Medicaid: An Overview

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Summary

Medicaid is a means-tested entitlement program that in FY2012 financed the delivery of primary and acute medical services as well as long-term services and supports to an estimated 57 million people, and cost states and the federal government $431 billion. In comparison, the Medicare program provided health care benefits to nearly 50 million seniors and certain individuals with disabilities in FY2012 at a cost of roughly $557 billion. Because Medicaid represents a large component of federal mandatory spending, Congress is likely to continue its oversight of Medicaid's eligibility, benefits, and costs.

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

Historically, Medicaid eligibility has generally 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 individuals under the age of 65 with income up to 133% of the federal poverty level (FPL) (effectively 138% FPL) at state option.

The ACA makes a number of other changes, which together represent the most significant reform to the Medicaid program since its establishment in 1965. In addition to the ACA Medicaid expansion, the ACA also expands Medicaid eligibility for children ages 6 to 18 and former foster care children; transitions to the modified adjusted gross income (MAGI) counting methodology for most nonelderly Medicaid enrollees; requires alternative benefit plan (ABP) coverage for certain Medicaid enrollees; provides enhanced federal matching funds for the ACA Medicaid expansion; increases uniformity among Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP) program integrity activities; and provides the Centers for Medicare & Medicaid Services (CMS) with the ability to test methods to improve coordination of care for dual-eligible beneficiaries, among a number of other changes.

This report describes the basic elements of Medicaid, focusing on who is eligible, what services are covered, how enrollees share in the cost of care, how the program is financed, and how providers are paid. The report also explains waivers, program integrity activities, and the dual-eligible population. In addition, the report describes the following selected issues: the ACA Medicaid expansion, the impact of the ACA health insurance annual fee on Medicaid, and the ACA maintenance of effort (MOE) with respect to Medicaid eligibility.

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Introduction

Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services, as well as LTSS, for a diverse low-income population, including children, pregnant women, adults, individuals with chronic disabling conditions, and people age 65 and older. In FY2012, Medicaid is estimated to have provided health care services to 56.7 million individuals[1] at a total cost of $431 billion, with the federal government paying $249 billion (about 58%) of that total.[2]

Medicaid is an important health care safety net[3] for low-income populations with approximately 18% of the U.S. population enrolled in Medicaid in CY2011.[4] For some types of services, Medicaid is a significant payer. For instance, in CY2011, Medicaid accounted for 42% of national spending on long-term services and supports (LTSS) and 25% of all mental health and substance abuse treatment spending.[5] Also, along with the State Children's Health Insurance Program (CHIP), Medicaid paid for almost half of all births in the United States (about 1.8 million hospital births) in 2010.[6]

Medicaid is one of the largest payers in the U.S. health care system, representing 15.1% of national health care spending in calendar year (CY) 2011; in that year, private health insurance and Medicare accounted for 33.2% and 20.5%, respectively.[7]

Medicaid was enacted in 1965 as part of the same law that created the Medicare program (the Social Security Amendments of 1965; P.L. 89-97). State participation in Medicaid is voluntary, though all states, the District of Columbia, and the territories[8] choose to participate. States are responsible for administering their Medicaid programs. Medicaid is jointly financed by the federal government and the states. Federal Medicaid spending is an entitlement,[9] with total expenditures dependent on state policy decisions and use of services by enrollees.

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[1] This enrollment figure is measured according to "person-year equivalents," which represents the average program enrollment over the course of a year, and differs from "ever enrolled" counts which measure the number of people covered by Medicaid for any period of time during the year. (Office of the Actuary [OACT], Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, *National Health Expenditure Projections 2012-2022: Forecast Summary,* 2013.)

[2] Centers for Medicare & Medicaid Services, CMS-64 data.

[3] The health care safety net is defined as those organizations and programs, in both the public and private sectors, with a legal obligation or a commitment to provide direct health care services to uninsured and underinsured populations.

[4] Calculation based on data from Medicaid and CHIP Payment and Access Commission (MACPAC), *Overview of Medicaid and CHIP,* January 2013.

[5] CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, December 16, 2012; MACPAC, *Overview of Medicaid and CHIP*, January 2013.

[6] MACPAC, *Report to the Congress on Medicaid and CHIP*, June 2013.

