



Medicaid Primer

Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports (LTSS), to a diverse low-income population, including children, pregnant women, adults, individuals with disabilities, and people aged 65 and older. In FY2017, Medicaid provided health care services to an estimated 74 million individuals at an estimated cost of \$600 billion, with the federal government paying about \$370 billion of that amount.

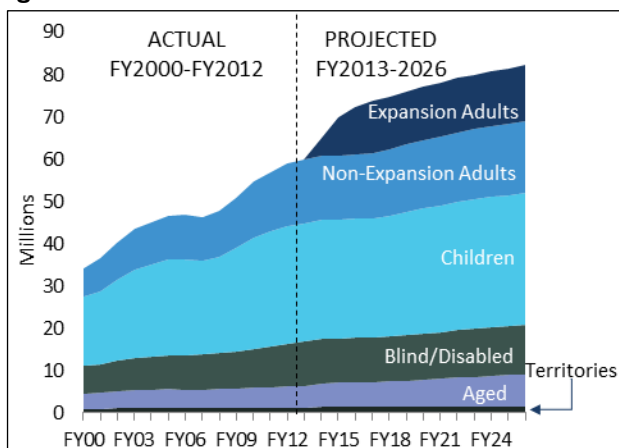
Participation in Medicaid is voluntary for states, though all states, the District of Columbia, and the territories choose to participate. The federal government requires states to cover certain mandatory populations and benefits but allows states to cover other optional populations and services. Due to this flexibility, there is substantial state variation in factors such as Medicaid eligibility, covered benefits, and provider payment rates. In addition, several waiver and demonstration authorities in statute allow states to operate their Medicaid programs outside of certain federal rules.

Eligibility

Historically, Medicaid eligibility generally has been limited to low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities. However, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) included the ACA Medicaid expansion, which expands Medicaid eligibility to non-elderly adults with income up to 133% of the federal poverty level (FPL) (effectively 138% of FPL with an income disregard of 5% of FPL) at state option.

Figure 1 shows historical and projected Medicaid enrollment for FY2000 through FY2026.

Figure 1. Medicaid Enrollment



Source: Centers for Medicare & Medicaid Services (CMS), 2017 Actuarial Report on the Financial Outlook for Medicaid, 2018.

To be eligible for Medicaid, individuals must meet both categorical (e.g., elderly, children, or pregnant women) and financial (i.e., income and sometimes assets limits) criteria in addition to requirements regarding residency, immigration status, and U.S. citizenship. Some eligibility groups are mandatory, meaning all states with a Medicaid program must cover them; others are optional.

Benefits

Medicaid coverage includes a variety of primary and acute-care services as well as LTSS. Not all Medicaid enrollees have access to the same set of services. Different eligibility classifications determine available benefits.

For traditional Medicaid benefits, states are required to cover a wide array of mandatory services (e.g., inpatient hospital, physician, and nursing facility care). States may provide optional additional services, such as personal care services, prescription drugs, and physical therapy.

Alternative Benefit Plan (ABP) coverage is required for enrollees in the ACA Medicaid expansion and optional for other Medicaid enrollees. Under ABPs, states have more flexibility to define which populations are served and what specific benefit packages enrollees will receive. In general, ABPs may cover fewer benefits than traditional Medicaid, but there are some requirements that might make ABPs more generous than private insurance (e.g., family planning services and nonemergency transportation).

Service-Delivery Systems

Medicaid enrollees generally receive benefits via one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, Medicaid enrollees get most or all of their services through an organization under contract with the state. States traditionally used FFS for Medicaid. However, since the 1990s, the share of Medicaid enrollees covered by managed care has increased, with about 81% of Medicaid enrollees covered by some form of managed care as of July 1, 2016.

Cost Sharing

In general, premiums and enrollment fees are prohibited in Medicaid. However, premiums may be imposed on certain enrollees, such as individuals with incomes above 150% of FPL, certain working individuals with disabilities, and certain children with disabilities. States can impose nominal co-payments, coinsurance, or deductibles on most Medicaid-covered benefits up to federal limits. The aggregate cap on out-of-pocket cost sharing is generally 5% of monthly or quarterly household income.

