

CRS Report for Congress

Medicaid: A Primer

Updated January 17, 2008

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Prepared for Members and
Committees of Congress

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Summary

In existence for 43 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 61 million people at an estimated cost to the federal and state governments of roughly \$317 billion. Of all federally supported programs, only Medicare comes close to this level of spending, and only Social Security costs more.

Each state designs and administers its own version of Medicaid under broad federal rules. State variability in eligibility, covered services, and how those services are reimbursed and delivered is the rule rather than the exception.

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, how providers are paid, and the role of special waivers in expanding eligibility and modifying benefits. The Deficit Reduction Act of 2005 or DRA (P.L. 109-171), as amended by the Tax Relief and Health Care Act of 2006 (P.L. 109-432), included many provisions affecting Medicaid. DRA allows states to make fundamental changes in Medicaid program design, including covered benefits and beneficiary cost-sharing. In 2007, the Bush Administration issued several regulations and program guidances affecting Medicaid. Most recently, the Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173) delayed implementation of two such regulations affecting school-based and rehabilitation services. Additional laws placed restrictions on other Administration actions as well. These and other major regulatory and legislative activity are summarized here. Lastly, basic program statistics and citations to in-depth CRS reports on specific topics are provided. This report will be updated.

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Medicaid: A Primer

Medicaid 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.

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 State Children’s Health Insurance Program (SCHIP) — are also entitlements,¹ 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 exclusively by the federal government, both Medicaid and SCHIP 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, SCHIP is a capped federal grant to states.

Even though Medicaid is an entitlement program in federal budget terms, states may choose to participate, and all 50 states do so. If they choose to participate, states must follow federal rules in order to receive federal reimbursement to offset a portion of their Medicaid costs.

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. To qualify for Medicaid coverage, applicants’ income (e.g., wages, Social Security benefits) and often their resources or assets (e.g., value of a car, savings accounts) must meet program *financial requirements*. These requirements vary considerably among states, and different rules apply to different population groups within a state. Medicaid eligibility is also subject to *categorical restrictions* — generally, it is available only to the elderly, persons with disabilities (as generally defined under the federal Supplemental Security Income Program, or SSI²), members of families with

¹ The term “entitlement” has two meanings in this context. Individuals who meet state eligibility 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 SCHIP grants. All states have qualified for SCHIP. There is no individual entitlement under SCHIP.

² SSI provides cash assistance to the elderly and adults with certain disabilities that
(continued...)

dependent children, and certain other pregnant women and children. In recent years, Medicaid has been extended to additional groups with specific characteristics, including certain women with breast or cervical cancer and uninsured individuals with tuberculosis.

In general, while Medicaid is targeted at individuals with low income, not all of the poor are eligible, and not all those covered are poor. For example, adults without a qualifying disability and no dependent children are *not* eligible for Medicaid, no matter how poor they are (unless a state has a special waiver; see the subsection on waivers below). And, the income standards applicable to some Medicaid eligibility groups exceed the poverty level, as described below. Moreover, from state to state, applicants with substantial differences in gross income may qualify for Medicaid under the same eligibility group, depending on the income methodology used (i.e., what types of income are counted, and how much, if any, income of a given type is disregarded or ignored).

Some eligibility groups are mandatory, meaning that all states 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 Aid to Families with Dependent Children (AFDC) cash assistance program,³
- families transitioning from welfare to work who receive up to 12 months of Medicaid coverage (reinstated and extended under DRA and P.L. 109-432),
- pregnant women and children under age six with family income below 133% of the federal poverty level (FPL),⁴
- children ages six through 18 with family income below 100% FPL,
- poor individuals with disabilities or poor individuals over age 64 who qualify for cash assistance under the SSI program,⁵ and
- 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

² (...continued)

significantly restrict their ability to be gainfully employed. In the case of children, disabilities must result in marked and severe functional limitations.

³ AFDC income standards are well below the federal poverty level, but states can modify (liberalize or further restrict) these criteria. Under the 1996 welfare reform law, AFDC was replaced with the Temporary Assistance for Needy Families (TANF) program. 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.

⁴ For example, in 2007, the FPL for a family of four was \$20,650 — 133% of FPL for such a family would equal \$27,464.