[7] Micah Hartman, Anne B. Martin, and Joseph Benson, et al., "National Health Spending in 2011: Overall Growth Remains Low, But Some Payers and Services Show Signs of Acceleration," *Health Affairs*, vol. 32, no. 1 (2013), pp. 87-99.

[8] The five territories are American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

[9] Medicaid is an entitlement for both states and individuals. The Medicaid entitlement to states ensures that, so long as (continued...)

States must follow broad federal rules in order to receive federal matching funds, but have flexibility to design their own version of Medicaid within the federal statute's basic framework. This flexibility results in variability across state Medicaid programs. Each state has a Medicaid state plan that describes how the state will administer its Medicaid program. States submit these Medicaid state plans to the federal Centers for Medicare and Medicaid Services (CMS) for approval.[10]

Medicaid was designed to provide coverage to groups with a wide range of health care needs who were historically excluded from the private health insurance market (e.g., individuals with chronic disabling conditions who require LTSS or indigent populations in geographic locations where access to providers is limited). Because of the diversity of the populations that Medicaid serves, Medicaid offers some benefits that are not typically covered by major insurance plans offered in the private market (e.g., nursing facility care or early and periodic screening, diagnosis, and treatment [EPSDT] services).[11] Medicaid also pays for Medicare premiums and/or cost sharing for low-income seniors and individuals with disabilities, who are eligible for both programs, referred to as dual-eligible beneficiaries. For other Medicaid enrollees, out-of-pocket costs are generally nominal, which may not be the case with most employer-sponsored or exchange health insurance coverage.[12] The Medicaid program pays for special classes of providers, such as federally qualified health centers (FQHCs), rural health clinics (RHCs), and Indian Health Service (IHS) facilities, that provide health care services to populations in areas where access to traditional physician care has been limited.

Since its inception, the Medicaid program has expanded in a number of different directions. Federal laws have changed virtually every aspect of the program, affecting eligibility, benefits, beneficiary cost-sharing, and fraud and abuse protections, among others. The Patient Protection and Affordable Care Act (ACA; P.L. 111-148 as amended) is the most recent federal law to make fundamental revisions to the Medicaid program, including a substantial expansion of Medicaid eligibility, beginning in 2014. The ACA will likely broaden Medicaid's role in providing health care coverage to the U.S. population, and increase the likelihood that, going forward, Congress's attention to health policy issues will involve Medicaid.

The ACA was designed to reduce the number of U.S. citizens without health insurance by preserving the existing system of employer-based health insurance, making changes to the individual insurance market, and expanding coverage to the uninsured through Medicaid and health insurance exchanges (also referred to as marketplaces).[13] Under the ACA, Medicaid and

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(...continued)

states operate their programs within the federal requirements, states are entitled to federal Medicaid matching funds. Medicaid is also an individual entitlement, which means that anyone eligible and enrolled in Medicaid under his or her state's eligibility standards is guaranteed Medicaid coverage.

[10] The state plan outlines Medicaid eligibility standards, provider requirements, payment methods, and health benefit packages among other program design criteria. Although this report describes federal Medicaid requirements, a number of these requirements can be waived, with approval from the Secretary of Health and Human Services (HHS), as discussed in the subsection on waivers.

[11] See "Benefits" section for a discussion of these benefits.

[12] For more information see CRS Report R42978, *Comparing Medicaid and Exchanges: Benefits and Costs for Individuals and Families*.

[13] Exchanges were established under the ACA as market places where certain individuals and businesses can purchase private health insurance. For more information about the exchanges, see CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach.

the exchanges are envisioned to work in tandem to provide a continuous source of subsidized coverage for lower-income individuals and families.[14] Medicaid agencies are required to coordinate with the exchanges to educate people about new health insurance options and assist them in navigating the enrollment process.

This report describes the basic elements of Medicaid, focusing on who is eligible, what services are covered, how enrollees share in the cost of care, how the program is financed, and how providers are paid. The report also explains waivers, program integrity activities, and the dual-eligible population. In addition, the report describes the following selected issues: the ACA Medicaid expansion, the impact of the ACA health insurance annual fee on Medicaid, and the ACA maintenance of effort (MOE) with respect to Medicaid eligibility.

