

THE MEDICAID PROGRAM: A BRIEF OVERVIEW

Introduction to Medicaid

Established in 1965, Medicaid is the largest publicly financed program providing health and long-term care coverage for certain groups of low-income people throughout the United States. Authorized under Title XIX of the Social Security Act, Medicaid is a means-tested individual and state entitlement program jointly financed by states and the federal government.

Within broad federal guidelines, states have the flexibility to design and manage their Medicaid programs. For example, they can set limits on services and decide what and how to pay providers. Although state participation in Medicaid is voluntary, every state has chosen to participate as of 1982.¹

Persons Covered by Medicaid

Medicaid eligibility is limited to individuals who fall into specified categories. Although federal law identifies over 25 different eligibility categories, they can be grouped into five broad coverage categories: children; pregnant women; adults in families with dependent children; individuals with disabilities; and the elderly. In addition to categorical eligibility, persons must also meet income and asset requirements, as well as immigration and residency requirements.²

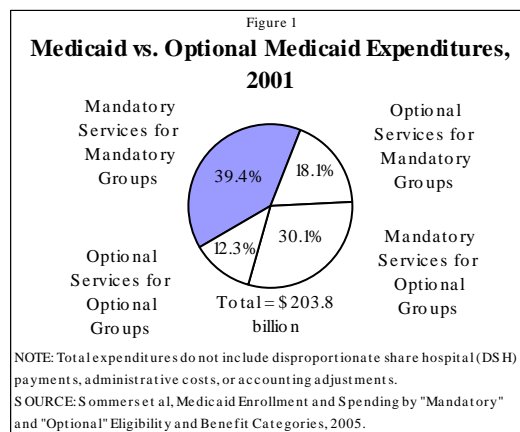
In 2003, Medicaid provided coverage to:

- 25 million children, representing more than one in four of all children

- 13 million adults, primarily low-income working parents
- 6 million persons age 65+
- 8 million persons with disabilities³

In 2004, over one-half of all Medicaid beneficiaries lived in working families.⁴ Within categories, certain groups must be covered, while others may be covered at state discretion. Mandatory coverage categories are those where an individual who belongs to the category and meets established financial and non-financial requirements *must* be covered. Optional coverage categories are those where states have the authority to extend coverage but are not required to do so. For example, states may, but are not required to, provide Medicaid coverage to persons who incur out-of-pocket medical expenses that, when subtracted from their income, put them below an income level that is established by the state.

As shown in Figure 1, 42 percent of all Medicaid spending in 2001 was for optional groups.⁵



Medicaid Coverage for Persons Enrolled in Medicare: The Dual Eligibles

In 2003, approximately 7.5 million people were enrolled in both Medicare and Medicaid.⁶ About 6.2 million of these dual enrollees received full Medicaid coverage (full dual eligibles); the remaining 1.3 million received Medicaid assistance but only to help pay their Medicare premium and/or cost-sharing obligations. In 2003, dual eligibles accounted for nearly 14 percent of all Medicaid enrollees⁷ but 40 percent of Medicaid spending for medical services.⁸ These enrollees are among the poorest, sickest, and highest users of health care services in the United States.⁹

Beginning in January 2006, dual eligibles will receive their prescription drug coverage through the new Medicare Part D drug benefit and will generally not be able to receive coverage for drugs under Medicaid.

Services Covered by Medicaid

In order to receive federal matching funds, state Medicaid programs are required to cover the following services for their mandatory populations:

- Inpatient¹⁰ and outpatient hospital services
- Physician, midwife, and nurse practitioner services
- Nursing home services for persons aged 21 and older
- Home health services for persons who qualify for nursing home care
- Pregnancy-related services
- Family planning services and supplies
- Laboratory and x-ray services

- Federally qualified health center and rural health clinic services
- Emergency services for non-citizens
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals under age 21¹¹

States may also receive federal funds to cover optional services for eligible individuals. Figure 1 shows that 30 percent of Medicaid spending in 2001 was for optional services. Some of these include:

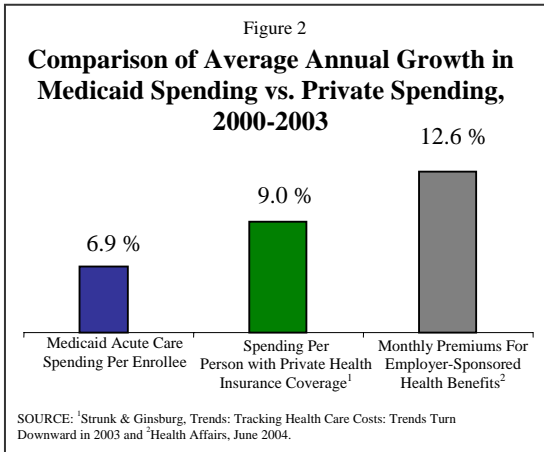
- Prescription drugs
- Eye glasses and eye exams
- Hearing aids
- Durable medical equipment
- Clinic services
- Nursing home services for persons under age 21
- Intermediate care facility services for persons with mental retardation
- Home and community-based services
- Dental, optometry, prosthetic, and tuberculosis services¹²

