



A Short Guide to Understanding MEDICAID

**Steven A. Grossman
September 2001**

Reprinted with permission from ViewsMakingNews.com

It has been observed that: "Medicaid is complicated beyond your wildest imagination."

Medicaid is a federal-state insurance program overseen by the Centers for Medicare and Medicaid Services (formerly the US Health Care Financing Administration) and administered by individual states. It is the medical safety net for millions of America's low-income mothers, children, elderly and disabled. Created in 1965, it is the third largest source of health insurance—behind employer-based coverage and Medicare.

In 1998, approximately 12% of all medical care was paid for through Medicaid. A state pays providers for care provided to Medicaid recipients, and the federal government matches part of the state's expenditures determined by a statutory formula called the Federal Medical Assistance Percentage, or "FMAP."

Health and patient advocacy organizations need to understand this broad and complex program in order to be effective state advocates, protecting and expanding the benefits received by the vulnerable populations they represent. This article will provide a general overview of the Medicaid program including basic eligibility criteria, services covered, and federal and state roles. Links are provided to sources that provide more detailed information.

Medicaid Basics, including Relationship with Medicare

Medicaid provides health and long-term care coverage to low-income and disabled Americans who have limited resources and who fall into one of the eligible categories. While there are myriad Federal requirements, states meet their local needs by choosing among an array of optional services, eligibility and income levels. In addition, many states have requested and been granted waivers that allow them to expand or to make changes to one or more aspects of their Medicaid program.

Thus, Medicaid is really 56 separate programs, one for each state, territory and the District of Columbia. One consequence of the diversity of program approaches is that an individual eligible for Medicaid in one state may not be eligible in another.

While media often focus on the program's role in helping poor women with young children, most of the monies are spent on the severely ill, persons with disabilities and on senior citizens (mostly women) who have outlived their resources and face large medical bills or an extended nursing home stay. This is reflected in the cost and service structure of the Medicaid program. Of the approximately 40 million Medicaid recipients:

- About 72% of beneficiaries are children (51%) and adults (21%)....who cost an average of \$1,000 to \$2,000 per person each year.
- About 28% of beneficiaries are aged (11%) and disabled (18%)....who cost an average of \$9,000 per person each year.

Thus, the overall program average of \$3,500 per beneficiary per year masks significant differences in care provided, appropriate measures of success, and amenability to cost-saving reforms. The higher cost of servicing the elderly and disabled underscores the importance of the relationship between Medicare and Medicaid.

While Medicaid is an entitlement program for low-income and certain disabled individuals, Medicare is an age-based and disability benefits program. Disabled individuals under age 65 cannot become eligible for Medicare until they have received Social Security Disability Insurance payments for twenty-four consecutive months. Medicaid does not impose any waiting period for those who qualify.

Medicaid serves approximately 6 million Medicare beneficiaries who are aged or disabled, although there are several eligibility categories and they differ in the mandatory services that are covered. Overall, this population is known as "dual eligible," and they represent a particularly vulnerable segment of the population, with a high percentage experiencing chronic illness or other debilitating conditions, including mental illness (40%), physical impairment or poor health (50%), Alzheimer's (12%), and diabetes (22%).

Eligibility: Who Does Medicaid Include?

There are three primary categories of individuals who are or may be eligible for Medicaid. They are:

- Categorically needy—mandated by Federal law
- Categorically related—state option
- Medically needy—state option

The "categorically needy" eligibility group is defined both by situation and income level. For example, federal law mandates coverage of children under age 6 whose family income is at or below 133% of the federal poverty level (FPL). Subject to income limitations, other categorically needy populations include: low-income parents with dependent children; pregnant women; recipients of Supplemental Security Income (SSI); children under 19 living in poverty (phased in until fully implemented in 2002); and

recipients of adoption or foster care assistance under the Social Security Act. Certain categories of Medicare beneficiaries also come under this category.

States have the option of making Medicaid available to additional populations for which Federal-matching support is available. These "categorically related" groups are often the same as the categorically needy, except with higher income levels. For example, infants up to age 1 and pregnant woman can be covered by a state up to 185% of the FPL, although each state can set its own percentage up to this limit. Other categorically related groups who are covered in many states (subject to income limits) include: children to age 21; institutionalized individuals; and certain aged, blind and disabled individuals.

Finally, there is a special subset of this categorically related group, known as the "medically needy." About 38 states have medically needy programs. This option allows states to provide Medicaid coverage to individuals who have extensive or expensive medical needs and would be eligible for Medicaid if they met the income or resources tests within their category. Depending on how the state structures its program, individuals may qualify categorically or have to spend down to a certain income or asset level. A number of other special eligibility and benefit rules may be applied, resulting in a highly restrictive "medically needy" program in some states and a broad program in others.

