

## 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.<sup>1</sup>

### Persons Covered by Medicaid

Medicaid eligibility is limited to individuals who fall into specified categories. Although federal law identifies over 25 different eligibility categories, these 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.<sup>2</sup>

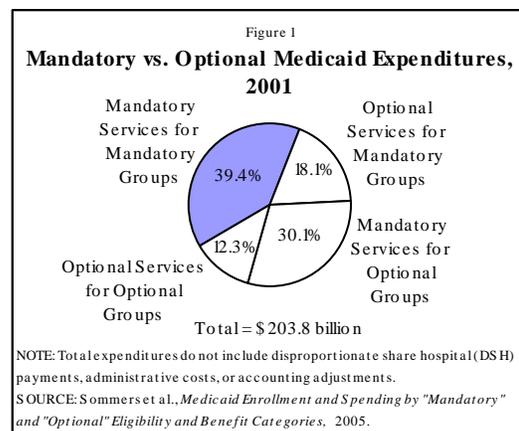
In 2003, Medicaid provided coverage to:

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

- 14 million adults, primarily low-income working parents
- 6 million persons age 65+
- 8 million persons with disabilities<sup>3</sup>

In 2004, two-thirds of all Medicaid beneficiaries lived in low-wage working families.<sup>4</sup> 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. This is known as the medically needy coverage category.

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



## **Medicaid Coverage for Persons Enrolled in Medicare: The Dual Eligibles**

In 2003, approximately 7.5 million people were enrolled in both Medicare and Medicaid.<sup>6</sup> 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 enrollees<sup>7</sup> but 40 percent of Medicaid spending for medical services.<sup>8</sup> These enrollees are among the poorest, sickest, and highest users of health care services in the United States.<sup>9</sup>

As of January 2006, prescription drug coverage for dual eligibles shifted from Medicaid to the new Medicare Part D drug benefit.

### **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:

- Inpatient<sup>10</sup> 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 21<sup>11</sup>

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:

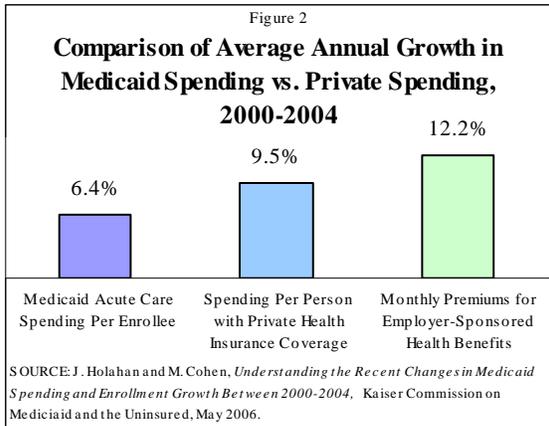
- Eye glasses and eye exams
- Hearing aids
- Durable medical equipment
- Clinic services
- Nursing home services for persons under age 21
- Intermediate care facility services for persons with mental retardation
- Home and community-based services
- Dental, optometry, prosthetic, and tuberculosis services<sup>12</sup>

### **Trends in Medicaid Spending**

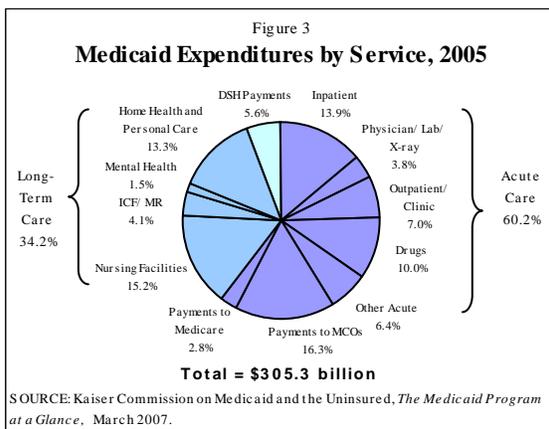
Medicaid spending (federal and state) increased by about one-third – from \$205.7 billion to \$295.9 billion – between fiscal years 2000 and 2004. The pace of spending growth slowed from 2002 to 2004, after reaching an 11.9% average annual growth rate from 2000 to 2002 that coincided with rapid enrollment growth during the 2001 recession.<sup>13</sup>