Eligibility

Eligibility for Medicaid is determined by both federal and state law, whereby states set individual eligibility criteria within federal minimum standards. Individuals must meet both *categorical* (e.g., elderly, individuals with disabilities, children, pregnant women, parents, certain nonelderly childless adults) and *financial* (i.e., income and sometimes assets limits) criteria.[15] In addition, individuals need to meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship. Some eligibility groups are mandatory, meaning that all states with a Medicaid program must cover them; others are optional. States are permitted to apply to CMS for a waiver of federal law to expand health coverage beyond the mandatory and optional groups listed in federal statute (see the "Medicaid Program Waivers" section for more information about waivers).

If a state participates in Medicaid, the following are examples of groups that *must* be provided Medicaid coverage:

- poor families that meet the financial requirements (based on family size) of the former Aid to Families with Dependent Children (AFDC) cash assistance program;
- pregnant women and children through age 18 with family income at or below 133% of the federal poverty level (FPL);[16]
- low-income individuals who are age 65 and older, or blind, or who are under age 65 and disabled who qualify for cash assistance under the Supplemental Security Income (SSI) program;
- recipients of adoption assistance and foster care (who are under age 18) under Title IV–E of the Social Security Act;

[14] For more information, see CRS Report R42978, *Comparing Medicaid and Exchanges: Benefits and Costs for Individuals and Families*.

[15] Some groups, such as young people under the age of 26 who have aged out of foster care, are eligible for Medicaid coverage without regard to the youths' income and assets.

[16] The poverty guidelines (also referred to as the federal poverty level) are a version of the federal poverty measure. They are issued each year in the *Federal Register* by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds for use for administrative purposes—for instance, determining financial eligibility for certain federal programs.

- certain individuals who age out of foster care, up to age 26, and do not qualify under other mandatory groups noted above; and
- certain groups of legal permanent resident immigrants (e.g., refugees for the first seven years after entry into the United States; asylees for the first seven years after asylum is granted; lawful permanent aliens with 40 quarters of creditable coverage under Social Security; immigrants who are honorably discharged U.S. military veterans) who meet all other financial and categorical Medicaid eligibility requirements.

Examples of groups that states *may* provide Medicaid to include

- pregnant women and infants with family income between 133% and 185% of the FPL;
- certain individuals who qualify for nursing facility or other institutional care and have incomes up to 300% of SSI benefit level, referred to as "the 300 percent rule";
- "medically needy" individuals who are members of one of the broad categories of Medicaid covered groups (i.e., are aged, have a disability, or are in families with children), but do not meet the applicable income requirements and, in some instances, assets requirements for those eligibility pathways;[17] and
- working people with disabilities.

Beginning in 2014, states have the option to expand Medicaid eligibility beyond the historical categorical eligibility groups to all citizens under age 65, who otherwise are not eligible for Medicaid with income at or below 133% of FPL (i.e., the ACA Medicaid expansion). The income limit is effectively 138% of FPL (after adjusting for a 5% income disregard applicable if individuals are at the highest income limits for coverage).[18] (For more information about the ACA Medicaid expansion, see "ACA Medicaid Expansion.")

Modified Adjusted Gross Income (MAGI)

As of January 1, 2014, the modified adjusted gross income (MAGI) rules are used in determining eligibility for most of Medicaid's nonelderly populations, including the ACA Medicaid expansion.[19] This change could mean some individuals currently eligible for Medicaid would no

[17] For these groups, states are required to allow individuals to spend down to the medically needy income standard by incurring and paying medical expenses.

[18] 42 CFR §435.603(d)(4).

[19] Under ACA, certain groups are exempt from income eligibility determinations for Medicaid based on MAGI. Prior law's income determination rules under Medicaid will continue to be used for determining eligibility for the following groups: (1) individuals who are eligible for Medicaid through another federal or state assistance program (e.g., foster care children and individuals receiving SSI), (2) the elderly, (3) certain disabled individuals who qualify for Medicaid on the basis of being blind or disabled without regard to whether the individual is eligible for SSI, (4) the medically needy, and (5) enrollees in a Medicare Savings Program (e.g., Qualified Medicare Beneficiaries for whom Medicaid pays the Medicare premiums or coinsurance and deductibles). In addition, MAGI does not affect eligibility determinations through Express Lane enrollment (to determine whether a child has met Medicaid or CHIP eligibility requirements), for Medicare prescription drug low-income subsidies, or for determinations of eligibility for Medicaid long-term services and supports.