Trends in Medicaid Spending

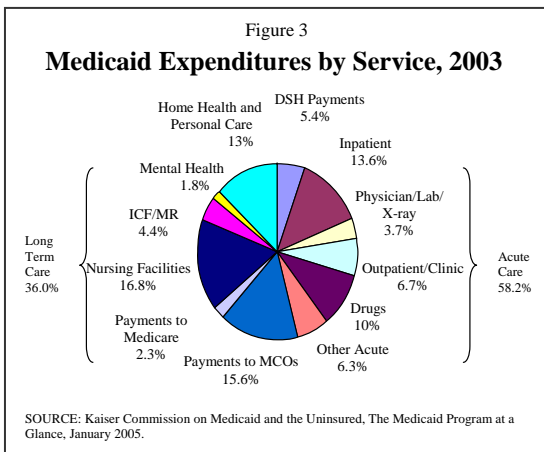
Medicaid spending (federal and state) increased by about one-third – from \$205.7 billion to \$275.5 billion – between fiscal years 2000 and 2003, largely driven by increases in enrollment of children and non-disabled adults. Job loss, economic decline, erosion in the availability and affordability of employer-sponsored coverage, and rising health care costs, especially prescription drugs – rather than recent eligibility expansions – are credited, in part, for the increased enrollment.¹³

Despite the increase in Medicaid spending between 2000 and 2003, the growth in per capita Medicaid acute care spending was less than the growth in per capita spending

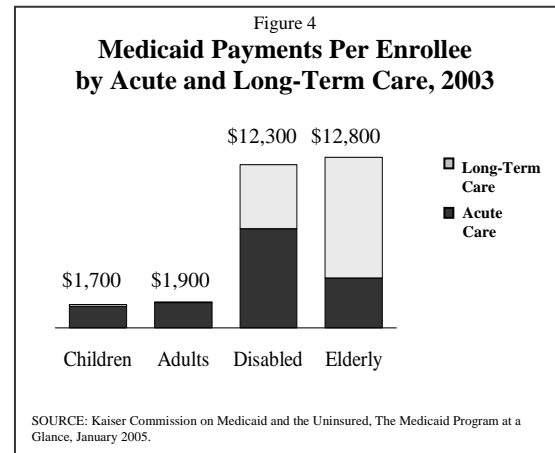
for those with private health insurance coverage, and almost one-half of the growth in spending on premiums for employer-sponsored health benefits (Figure 2).



Federal and state Medicaid spending for services and disproportionate share hospital (DSH) payments totaled \$266 billion in 2003 (this number does *not* include administrative costs and adjustments). As shown in Figure 3, acute-care services comprised over one-half (58 percent) of total service-related spending, and long-term care services made up 36 percent. In addition, payments for Medicare premiums accounted for about 2 percent, while disproportionate share hospital payments represented about 5 percent (Figure 3).



Although low-income children and parents comprise the majority (three-fourths) of Medicaid beneficiaries, the majority of Medicaid spending is attributable to long-term care services for the elderly and people with disabilities.¹⁴ Figure 4 provides more detail on both the level of Medicaid spending for the key populations covered as well as the mix of acute and long-term care services.



Medicaid Financing

States receive matching payments from the federal government to help pay for Medicaid coverage. The matching rate, called the Federal Medical Assistance Percentage (FMAP), currently ranges from 50 to 83 percent depending on a state's per capita income; wealthier states receive lower federal matches and poorer states receive higher matches.¹⁵ For example, if a state has a 70 percent matching rate, for every \$1.00 that it spends on a Medicaid covered service, it will receive \$2.33 from the federal government. Although it has remained substantially unchanged over the years, the FMAP formula is frequently criticized because it does not reflect state fiscal capacity, does not respond well to changing national and state-specific fiscal capacity, and does not consider the concentrations of poverty within states.¹⁶

¹Vic Miller and Andy Schneider. *The Medicaid Matching Formula: Policy Considerations and Options for Modification* (AARP, Washington, DC, September 2004).

² Kaiser Commission on Medicaid and the Uninsured. *The Medicaid Resource Book* (Kaiser Commission on Medicaid and the Uninsured, Washington, DC, July 2002).

³Kaiser Commission on Medicaid and the Uninsured. *The Medicaid Program at a Glance* (Kaiser Commission on Medicaid and the Uninsured, Washington, DC, January 2005).

⁴ Refers to noninstitutionalized population only. United States Bureau of the Census. Current Population Survey 2004 (U.S. Bureau of Labor Statistics, Washington, DC, 2004).

⁵ Anna Sommers, Arunabh Ghosh, and David Rousseau. *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories* (Kaiser Commission on Medicaid and the Uninsured, Washington, DC, June 2005).

⁶ John Holahan and Arunabh Ghosh. *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003* (Kaiser Commission on Medicaid and the Uninsured, Washington, DC, July 2005).

⁷ *Ibid.*

⁸ *Ibid.*

⁹ Medicare Payment Advisory Commission (MedPac). *Report to Congress: New Approaches in Medicare* (MedPac: Washington, DC, June 2004).

¹⁰ Mandatory inpatient hospital services do not include services in an institution for mental disease.

¹¹ Centers for Medicare and Medicaid Services. *Medicaid Services* (USDHHS, CMS) on the web at www.cms.hhs.gov/medicaid/mservice.asp

¹² *Ibid.*

¹³John Holahan and Arunabh Ghosh. "Understanding the Recent Growth in Medicaid Spending, 2002-2003," *Health Affairs* (Project Hope, January 26, 2005).

¹⁴ *Supra* note 3.

¹⁵ The FMAP formula only applies to Medicaid services. However, states may receive "enhanced" FMAP under certain circumstances. Medicaid administrative costs are matched at a different rate.

¹⁶*Supra* note 1.

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