Despite the increase in Medicaid spending between 2000 and 2004, 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). This was largely the result of policy changes made at the state level to

reduce benefits and to control provider reimbursement rates.<sup>14</sup>

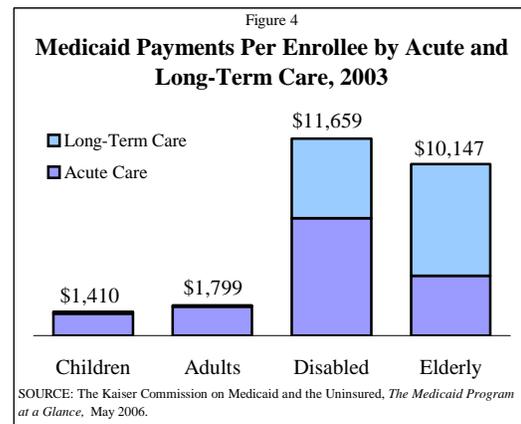


Federal and state Medicaid spending for services and disproportionate share hospital (DSH) payments totaled \$305 billion in 2005 (this number does *not* include administrative costs and adjustments). As shown in Figure 3, acute-care services comprised over one-half (60 percent) of total service-related spending, and long-term care services made up 34 percent. In addition, payments for Medicare premiums accounted for about 3 percent, while disproportionate share hospital payments represented about 6 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.<sup>15</sup> 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 50.00 to 76.29 percent depending on a state's per capita income<sup>16</sup>; wealthier states receive lower federal matches and poorer states receive higher matches. For example, if a state has a 70 percent matching rate, then for every \$1.00 that it spends on a Medicaid covered service, it will receive \$2.33 from the federal government.<sup>17</sup> 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.<sup>18</sup>

<sup>15</sup>Vic Miller and Andy Schneider. *The Medicaid Matching Formula: Policy Considerations and Options for Modification* (AARP, Washington, DC, September 2004).

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

<sup>3</sup> Kaiser Commission on Medicaid and the Uninsured. *The Medicaid Program at a Glance* (Kaiser Commission on Medicaid and the Uninsured, Washington, DC, May 2006).

<sup>4</sup> Kaiser Commission on Medicaid and the Uninsured. *Medicaid: A Primer* (Kaiser Commission on Medicaid and the Uninsured, Washington, DC, July 2002).

<sup>5</sup> 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).

<sup>6</sup> 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).

<sup>7</sup> *Ibid.*

<sup>8</sup> *Ibid.*

<sup>9</sup> Medicare Payment Advisory Commission (MedPAC). *Report to Congress: New Approaches in Medicare* (MedPAC: Washington, DC, June 2004).

<sup>10</sup> Mandatory inpatient hospital services do not include services in an institution for mental disease.

<sup>11</sup> Centers for Medicare and Medicaid Services. *Medicaid At-a-Glance 2005: A Medicaid Information Source* (USDHHS, CMS) on the web at [www.cms.hhs.gov/MedicaidGenInfo/Downloads/MedicaidAtAGlance2005.pdf](http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/MedicaidAtAGlance2005.pdf)

<sup>12</sup> *Ibid.*

<sup>13</sup> John Holahan and Mindy Cohen. "Understanding the Recent Changes in Medicaid Spending and Enrollment Growth Between 2000-2004." (Kaiser Commission on Medicaid and the Uninsured, May 2006).

<sup>14</sup> *Ibid.*

<sup>15</sup> *Supra* note 3.

<sup>16</sup> "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the State Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2007 Through September 30, 2008." Federal Register 71(30 November 2006): 69209-69211.

<sup>17</sup> 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. *Supra* note 1.

<sup>18</sup> *Supra* note 1.

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