longer be found eligible (and vice versa) due to the change in the way income is counted for Medicaid eligibility. For example, the conversion to MAGI might make some children that are currently eligible for Medicaid ineligible because stepparent income is often excluded from current income counting rules but included for MAGI. On the other hand, children currently not eligible might become eligible because MAGI excludes child support income, which is generally included for current income counting rules.[20]

MAGI is defined as the Internal Revenue Code's adjusted gross income (AGI, which reflects a number of deductions, including trade and business deductions, losses from sale of property, and alimony payments) increased (if applicable) by tax-exempt interest and income earned by U.S. citizens or residents living abroad.[21] While the Internal Revenue Service's definition of MAGI excludes non-taxable social security benefits, P.L. 112-56, enacted on November 21, 2011, changed the definition of income for Medicaid eligibility to include such non-taxable social security benefits.

Under the MAGI counting rules, the state will look at the individual's MAGI, deduct 5%, which the law provides as a standard disregard, and compare that income to the new income standards set by each state in coordination with CMS. See **Table A-1** for the new MAGI-based eligibility levels adjusted for the 5% disregard effective January 1, 2014.

The transition to the MAGI income rules has significant implications for the Medicaid eligibility determination process. It represents a major change in terms of the types of information collected (such as what counts as income) and the definition of household (such as the inclusion of the income of a step parent) compared to former Medicaid eligibility rules. These changes necessitate a redesign of the existing Medicaid eligibility and enrollment systems for each state. The system must be integrated with the exchanges as well as with other social programs that serve low-income populations (e.g., the Temporary Assistance for Needy Families [TANF] and the Supplemental Nutrition Assistance Program [SNAP]).

Medicaid Enrollment Trends

Figure 1 shows historical and projected Medicaid enrollment for FY2000 through FY2021 (see **Table B-1** for state-by-state Medicaid enrollment for FY2010). The figure shows steady enrollment growth, especially among non-disabled children and adults, punctuated by years of faster enrollment growth in periods immediately after recessions.[22] During periods of economic downturn, state Medicaid programs face program enrollment increases at a faster rate because job and income losses make more people eligible. One study estimated that for every 1% increase in the national unemployment rate, Medicaid enrollment increases by 1 million individuals.[23]

[20] John L. Czajka, *Translating Modified Adjusted Gross Income (MAGI) to Current Monthly Income*, State Health Access Reform Evaluation, May 2013.

[21] For more information, see CRS Report R41997, *Definition of Income for Certain Medicaid Provisions and Premium Credits in ACA*.

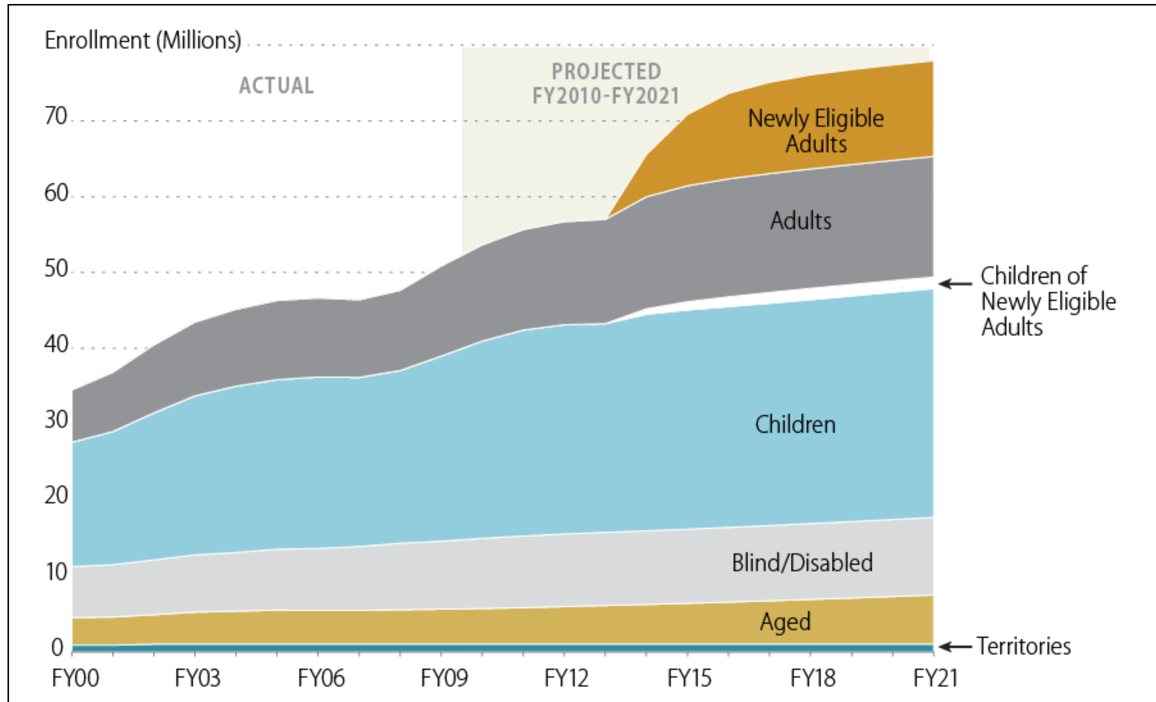
[22] According to the National Bureau of Economic Analysis, the United States was in recession from March 2001 through November 2001 and December 2007 through June of 2009.