⁵ Some states use income, resource and disability standards that differ from current SSI standards.

quarters of creditable coverage under Social Security; immigrants who are honorably discharged U.S. military veterans).

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

- 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 (added under DRA),
- 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,
- “medically needy” individuals who meet categorical requirements (e.g., are over 64 or under 19, have a disability, are pregnant, or are members of families with dependent children) with income up to 133 $\frac{1}{3}$ % of the maximum payment amount applicable under states’ former AFDC programs based on family size.⁶ Unlike most other eligibility groups, medical expenses (if any) may be subtracted from income in determining financial eligibility for medically needy coverage, which is often referred to as “spend down,” and
- legal immigrants after their first five years in this country.

DRA made significant changes to asset transfer rules that potentially affect eligibility for Medicaid’s long-term care services (both institutional care and services provided in homes or the community, described below). In general, states must delay the start date for Medicaid enrollment for individuals who transfer assets for less than the fair market value on or after a “look-back date” of five years prior to application (rather than the three years typically applicable under prior law). Under DRA, the penalty period begins *on the later of*: (1) the first month following the date of the improper transfer (as under prior law), or (2) the date the person is Medicaid-eligible and would qualify for an institutional level of care. In sum, these DRA changes could lengthen the period of ineligibility for some individuals.

What Benefits Does Medicaid Cover?

Like eligibility, federal rules require states 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:

⁶ This limit can be raised or lowered based on specific provisions in the 1996 welfare reform legislation.

- 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 categorically needy groups⁷ must be equal in amount, duration, and scope. Likewise, services available to medically needy groups⁸ 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, also 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:

- inpatient hospital services (excluding services for mental disease),
- services provided by federally qualified health centers,
- laboratory and x-ray services,
- physician services,
- pregnancy-related services,
- 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 that are offered by many states:

- prescribed drugs (covered by all states),
- routine dental care,
- physician-directed clinic services,
- other licensed practitioners (e.g., optometrists, podiatrists, psychologists),
- inpatient psychiatric care for the elderly and for individuals under age 21,

⁷ 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.

⁸ Medically needy groups include individuals meeting the same categorical restrictions, but different (typically somewhat higher) financial standards apply.

- nursing facility services for individuals under age 21,
- physical therapy,
- prosthetic devices, and
- transportation.

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). 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 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.
- While all women who qualify for Medicaid are eligible for pregnancy-related services, women who qualify under one of the *pregnancy-related eligibility groups* are eligible for *only* pregnancy-related services (including treatment of conditions that may complicate pregnancy) through a period of 60 days postpartum.
- 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 and delivery services for pregnant women, (2) ambulatory services for individuals under 18 and those entitled to institutional services, and (3) home health services for individuals entitled to nursing facility care.⁹
- 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.”

Another example of special long-term care benefits for targeted populations is *home and community based services*. Under Section 1915(c) of the federal Medicaid statute, the Secretary of Health and Human Services (HHS) may waive certain Medicaid requirements allowing states to cover a broad range of home and

⁹ 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.

community-based services (HCBS) for persons who would otherwise be eligible for Medicaid-funded institutional care. Waiver participants must be members of targeted groups (as designated by the state), including the aged, persons with physical disabilities, persons with mental retardation or developmental disabilities (MR/DD), and persons with mental illness. Benefits may include, for example, personal care (e.g., assistance with eating/drinking, toileting, medication management); habilitation services (e.g., assistance with socialization and adaptive skills) for individuals with MR/DD; transportation; case management; psychosocial rehabilitation and clinic services for persons with chronic mental illness. A cost-effectiveness test requires that expenditures for HCBS not exceed the cost of institutional care that would have otherwise been provided to waiver participants. Thus, states may cap enrollment and/or set expenditure limits on a per capita or aggregate basis to meet this requirement.

DRA allows states to establish HCBS under a new optional benefit category; thus, under specific circumstances, certain services no longer require a Section 1915(c) waiver. States have long complained that waiver requirements and processes are burdensome. To add this new HCBS benefit, states will instead submit a Medicaid state plan amendment to the federal government for approval. This new benefit is available to certain individuals with income below 150% FPL who are not required to need an institutional level of care to qualify. Unlike other state plan benefits, states offering this new HCBS benefit will be allowed to cap the number of enrollees and establish waiting lists as they did under Section 1915(c) waivers.