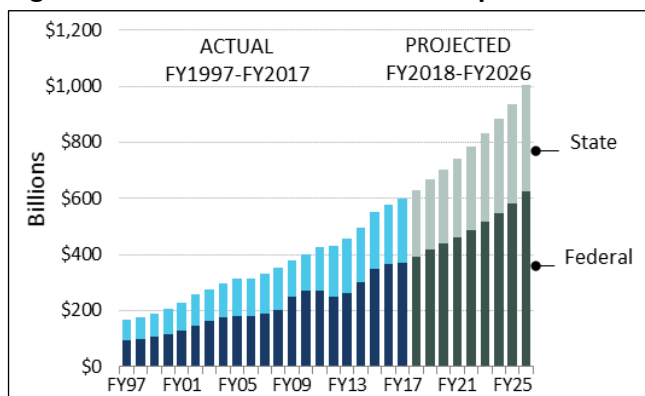
Provider Payments

For the most part, states establish their own payment rates for Medicaid providers. Federal statute requires that these rates be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that Medicaid enrollees have access to covered benefits at least to the same extent that the general population in the same geographic area has access to these benefits. However, low Medicaid payment rates and their impact on provider participation have been perennial policy concerns.

Financing

The federal government and the states share the cost of Medicaid. The federal government reimburses states for a portion of each state’s Medicaid program costs. Federal Medicaid funding is an open-ended entitlement to states, which means there is no upper limit or cap on the amount of federal Medicaid funds a state may receive.

Figure 2. Federal and State Medicaid Expenditures



Source: Actual expenditures are from Form CMS-64 data as of September 2018. Projected expenditures are from CMS, 2017 Actuarial Report on the Financial Outlook for Medicaid, 2018.

Figure 2 shows historical and projected Medicaid expenditures from FY1997 through FY2026. In FY2017, Medicaid spending on services and administrative activities in the 50 states, the District of Columbia, and the territories totaled \$600 billion. Medicaid expenditures are estimated to grow to \$1,006 billion in FY2026.

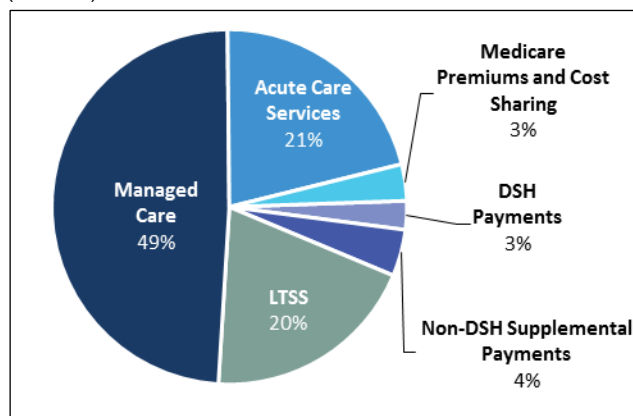
The federal government’s share for most Medicaid expenditures is called the federal medical assistance percentage (FMAP). The FMAP formula is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes). In FY2019, FMAP rates range from 50% (14 states) to 76.4% (Mississippi). Other federal Medicaid matching rates are provided for certain states, situations, populations, providers, and services.

Medicaid Benefit Spending

Figure 3 shows the distribution of Medicaid expenditures on benefits by type of service for FY2017. Capitated payments (i.e., predetermined fixed amounts) under

managed-care arrangements accounted for 49% of benefit spending, while LTSS and acute-care services each represented about 20% of Medicaid benefit spending.

Figure 3. Medicaid Benefit Spending, by Service (FY2017)



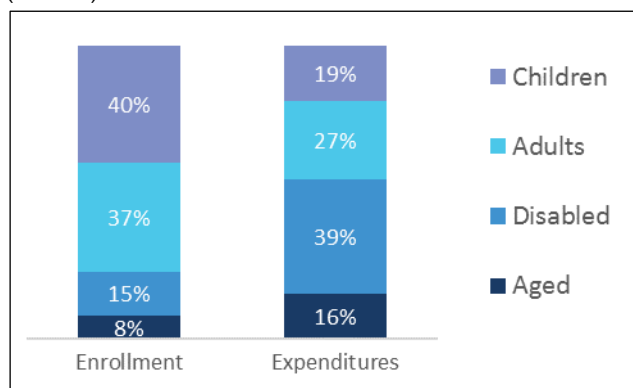
Source: Congressional Research Service analysis of Form CMS-64 data for FY2017, as of September 2018.

Notes: DSH = disproportionate share hospital payments to hospitals treating large numbers of low-income patients.

Enrollment Versus Expenditures

Different Medicaid enrollment groups have different service-utilization patterns. As shown in **Figure 4**, for FY2016, an estimated 40% of all Medicaid enrollees were children, but they accounted for only an estimated 19% of Medicaid’s total benefit spending. In contrast, individuals with disabilities represented an estimated 15% of all Medicaid enrollees but accounted for the largest share of Medicaid benefit spending (an estimated 39%), due in part to the utilization of LTSS.

Figure 4. Estimated Medicaid Enrollment and Expenditures for Benefits, by Enrollment Group (FY2016)



Source: CMS, 2017 Actuarial Report on the Financial Outlook for Medicaid, 2018.

Alison Mitchell, Analyst in Health Care Financing

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