[23] John Holahan and A. Bowen Garrett, *Rising Unemployment, Medicaid and the Uninsured*, Kaiser Commission on Medicaid and the Uninsured, Publication #7850, January 2009.

The ACA changes to Medicaid eligibility (including, but not limited to, the ACA Medicaid expansion) are projected to add 8.6 million people to Medicaid in FY2014 and 18.3 million people by FY2021. About 83% of new adult enrollees are projected to be "newly eligible" (i.e., eligible for Medicaid through the ACA Medicaid expansion), while 17% are projected to be individuals who would have been eligible for Medicaid prior to the ACA changes, but were not enrolled.[24]

Figure 1. Past and Projected Medicaid Enrollment, by Population

FY2000–FY2021



Source: Christopher J. Truffer, John D. Klemm, and Christian J. Wolfe, et al., *2012 Actuarial Report on the Financial Outlook for Medicaid*, Centers for Medicare & Medicaid Services' Office of the Actuary, 2013.

Notes: Enrollment is measured by "person-year equivalents," which is the average enrollment over the course of the year.

For purposes of this figure, "Newly Eligible Adults" are adult enrollees who are newly eligible in 2014 and later as a result of the expanded eligibility criteria in the ACA. "Children of Newly Eligible Adults" are defined here as the dependent children of newly eligible adult enrollees, even if these children were eligible under current criteria. Currently eligible adults who become enrolled as a result of the publicity and outreach efforts associated with the ACA are included with "Adults," and their dependent children are included with "Children" in this figure.

Share of Enrollment Versus Expenditures, by Population

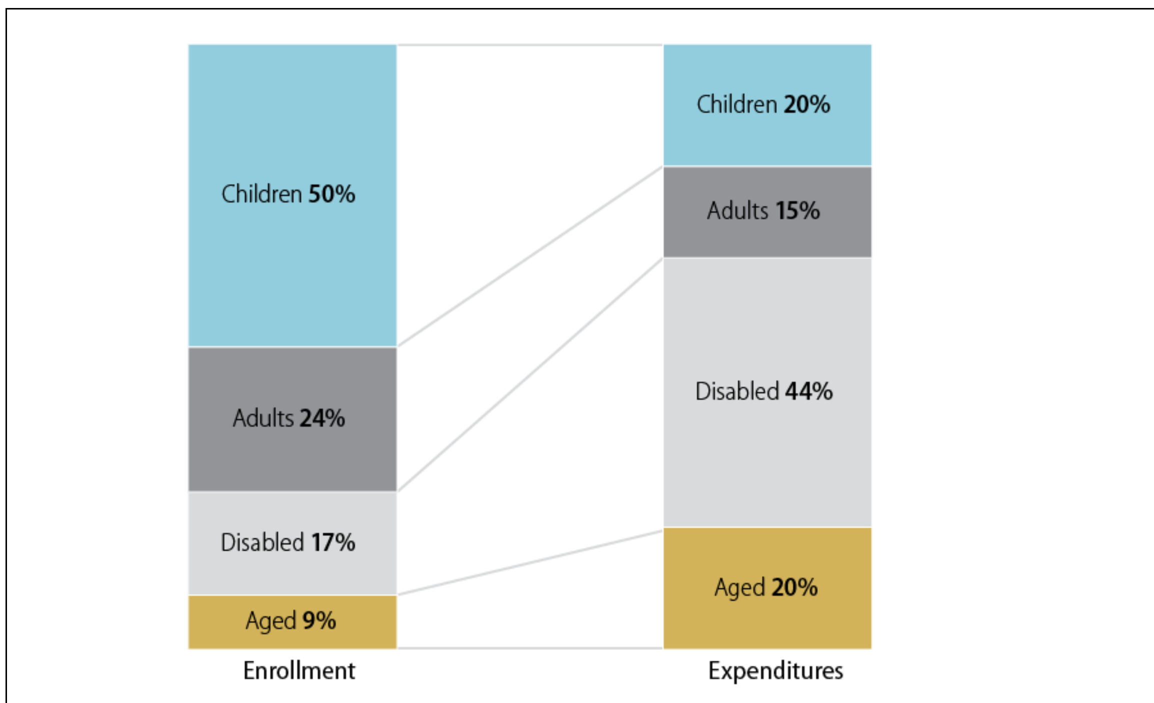
Different Medicaid enrollment groups have very different service utilization patterns. Larger enrollment groups account for a smaller proportion of the Medicaid expenditures and some

