and is financed by shared Federal and State funds. Each Medicaid policy and program plan is also a joint endeavor. Within broad national guidelines established by Federal statutes, regulations, and policies each of the States (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility and services are therefore complex, and vary considerably from State to State and within each State over time.

In 1995, more than 36 million persons received Medicaid services. Total outlays amounted to $159.5 billion ($85.5 billion in Federal and $66.3 billion in State funds). Of the total amount, $120 billion was for vendor payments; $14 billion for premium

payments (for example, to HMOs and Medicare); and $19 billion was for payments to disproportionate share hospitals.

Eligibility and Coverage

Once eligibility for Medicaid is determined, coverage generally is retroactive to the third month prior to application. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any eligibility group.

Low income is only one test for Medicaid eligibility; assets and resources also are tested against established thresholds determined by each State. For instance, Medicaid rules for the treatment of income and resources of married couples when one spouse requires nursing home care and the other remains living at home are intended to prevent the impoverishment of the spouse remaining in the community. Before the institutionalized person's money is used to pay for the cost of institutional care, a minimum monthly maintenance needs allowance is deducted for bringing the income of the spouse living in the community up to a moderate level; and a State-determined level of resources is preserved.

Within Federal guidelines, States have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for eligibility. States must cover "categorically needy" individuals (which usually includes recipients of SSI and families with dependent children receiving cash assistance, as well as other mandatory low-income groups such as pregnant women, infants, and children with incomes less than specified percent of the Federal poverty level) and certain low-income Medicare beneficiaries.

Mandatory Eligibility Groups

States are required to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. The following (effective July 1997) displays the mandatory Medicaid eligibility groups:

- Recipients of AFDC.
- Recipients of TANF. (In those States with TANF programs, those individuals who would have met the State's AFDC program's eligibility requirements under rules in effect on July 16, 1996 generally are eligible.)
- Children under age 6 who meet the State's AFDC financial requirements or whose family income is at or below 133% of the Federal poverty level.
- Pregnant women whose family income is below 133% of the Federal poverty level (services are limited to pregnancy, complications of pregnancy, delivery, and 3 months of post-partum care).
- Certain Medicare beneficiaries.

- SSI recipients (or aged, blind, or disabled individuals in States that apply more restrictive eligibility requirements).
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.
- Special protected groups (typically individuals who lose their cash assistance from AFDC or SSI due to earnings from work or increased Social Security benefits, but who may keep Medicaid for a period of time).
- All children born after September 30, 1983, in families with incomes at or below the Federal poverty level who are under age 19. (This phases in coverage, so that by the year 2002, all poor children under age 19 will be covered).

Medicare Beneficiaries.—Medicaid provides help for certain Medicare beneficiaries. This assistance allows low-income beneficiaries to maintain full Medicare coverage.

There are three groups who receive at least some help from the Medicaid program: (1) QMBs (Qualified Medicare Beneficiaries)—persons who have incomes at or below 100% of the Federal poverty level and resources at or below 200% of the SSI limit. (The QMB group includes those who are fully eligible for Medicaid also.) For QMBs, the State pays the Medicare cost sharing expenses subject to the limits that States may impose on payments rates. (2) SLIMBs (Specified Low-Income Medicare Beneficiaries)—persons who meet all QMB requirements except that their incomes are slightly higher. For those persons, the State plan pays only the Medicare Part B premium. (3) QDWIs (Qualified Disabled and Working Individuals)—persons who were formerly qualified as disabled Medicare beneficiaries but whose incomes exceed the maximum for that program because they returned to work (despite their disability) and thus they are no longer eligible for monthly Social Security benefits. Medicaid must pay the Medicare Part A premium for QDWIs whose income does not exceed 200% of the Federal poverty level.

Optional Eligibility Groups

States also have the option of providing Medicaid coverage for certain other "categorically related" groups of persons receiving Federal matching monies. These optional groups share the characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. These "permissible" groups, for whom Federal matching monies are allowed, include:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is no more than 185% of the Federal poverty level guidelines. (The exact percentage is set by each State.)
- Children under age 21 who meet the AFDC income and resources requirements.