Finally, as an alternative to providing all of the mandatory and selected optional benefits under traditional Medicaid, DRA gives states the option to enroll state-specified groups in new benchmark and benchmark-equivalent benefit plans. These plans are nearly identical to the benefit packages offered through the State Children's Health Insurance Program (SCHIP). The benchmark options include

- the Blue Cross/Blue Shield preferred 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 includes (1) inpatient and outpatient hospital services, (2) physician services, (3) lab and X-ray services, (4) well-child care, including immunizations, and (5) 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 (1) prescribed drugs, (2) mental health services, (3) vision care, and (4) hearing services.

For any child under age 19 in one of the major mandatory and optional Medicaid eligibility groups, wrap-around benefits must include EPSDT. States may choose to provide other wrap-around and additional benefits. Wrap-around typically refers to situations in which the state provides a specific service (e.g., rehabilitation services, nursing home care) to beneficiaries enrolled in a plan that does not cover that service.

For a given group of beneficiaries, ensuring coordination of care between two (or more) entities responsible for managing different benefits (e.g., the state Medicaid agency and a managed care plan) is always an issue, and one that is not unique to these DRA provisions.

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 rates, the breadth of benefits offered, the generosity of provider reimbursement rates, and other supplemental payments.¹⁰

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).¹¹ The federal share, called the federal medical assistance percentage (FMAP), is at least 50% of state Medicaid benefit costs, and can be as high as 83% (statutory maximum). For FY2008, the federal share for benefit costs ranges from 50% (in 13 states) up to just over 76% (in one state).

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. The implementation and operation of immigration status verification systems by each state is fully financed by the federal government. Overall, administrative costs represent about 5% of total Medicaid spending in a given year.

For Hurricane Katrina fiscal relief, DRA appropriated \$2 billion to cover the state share of Medicaid expenditures for certain states that provided care to affected individuals or evacuees under approved multi-state Section 1115 waiver projects and

¹⁰ Key supplemental payments are described in CRS Report 97-483, *Medicaid Disproportionate Share Payments*, and in CRS Report RL31021, *Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action*. P.L. 109-432 made some technical changes to certain supplemental payments (e.g., disproportionate share hospital or DSH payments). More recently, P.L. 110-173 extended DSH payments for Tennessee and Hawaii.

¹¹ For one benefit, 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.

under existing Medicaid (and SCHIP) state plans, for certain administrative expenses, and to restore access to health care in impacted communities (as approved by the Secretary of HHS).

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 which may complicate pregnancy. In addition, such cost-sharing cannot be charged for:

- 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 furnished to individuals receiving hospice care;
- 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. Nominal amounts are defined in regulations and are generally between \$0.50 and \$3, depending on the cost of the service provided. For working individuals with disabilities who qualify for Medicaid under 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. The DRA (as amended by P.L. 109-432) made some changes to these traditional service-related cost-sharing rules; see below for more details.

Participation-Related Cost-Sharing Under Traditional Medicaid

Premiums and enrollment fees are prohibited under traditional Medicaid, except for the following groups:

- For certain families transitioning from welfare to work, states may charge premiums but only for the final six months of receiving transitional Medicaid coverage.
- For pregnant women and infants with family income that exceeds 150% of the 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. Those fees are not capped when charged to individuals with a disability qualifying under the provisions of BBA97 whose family income does not exceed 250% FPL. 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

As an alternative to traditional Medicaid, DRA (as modified by P.L. 109-432) provides states with a new option for premiums and service-related cost-sharing. Under this option, states may impose premiums and cost-sharing for any group of individuals for any type of service, 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,
- 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 cannot exceed 5% of monthly or quarterly family income.

Certain groups (e.g., some children, pregnant women, individuals with special needs) are exempt from paying premiums under this new DRA option. Also, certain groups and services (e.g., preventive care for children, emergency care, family planning services) are exempt from the service-related cost-sharing provisions. Nominal cost-sharing amounts in regulations will be indexed (increased) by medical inflation over time. Special rules apply to cost-sharing for non-preferred prescription drugs, and for emergency room copayments for non-emergency care. DRA also allows states to condition continuing Medicaid eligibility on the payment of premiums. Providers may also deny care for failure to pay service-related cost-sharing.