[24] Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services, *2012 Actuarial Report on the Financial Outlook for Medicaid*, 2013.

smaller enrollment groups are responsible for a larger proportion of Medicaid expenditures. As shown in **Figure 2**, for FY2011, roughly half of Medicaid enrollees were children without disabilities, who accounted for only about 20% of Medicaid's total benefit spending. The next-largest enrollee group—adults—accounted for about 24% of all enrollees, but only about 15% of benefit expenditures. In contrast, individuals with disabilities represented about 17% of Medicaid enrollees, but accounted for the largest share of Medicaid benefit spending (about 44%). Finally, the elderly represented about 9% of Medicaid enrollees, but about 20% of all benefit spending. While these statistics vary somewhat from year to year and state to state, the patterns described above generally hold true across years.[25]

Figure 2. Estimated Medicaid Enrollment and Expenditures for Benefits, by Enrollment Group as a Share of Total

FY2011



Source: Christopher J. Truffer, John D. Klemm, and Christian J. Wolfe, et al., *2012 Actuarial Report on the Financial Outlook for Medicaid*, Centers for Medicare & Medicaid Services' Office of the Actuary, 2013.

Notes: Totals and components exclude DSH expenditures (i.e., payments to hospitals treating large numbers of low-income patients), territory enrollees and expenditures, and other adjustments.

Benefits

Federal law provides two primary benefit packages for state Medicaid programs: (1) traditional benefits and (2) alternative benefit plans (ABPs). Each of these packages is summarized below. In addition, states can use waiver authority (e.g., Section 1115 of the Social Security Act) to tailor

[25] Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services, *2012 Actuarial Report on the Financial Outlook for Medicaid*, 2013.

benefit packages to specified Medicaid subgroups (see "Medicaid Program Waivers" for more information about Section 1115 waivers).

Traditional Medicaid Benefits

The traditional Medicaid program requires states to cover a wide array of mandatory services (e.g., inpatient hospital care, lab/x-ray services, physician care, nursing facility services for individuals aged 21 and over). In addition, states may provide optional services, some of which are commonly covered (e.g., personal care services for the frail elderly and individuals with disabilities who need long-term services and supports, prescribed drugs, physician-directed clinical services, physical therapy, and prosthetic devices).

States define the specific features of each covered benefit within four broad federal guidelines:

- Each service must be sufficient in "amount, duration, and scope" to reasonably achieve its purpose. States may place appropriate limits on a service based on such criteria as medical necessity.
- Within a state, services available to the various categorically needy groups[26] must be equal in amount, duration, and scope. These requirements are the "comparability" rule.
- With certain exceptions, the amount, duration, and scope of benefits must be the same statewide, referred to as the "statewideness" rule.
- With certain exceptions, enrollees must have "freedom of choice" among health care providers or managed care entities participating in Medicaid.

The breadth of coverage for a given benefit can, and does, vary from state to state, even for mandatory services. For example, states may place different limits on the amount of inpatient hospital services a beneficiary can receive in a year (e.g., up to 15 inpatient days per year in one state versus unlimited inpatient days in another state)—as long as applicable requirements are met regarding comparability; statewideness; and sufficiency of amount, duration, and scope. Exceptions to state limits may be permitted under circumstances defined by the state.