- Recipients of State supplementary payments.
- Individuals who would be eligible if institutionalized, but who are receiving care under home and community based services waivers.
- Institutionalized individuals eligible under a special income level (the amount is set by each State—up to 300% of the SSI Federal benefits rate).
- Tuberculosis (TB) infected persons who would be financially eligible for Medicaid at the SSI level. (Eligibility is only for TB-related ambulatory services and drugs.)
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the Federal poverty level.
- "Medically needy" persons.

Medically Needy.— These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by the State. Medically needy income levels are higher than the regular Medicaid eligibility levels; thus, persons may qualify immediately, or may "spend down" by incurring medical and/or remedial care expenses that cause them to be at or below their State's level for this medically needy program.

The medically needy program does not have to be as extensive as the program for the categorically eligible groups, and may be quite restrictive in rules as to who is covered and/or as to what services are offered. Federal matching monies are available. However, if a State elects to have any medically needy program, there are Federal requirements that certain groups and certain services must be included. Children under age 19 and pregnant women must be covered; and prenatal and delivery care for pregnant women, and ambulatory care for children must be provided. A State may elect to provide eligibility to certain additional groups, and may elect to provide certain additional services. In 1995, 43 States elected to have a medically needy program, and provided at least some services for at least some medically needy recipients. The remaining States utilized the "special income level" option (above) to assist other low-income persons who are aged and institutionalized.

Recent Changes to Eligibility Requirements

Welfare reform legislation enacted in 1996 (The Personal Responsibility and Work Opportunity Reconciliation Act) will change Medicaid eligibility requirements as States implement the new legislation. Many noncitizens (who might otherwise qualify for Medicaid) entering the country on or after August 22, 1996, are not eligible. However, the States have the option to continue coverage

for most noncitizens who were already receiving Medicaid and to receive Federal matching funds.

The new legislation also eliminates the AFDC cash assistance program and replaces it with a block grant program called Temporary Assistance for Needy Families (TANF). However, families who met the AFDC eligibility criteria prior to welfare reform will usually continue to be eligible for Medicaid.

In most States, individuals who are eligible for SSI are also eligible for Medicaid. The law will result in some children losing SSI. Many of the children affected will still continue to be covered under Medicaid because they meet other Medicaid eligibility criteria.

Services

In order to receive Federal matching funds, the State programs must offer certain *basic* services. Within broad Federal guidelines, the States determine the amount and duration of services offered under their programs. They may limit, for example, the days of hospital care or the number of physician visits covered. However, some restrictions apply: Limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits. Limits on required (nonoptional) services may not discriminate among beneficiaries based on medical diagnosis or conditions.

With certain exceptions, the States must allow Medicaid recipients freedom of choice among participating providers of health care services. States may pay for the services through

Basic Medicaid Services

- Inpatient hospital services
- Outpatient hospital services
- Prenatal care
- Vaccines for children
- Physician services
- Nursing facility services for individuals aged 21 or older
- Home health care for persons eligible for skilled nursing services
- Family planning services and supplies
- Rural health clinic services
- Laboratory and X-ray services
- Pediatric and family nurse-practitioner services
- Federally qualified health center (FQHC) services and ambulatory and services of an FQHC that would be available in other settings.
- Nurse-midwife services
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for children under age 21

various prepayment arrangements, such as an HMO. In general, States are required to provide comparable services to all categorically needy eligible persons.

The States may also receive Federal funding for providing other approved optional services. There are currently 34 optional services which may be provided with Federal support. The most common of these are diagnostic services, prescription drugs and prosthetic devices, clinic services, nursing facility services for the aged and disabled, intermediate care facilities for the mentally retarded, optometrist services and eyeglasses, rehabilitation and physical therapy services, and transportation services.

Additionally, States may also pay for home and community based care to certain persons with chronic impairments. Another option allows eight States (as a demonstration project) to pay for community supported living arrangement services for persons with mental retardation or a related condition.

