Addendum: A brief summary of the Medicaid program

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Following is a simple summary of a most complex subject and, as such, it should be used only as a general guide to understanding the Medicaid program. Changes in the laws, which became effective on April 1, 1990, are reflected.

Medicaid eligibility

States generally have broad discretion in determining, within Federal guidelines and with Federal medical assistance percentage (FMAP) support, which groups their Medicaid programs will cover and their financial criteria for Medicaid eligibility. However, States are required to provide Medicaid enrollment for persons who receive federally assisted income-maintenance assistance payments, as well as for related groups not receiving cash payments. These mandatory Medicaid eligibility groups include:

- Recipients of Aid to Families with Dependent Children (AFDC), and two-parent, unemployed families whose cash assistance the State has elected to limit, including a limited extension of coverage for those who lose AFDC because of earnings from work.
- Supplemental Security Income (SSI) recipients, or aged, blind, or disabled individuals in States that apply more restrictive eligibility requirements.
- Pregnant women and children to age 6 whose family income is below 133 percent of the Federal poverty level.
- Certain Medicare beneficiaries (described later).
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.
- Certain other specifically defined groups (with protected coverage for limited periods).

States also have the option to provide Medicaid enrollment for other "categorically needy" groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. The broadest range of optional groups that States may enroll (and receive FMAP funds for) under the Medicaid program include:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is at or below 185 percent of the Federal poverty level (the percentage to be set by each State).
- Other children under age 8, plus aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the Federal poverty level.
- Children under age 21 who meet income and resources requirements for AFDC, but who otherwise are not eligible for AFDC.
- Institutionalized individuals with income and resources below specified limits.
- Persons receiving care under home and community-based waivers.
- Recipients of State supplementary payments.
- "Medically needy" persons.

The option to have a "medically needy" (MN) program allows States to provide Medicaid eligibility to certain additional individuals and families: those who meet the eligibility requirements, except that they have income above what is allowed under the mandatory or optional categorically needy levels, but below the MN level for that State. Within this MN option, qualified persons may also "spend down" to Medicaid eligibility by incurring medical care expenses that reduce their excess income to a level below that allowed by their State's plan.

If a State elects to have a medically needy program, it is required to enroll certain children under age 18 and pregnant women. It may also choose to enroll as medically needy persons: aged, blind, or disabled persons; caretaker relatives of children deprived of parental support and care; and certain other financially eligible children up to age 21. During 1989, 39 States provided Medicaid to at least some groups under a medically needy program.

The Medicare Catastrophic Coverage Act of 1988 accelerates eligibility for Medicaid for some nursing home patients by protecting more family income and assets for the institutionalized persons' spouses at home.

Medicaid does not provide health care services for all poor persons. To be eligible for Medicaid, a person must belong to one of the designated groups, as well as meet income and assets/resources tests. Even under the broadest provisions of the Federal statute (except for a few emergency services for certain persons) the Medicaid program does not provide health care services, even for very poor persons, unless they are: under age 21, pregnant, aged, blind, disabled, or in certain AFDC-type families.

Some States also have some additional " State-only" programs to provide medical assistance for specified poor persons who do not qualify for the Medicaid program. These programs also vary greatly among States. Matching Federal funds are not provided for these State-only programs.

Scope of services

Title XIX of the Social Security Act requires that, in order to receive Federal matching funds, certain basic services must be offered in any State Medicaid program:

- Inpatient hospital services.
- Outpatient hospital services.
- Prenatal care.
- Physician services.
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for children under age 21, including services beyond those normally in State plans for conditions identified in the screening examination.
- Skilled nursing facility (SNF) services for individuals age 21 or over.
- Home health care for persons eligible for skilled nursing services.

- Family planning services and supplies (at 90 percent FMAP for all States).
- Rural health clinic services.
- Laboratory and X-ray services.
- Nurse-midwife services.
- Certain federally qualified ambulatory and health center services.