Finally, DRA provides an opportunity to test an alternative to traditional Medicaid that covers certain benefits combined with a new beneficiary cost-sharing structure, similar to health savings accounts in the private sector. In general, the Secretary is required to establish a demonstration for health opportunity accounts (HOAs) for which participants would have an HOA to pay for state-specified services, and, after an annual deductible is met (set at 100%, but no more than 110% of the annual state contribution to the HOA), would also provide coverage for Medicaid items and services otherwise available in the state. HOA contributions could be made by the state or by other persons or entities, including charitable organizations as permitted under current law. Including federal shares, the state contributions generally may not exceed \$2,500 for each adult and \$1,000 for each child.

How are Providers Paid Under Medicaid?

For the most part, states establish their own payment rates for Medicaid providers. Federal regulations require 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.

Prior to DRA, providers could not deny care or services based on an individual's ability to pay Medicaid cost-sharing amounts. However, this requirement did not eliminate the liability of a Medicaid beneficiary for payment of such amounts. In practice, some states have allowed providers to refuse to provide services to Medicaid beneficiaries who have failed to make copayments in the past, but most states do not have specific policies on this issue.¹² As noted above, DRA permits providers to deny care for failure to pay service-related cost-sharing.

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 are

¹² 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>].

uncollectable (with the exception of providers reimbursed by the state under Medicare reasonable cost reimbursement principles¹³). 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 SCHIP). Some policy makers 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 (e.g., childless adults without a disability), 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 guidance¹⁴ 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. For example, states may move certain existing Medicaid populations into managed care

¹³ 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 Medicare Payment Advisory Commission, Report to the Congress: Selected Medicare Issues (June 2000), pp. 112-113, available at [http://www.medpac.gov/publications/congressional_reports/Jun00%20Entire%20report.pdf].

¹⁴ Medicaid Program; Demonstration Proposals Pursuant to Section 1115(a) of the Social Security Act; Policies and Procedures, 59 *Federal Register* 49249, September 27, 1994.

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 imposed under waivers.

Some Medicaid Statistics

In FY2007, a total of 60.9 million people were enrolled in Medicaid at some time during the year. Nearly one-half of these beneficiaries (29.2 million) were children, and 16.2 million were adults in families with dependent children. There were also 9.5 million individuals with disabilities and 6.0 million people over the age of 65 enrolled in Medicaid that year.¹⁵ 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 \$316.7 billion for FY2006.¹⁶

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. For example, for FY2005:

- While the majority of enrollees were children without disabilities (roughly 50%), such children accounted for only about 17% 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, and for managed care premiums.
- The next-largest beneficiary group — adults without disabilities in families with dependent children — accounted for about 26% of all enrollees, but only about 12% 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 43%) 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.

¹⁵ Beneficiary statistics for FY2007 were taken from Table 11, *2007 CMS Statistics*, U.S. Department of Health and Human Services [<http://cms.hhs.gov/CapMarketUpdates/Downloads/2007CMSstat.pdf>].

¹⁶ Total Medicaid spending for FY2006 was taken from Table 26, *2007 CMS Statistics*, U.S. Department of Health and Human Services.

- Finally, the elderly represented about 9% of Medicaid enrollees, but about 23% of all expenditures for benefits. For the aged, the vast 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.

Beginning in 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 new Medicare prescription drug benefit (known as Medicare Part D) instead of through Medicaid. While the long-term impact of the Part D program on Medicaid is unclear, Medicaid's drug costs for these populations have been considerably reduced. In fact, CY2006 was the first time in Medicaid's 43-year history that overall spending decreased, due in part to the new Medicare Part D benefit and also to slower overall enrollment growth compared to prior years.¹⁷

Where is Medicaid Headed?