In addition, States can participate in Title XXI of the Social Security Act, the State Children's Health Insurance Program (SCHIP). This allows States to expand their existing initiatives for insuring children and also to fund expanded Medicaid eligibility for children. Many states also have other state programs that assist the near poor and others not eligible for Medicaid, programs for which they do not receive matching federal funds. Plus every state has various programs that provide rehabilitative assistance to the disabled, especially children.

Coverage: What Does Medicaid Pay For?

There are certain federally mandated services specified in law, along with a list of optional services for which a Federal match is available.

Among the mandated services are: inpatient and outpatient services; prenatal care; vaccines for children; physician services; nursing services for persons over 21; family planning; home health care for certain individuals; and early and periodic screening, diagnostic and treatment (EPSDT) services for children under 21.

There are about 34 currently approved optional services for which federal funding is available. States can provide as many or as few as they would like. Also, they can provide services to their categorically needy population that they do not provide to other groups. The most common include: diagnostic services; clinic services; rehabilitation and physical therapy services; optometrist services and eyeglasses; intermediate care services for the mentally retarded (ICFs/MR) and home and community based care to certain persons with chronic impairments.

Optional mental health services include: inpatient psychiatric services for patients age 21 and younger; services provided by licensed non-physician practitioners (e.g. psychologists and social workers); case management, diagnostic, screening, preventive and rehabilitative services; and clinic services furnished under the direction of a physician.

Recognizing that prescription drugs are an increasingly important component of comprehensive health care, all states have chosen the option of providing prescription drug coverage for their categorically needy populations and most cover some or all of the other populations. There have been two major divergent thrusts for national policymaking in this area of Medicaid to: protect against a two-tier system of care by specifying that states must include all FDA-approved products with certain minor exceptions; and allow states to have prior authorization and formulary programs.

The Omnibus Budget Reconciliation Act of 1993 allowed states to establish drug formularies to limit coverage to specific drugs or classes of drugs, and to require prior authorization from a Medicaid authority before certain drugs can be dispensed. Currently, there are 31 states that have prior authorization programs, most limited in scope and each different in its requirements and coverage.

A state's drug formulary must include all drugs made by manufacturers that have entered into a rebate agreement with the federal government. Manufacturers are required to pay each state a rebate for its prescription drug products that have been paid for by Medicaid. The amount is set at the higher of a set percentage (15.1%) or the best price given to any non-government customer. Regardless of rebate agreements, states also may require prior authorization from a Medicaid authority before certain drugs may be dispensed.

In addition to mandatory and optional services, there are several additional program options, such as PACE, which provides comprehensive alternative care for the non-institutionalized elderly who would otherwise be in a nursing home. States may also provide additional services or may cover non-Medicaid eligible individuals for which the federal government will not provide matching funds.

Other Important Features of Medicaid

Co-Pays:

States may impose cost sharing (deductibles, coinsurance and co-payments) on Medicaid recipients, provided the amount is nominal and that it is not applied to certain populations and services. For example, no cost sharing may be applied to pregnant women and children under 18. In addition, co-payments cannot be applied to emergency medical services or family planning services, regardless of a recipient's category.

Non-Discrimination:

States may provide different services to different eligibility categories. However, they may not discriminate by disease group, geographic area or within an eligibility category. Waivers (see below) are sometimes used to allow demonstrations that have the effect of providing differential service or eligibility packages, for example limiting a program to a specific urban or rural catchment area.

Waivers

States can apply for and receive permission to run portions of their Medicaid program in ways that would otherwise not be allowed under Federal rules. This is an increasingly important source of flexibility for states. Generally, waivers must be for innovative delivery or reimbursement systems; experiments with covering uninsured populations; demonstrations in which freedom of choice provisions are waived for certain populations; and for home and community based services.

Medicaid Managed Care

Between 1993 and 1998, the Medicaid managed care population grew from 14 percent of enrollees to 54 percent. The application of pre-paid health care and comprehensive services is highly attractive to both federal and state policymakers and has been further extended through a number of managed care waivers that give states even more flexibility. However, the success of this approach is still widely debated.

Conclusion

Medicaid is a complex program, highly variable from state to state. While this often makes it confusing, it also means that voluntary health associations and other advocates can be strong influences at the state level for the eligibility, coverage, and other provisions that assist their members. Better understanding of the overall program, as well as the many facets of your own state's program, are essential preparation for successful advocacy.

Links:

[LINKS ARE OUTDATED AND HAVE BEEN OMITTED]