

The Basics

Medicaid

The Medicaid program (Title XIX of the Social Security Act) is a state-administered health insurance program that is jointly funded by the federal and state governments. The states operate individual Medicaid programs within broad federal guidelines (administered by the Centers for Medicare and Medicaid Services). The federal Medicaid statute and regulations lay out a set of more than 25 mandatory, or “categorical,” eligibility groups and a set of benefits that must be provided. In addition, the states have flexibility to choose among an additional set of “optional” eligibility and benefits categories that, together with the mandatory groups, make up a unique state Medicaid Plan.

Created in 1965 along with the Medicare program, Medicaid has grown from a small entitlement program—serving only 4 million beneficiaries in 1966, at a cost of \$400 million—into a significant state and federal budget item. By 2002, Medicaid was serving 51 million individuals at a cost of \$216 billion in combined state and federal spending.

WHO IS ELIGIBLE?

The Medicaid program is often considered three programs in one, providing health care services to low-income children, families, and pregnant women; long-term care services for the elderly and disabled; and assistance with the costs of Medicare coverage for low-income elders. Although there are many complex and specific rules, Medicaid eligibility is generally based on an individual’s family income and assets, and, in some cases, his or her degree of medical need.

Families and Children

All states *must* cover the following groups of children, families and pregnant women:

- Children age 6 to 19 with family incomes below the federal poverty level (FPL) (\$15,670 for a family of three in 2004).
- Children under age 6 with family incomes below 133 percent of the FPL (\$20,893 for a family of three in 2004).
- Children and certain adults who would be eligible for cash assistance under pre-welfare reform rules (as of July 1996).
- Through transitional medical assistance, children and certain adults with incomes below 185 percent of the FPL in families that are leaving welfare for work.
- Children in foster care or an adoption assistance program.
- Pregnant women with incomes below 133 percent of the FPL.

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States also have the option to expand coverage to higher income levels for all of the eligibility groups described above, and most have done so. Since the passage of the State Children's Health Insurance Program (SCHIP) in 1997, 40 states have expanded Medicaid/SCHIP eligibility for children up to at least 200 percent of the FPL (\$31,340 for a family of three in 2004). And more than half the states have expanded eligibility for pregnant women up to at least 185 percent of the FPL.

The Elderly and Disabled

- States *must* provide Medicaid coverage for all elderly and disabled individuals receiving cash benefits under the Supplemental Security Income (SSI) program.
- *Qualified severely impaired individuals* are working and have earnings above the SSI eligibility limits but are permitted to continue receiving Medicaid benefits, despite the loss of SSI coverage.
- In 1997, Congress added a new optional eligibility category for the working disabled to allow individuals with disabilities to continue receiving Medicaid while they are working. States can provide coverage to individuals with incomes up to 250 percent of the FPL (\$23,275 for an individual in 2004).

Applying to both families and children and the elderly and disabled, *medically needy* is an optional eligibility category under which the state allows an individual to qualify for Medicaid by deducting the cost of the person's medical care from his or her annual income when determining eligibility. This concept of "spending down" to Medicaid eligibility is often used for elderly individuals who are in nursing facilities, assisted living, or other community-based settings and have high medical or prescription drug expenses. Thirty-nine states provide eligibility to medically needy individuals.

Low-Income Medicare Beneficiaries

- *Qualified Medicare beneficiaries (QMBs)* — Medicaid pays all premiums and cost sharing for Medicare beneficiaries who have incomes below 100 percent of the FPL and limited resources.
- *Specified low-income Medicare beneficiaries (SLMBs)* — Medicaid pays for the Medicare Part B premium for individuals who have incomes between 100 percent and 120 percent of the FPL and limited resources.
- States also have the option to pay the Medicare Part B premium for *qualifying individuals, or QIs*, who have incomes up to 135 percent of the FPL and limited resources.
- *Qualified disabled working individuals, or QDWIs*, who have not worked long enough to be eligible for Medicare can receive the Medicare Part A premium if they have incomes below 200 percent of the FPL and limited resources.

WHAT SERVICES ARE COVERED?

The federal law requires that certain basic services must be offered to the categorically needy population in any state Medicaid program:

- Inpatient and outpatient hospital services.
- Physician services.

- Medical and surgical dental services.
- Nursing facility (NF) services for individuals aged 21 or older.
- Home health care for persons eligible for nursing facility services.
- Family planning services and supplies.
- Health clinic services and any other ambulatory services offered by a health clinic that are otherwise covered under the state plan.
- Laboratory and x-ray services.
- Pediatric and family nurse practitioner services.
- Nurse-midwife services (to the extent authorized under state law).
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals under age 21.

States may also receive federal funding if they elect to provide other optional services. Commonly covered optional services under the Medicaid program include prescription drugs (which all states cover), clinic services, nursing facility services for the under age 21, services in an intermediate care facility for the mentally retarded (ICF/MR), optometrist services and eyeglasses, and dental services.

States may provide home and community-based services to certain individuals who are eligible for Medicaid, including case management, personal care services, respite care services, adult day health services, and home health services. Under the Breast and Cervical Cancer Prevention and Treatment Act of 2000, states may provide medical services to certain women who have been found to have breast or cervical cancer or precancerous conditions.

WHAT ABOUT COST SHARING?

Because of the limited disposable income of most Medicaid eligibles, the Medicaid statute and regulations place strict limits on cost sharing. The law requires that Medicaid benefits be provided at no cost to children and pregnant women. No premiums or deductibles are permitted for mandatory populations, but states may charge “nominal” copayments for services provided to adults. Regulations limit nominal amounts to generally no more than three dollars. For institutional services (for example, hospital and nursing facility), states may charge coinsurance that amounts to 50 percent of the cost of the first day of care. Medicaid-covered services must be provided regardless of the individual’s ability to meet his or her cost-sharing obligation.

HOW IS MEDICAID FINANCED?

Medicaid is funded by a combination of federal and state dollars provided through a matching structure. The federal government matches state spending on an open-ended basis, using a calculation called the federal medical assistance percentage (FMAP). The FMAP is determined annually for each state using a formula that compares the state’s average per capita income level with the national average income level. FMAPs range from 50 percent in the wealthier states (for example, Maryland, California, and New York) to 77 percent in the poorest state (Mississippi).

Medicaid programs currently make up an average of 20 percent of the states’ budgets, second only to elementary and secondary education.

For more information:

- Centers for Medicare and Medicaid Services Web site, <http://www.cms.gov>.
- Andy Schneider, “The Medicaid Resource Book,” Kaiser Commission on Medicaid and the Uninsured, July 2002, at <http://www.kff.org/medicaid/2236-index.cfm>.