Medicaid's role in providing access to health care for millions of Americans has been regularly scrutinized by Congress, resulting in important legislative changes. For example, in the 1980s, eligibility expansions for pregnant women and children were adopted. In the mid-1990s, welfare reform restricted access to Medicaid for new immigrants, and removed the automatic link between receipt of cash assistance and Medicaid for low-income families. In the 1990s, managed care was expanded significantly as was coverage for workers with disabilities. Largely because of concerns about questionable financing practices at the state level, on several occasions, Congress has restricted supplemental Medicaid payments made to hospitals serving a disproportionate share of Medicaid and uninsured patients (also called DSH payments). Similarly, in 2000, Congress also required new, more restrictive upper payment limit rules for institutional providers under Medicaid. Other significant changes, such as the recently enacted DRA, have also been made.

In February every year, the President submits a federal budget proposal to the Congress. In the President's FY2008 budget proposal, a number of changes to Medicaid were outlined. Some of proposed changes would require legislative action by Congress, while others would be implemented administratively (e.g., via regulatory changes, issuance of program guidance, etc.).¹⁸ The Administration has issued a number of rules and program guidances, some of which have been modified by Congress through subsequent legislation. For example, P.L. 109-432 prevents the President's provider tax proposal to limit the extent to which states may tax certain providers to obtain additional federal Medicaid funds from being implemented via

¹⁷ A. Catlin, C. Cowan, M. Hartman, and S. Heffler, "National Health Spending in 2006: A Year of Changes for Prescription Drugs," *Health Affairs*, Vol. 27, No. 1, pages 1 - 16, January/February 2008.

¹⁸ See CRS Report RL33866, *Medicaid, SCHIP, and Health Insurance: FY2008 Budget Issues*.

administrative action. This law also sets the provider tax ceiling to 6% of revenues, except for the period of January 1, 2008-September 30, 2011, during which the rate is fixed at 5.5% (compared to 3% in the President's proposal).

A final rule would also restrict the use of certain intergovernmental transfers and certified public expenditures to finance the non-federal share of Medicaid costs and would implement payment caps for government providers.¹⁹ In addition, a proposed rule would end federal payments associated with graduate medical education²⁰ costs under the Medicaid. P.L. 110-28 delayed implementation of these two rules for one year (until May 25, 2008). This law also requires the use of tamper-resistant pads for Medicaid prescriptions, and provides a Medicaid Pharmacy Plus waiver extension. Subsequently, P.L. 110-90 delayed implementation of the tamper-resistant pads provision for six months (until March 31, 2008). This law also temporarily extended transitional medical assistance for families who lose Medicaid eligibility due to increased earnings and the Medicaid Qualifying Individuals (QI-1) program that pays the Medicare Part B premiums for low-income Medicare beneficiaries through December 31, 2007, both of which were then further extended through June, 2008 under P.L. 110-173. The Administration also issued rules to clarify what constitutes federally-reimbursable rehabilitation services²¹ and to restrict federal payments for school-based administration and transportation services²² under Medicaid. P.L. 110-173 delayed implementation of these two rules until June 30, 2008.

At the start of the 2nd session of the 110th Congress, it is difficult to predict what, if any, changes to Medicaid may be in the offing. The upcoming budget resolution process may provide a blueprint for such action.

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¹⁹ Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership; *72 Federal Register* 29748, May 29, 2007.

²⁰ Medicaid Program; Graduate Medical Education, *72 Federal Register* 28930, May 23, 2007.

²¹ Medicaid Program; Coverage for Rehabilitative Services, *72 Federal Register* 45201, August 13, 2007.

²² Medicaid Program; Elimination of Reimbursement under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School, *72 Federal Register* 73635, December 28, 2007.

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CRS Report RS21837, *Implications of the Medicare Prescription Drug Benefit for Dual Eligibles and State Medicaid Programs*, by Karen Tritz.

CRS Report RL33919, *Long-Term Care: Consumers, Providers, Payers and Programs*, by Carol O'Shaughnessy, Julie Stone, Laura Shrestha, and Tom Gabe.

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CRS Report 97-975, *Health Insurance Coverage of Children, 2006*, by Chris L. Peterson and April Grady.

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CRS Report RL33251, *Side-by-Side Comparison of Medicare, Medicaid and SCHIP Provisions in the Deficit Reduction Act of 2005*, by Karen Tritz, et al.