Payment for Services

Medicaid operates as a vendor payment program, with payments made directly to providers who must accept the Medicaid reimbursement level as payment in full. Each State has broad discretion in determining (within federally imposed upper limits and specific restrictions) the reimbursement methodology and resulting rate for services, with two exceptions: For institutional services, payment may not exceed amounts that would be paid under Medicare payment rates; and for hospice care services, rates cannot be lower than Medicare rates.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid recipients. However, certain recipients are excluded: pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to institutional care, and categorically needy HMO enrollees. Emergency services and family planning services are exempt from copayments for all recipients.

The amount of total Federal outlays for Medicaid has no set limit (cap); rather, the Federal Government must match (at a predetermined percentage) the mandatory services plus the optional services the State decides to provide, and matches (at the appropriate administrative rate) necessary and proper administrative costs.

In 1995, total Medicaid payments averaged $3,311 per recipient. However, many Medicaid recipients require relatively small expenditures per person per year. For example, data indicate that Medicaid vendor payments for over 17 million children under age 21 averaged $1,047 per child. Other groups have very large expenditures per person. Over 151,000 recipients requiring ICF/MR care had average vendor payments of more than $68,600 per person (plus the cost of other services and acute care provided outside of

the ICF/MR facility). Medicaid pays the medical costs of approximately 50% of persons with AIDS. A relatively small number of patients requiring very specialized and intensive medical care (for example, very premature babies and severely burned victims) can have expenses amounting to $4,000 per person per day. A few persons with continuing, extensive medical care needs (for example, high spinal cord or massive brain injuries) can require $100,000 of Medicaid vendor payments per person per year after year for decades.

Medicaid's compound rate of growth is projected to be 7.5% per year. If current expenditure trends continue, total payments (Federal and State) could increase to $230 billion by the year 2000.

Number of Medicaid recipients and total and average vendor payment amounts, by eligibility category and type of service, fiscal year 1995

Category and service	Number of recipients (in thousands)	Total payments (in millions)	Average payment
Category			
All recipients	36,282	$120,141	$3,311
Dependent children under age 21	17,164	17,976	1,047
Adults in families with dependent children	7,604	13,511	1,777
Persons aged 65 or olde	4,119	36,527	8,868
Blind persons	92	848	9,256
Disabled persons	5,767	48,570	8,422
Other (unknown included)*	1,537	2,708	1,762
Service			
General hospital	5,581	26,331	4,735
Mental hospital	84	2,511	29,847
Nursing facility	1,667	29,052	17,424
CF/MR	15,326	10,383	68,613
Prescribed drugs	23,723	9,791	413
Physician	23,789	7,360	309
Outpatient hospital	16,712	6,627	397
Home health	1,639	9,406	5,740
Other care	11,416	9,214	807
Clinical services	5,322	4,280	804
Laboratory and X-rays	13,064	1,180	90
Dental	6,383	1,019	160
Other practitioner	5,528	986	178
Family planning	2,501	514	206
Rural health clinic	1,242	216	174
EPSDT	6,612	1,169	177
Unknown	6	101	17,549

*Unknown numbers are high because Section 1115 (health care reform demonstrations) waiver data for Oregon and Tennessee were placed in the Unknown category.

Financing and Administration

The portion of the Medicaid program that is paid by the Federal Government, known as the Federal Medical Assistance Percentage (FMAP), is determined annually for each State by a formula that compares the State's average per capita income level with the national average. By law, the FMAP cannot be lower than 50% nor greater than 83%. In 1997, the FMAPs vary from 50% (13 States and the District of Columbia) to 77.2% (Mississippi), with the average Federal share among all States being 57.0%. The Federal Government also reimburses States for 100% of the cost of services povided through facilities of the Indian Health Services.

The Federal Government also shares in the State's expenditures for administration of the Medicaid program. Most administrative costs are matched at 50% for all States. Depending on the complexities and need for incentives for a particular service, higher matching rates are authorized for certain functions and activities.

Medicaid, FY '95
[in billions]

Total outlays	**159,479**
Federal share	89,029
State share	70,450
Medical assistance payments	**151,817**
Federal share	85,486
State share	66,331
Administrative payments	**7,662**
Federal share	3,543
State share	4,119

The Health Care Financing Administration (HCFA) within the Department of Health and Human services is the Federal agency that purchases health care services for the Medicaid program. HCFA administers the program from its headquarters in Baltimore, Maryland, and through 10 regional offices nationwide.