States may also receive Federal matching funds if they elect to provide other optional services (currently 32 options). The most commonly covered optional services under the Medicaid program include:

- Clinic services.
- Intermediate care facility (ICF) services for the aged and disabled.
- ICF services for the mentally retarded.
- Optometrist services and eyeglasses.
- Prescribed drugs.
- Prosthetic devices.
- Dental services.

Amount and duration of services

Within broad Federal guidelines, States determine the duration and amount of services offered under their Medicaid programs. They may limit, for example, the days of hospital care or the number of physician visits covered. With certain exceptions, a State's Medicaid plan must allow recipients freedom of choice among participating providers of health care. States may provide and pay for Medicaid services through various pre-payment arrangements, such as health maintenance organizations.

In general, States are required to provide comparable services to all categorically needy enrollees. Under two important exceptions, States provide additional services to limited groups:

- States may request administrative "waivers" under which they offer an alternative health care package for persons who would otherwise be institutionalized under Medicaid. States are not limited in the scope of services they can provide under such waivers so long as they are cost effective (except that, other than as a part of respite care, they may not provide room and board for such waivered recipients).
- Under the EPSDT program, services that are identified as needed by enrolled children must be provided by Medicaid, even if those services are not included as part of that State's Medicaid plan.

Medicaid and Medicare relationship

Some aged or disabled poor persons are covered under both the Medicaid and the Medicare (Title XVIII of the Social Security Act) programs. These persons are known as "dual enrollees" or "crossover enrollees". The Medicare program provides hospital insurance (Part A) and supplementary medical insurance (Part B). For those persons who are aged (65 years or over) or disabled and who have insured status under Social Security, coverage for Part A is automatic. (Other persons age 65 or over but not covered by Social Security may obtain Part A coverage by paying the monthly premium.)

Coverage for Part B, however, requires payment of a monthly premium. State Medicaid programs pay the premiums, deductibles, and coinsurance for some or all dual enrollees. Medicaid supplements Medicare, providing certain health care services for the dual enrollees that are not provided under Medicare, such as hearing aids, eye glasses, and skilled nursing facility services beyond the 100-day Medicare limit.

The portion of the Medicare Catastrophic Coverage Act of 1988 that was not repealed in 1989 requires that State Medicaid programs begin (on a phased-in basis) to pay for the Medicare premiums, deductibles, and coinsurance for certain other aged or disabled "qualified Medicare beneficiaries" (QMBs): those with incomes at or below 90 percent of the Federal poverty level (phased in to 100 percent by 1992) and with resources at or below twice the standard allowed under SSI. This assures Medicare coverage for those Medicare beneficiaries who are not quite poor enough to qualify for Medicaid, but who would have difficulty paying the Medicare copayments.

The QMBs with income and resources above Medicaid eligibility levels are not eligible for full Medicaid coverage because of the new law; they benefit because their Medicare cost-sharing expenses are covered by Medicaid. In addition, the Omnibus Budget Reconciliation Act of 1989 requires Medicaid buy-in of Part A Medicare coverage for disabled persons who lost Medicaid coverage because of their return to work.

Payment rates for services

Medicaid operates as a vendor payment program. States pay the providers of medical services for care rendered to enrolled individuals. Providers must accept the Medicaid reimbursement level as payment in full. Payment rates must be sufficient to enlist enough providers so that Medicaid care and services are available under the plan at least to the extent that such care and services are available to the general population in that geographic area. Also, States must augment payments to qualified hospitals that provide inpatient health care services to a disproportionate number of Medicaid enrollees and/or other low-income persons.

States have broad discretion in determining the reimbursement methodology and resulting rates for services, subject to Federal upper limits, with two exceptions: for institutional services, payments may not exceed Medicare reasonable-cost payment rates; and for hospice care services, they must pay Medicare rates.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid enrollees for certain services. Emergency services and family planning services must be exempt from such copayments by enrollees. Certain Medicaid enrollees must be excluded from this cost sharing: pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to institutional care, and categorically needy enrollees in health maintenance organizations.