The federal Medicaid statute also delineates special benefits or special rules regarding certain benefits for targeted populations. For example:

- Most Medicaid children under age 21 are entitled to *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services*. Under EPSDT, children receive well-child visits, immunizations, laboratory tests, and other screening services at regular intervals. In addition, medical care that is necessary to correct or ameliorate identified defects, physical and mental illness, and other conditions must be provided, including some services that states may not otherwise cover in their Medicaid programs.

[26] Categorically needy groups include families with children, the elderly, persons with disabilities, and certain other pregnant women and children who meet former AFDC- and SSI-related financial standards, or have income below specified percentages of the FPL. Beginning in 2014, or earlier at state option, this classification will also include non-elderly, non-pregnant adults.

- *Unauthorized aliens* (i.e., illegal aliens, foreign nationals who are not lawfully present in the United States) are ineligible for Medicaid. Individuals who meet the eligibility requirements for Medicaid but are ineligible due to immigration status may receive Medicaid coverage for emergency conditions (i.e., emergency Medicaid) only, which includes costs associated with emergency labor and delivery for pregnant women and excludes costs for organ transplants.
- Special benefit rules apply to optional *medically needy populations* (for more information about the medically needy see "Eligibility"). States may offer a more restrictive benefit package than is provided to categorically needy populations, but at a minimum, must offer (1) prenatal, delivery, and postpartum services for pregnant women, (2) ambulatory services as defined in the state Medicaid plan for individuals under 18 and those entitled to institutional services, and (3) home health services for individuals entitled to nursing facility care.[27]
- Medicaid law gives states the option to extend *home- and community-based services* (HCBS) to Medicaid enrollees under the HCBS state plan option (Section 1915[i] of the Social Security Act) without requiring a Secretary-approved waiver for this purpose (under Sections 1915[c] or 1115 of the Social Security Act).

Alternative Benefit Plans (ABPs)

Alternative benefit plans (ABPs) are a Medicaid benefit structure that has different requirements than the traditional Medicaid benefits.[28] For example, under ABPs states may waive the "statewideness" and "comparability" requirements that apply under traditional Medicaid. This flexibility permits the state to define populations that will be served and the specific benefit packages that will apply. In general, ABPs may cover fewer benefits than traditional Medicaid, but there are some requirements, such as coverage of EPSDT services, family planning services and supplies, and both emergency and non-emergency transportation to and from providers that might make them more generous than private insurance.

States that choose to implement the ACA Medicaid expansion are required to provide the individuals newly eligible for Medicaid through the expansion Medicaid services through ABPs

[27] Broader requirements apply if a state has chosen to provide coverage for medically needy persons in institutions for mental disease and intermediate care facilities for the mentally retarded. In these cases, states are required to cover the same services as those which are mandatory for the categorically needy, or alternatively, the care and services described in 7 of the first 24 paragraphs in the federal Medicaid statute defining covered mandatory and optional services.

[28] Prior to the ACA, ABPs were referred to as benchmark and benchmark-equivalent benefit packages (as per the Deficit Reduction Act of 2005, P.L. 109-171). Pre-ACA Benchmark coverage included one of the four benchmark options: (1) the standard Blue Cross/Blue Shield preferred provider option offered through the Federal Employees Health Benefit program; (2) State employee coverage that is offered and generally available to state employees; (3) commercial HMO with the largest insured commercial non-Medicaid enrollment in the state; and/or (4) Secretary-approved coverage, a benefit package the Secretary has determined to provide coverage appropriate to meet the needs of the population. Pre-ACA Benchmark-equivalent coverage was required to have the same aggregate actuarial value as one of the benchmark plans and was also required to include (1) inpatient and outpatient hospital services; (2) physician services; (3) lab and x-ray services; (4) emergency care; (5) well-child care, including immunizations; (6) prescribed drugs; (7) mental health services; and (8) other appropriate preventive care (designated by the Secretary). Such coverage was also required include at least 75% of the actuarial value of coverage under the applicable ABP for vision care and hearing services (if any).

(with exceptions for selected special-needs subgroups). In addition, states have the option to provide ABP coverage to other subgroups.

ABPs must cover at least the 10 essential health benefits (EHBs) that also apply to the qualified health plans offered in the exchanges.[29] In addition, ABP coverage must comply with the federal requirements for mental health parity,[30] and special rules also apply with regard to prescription drugs, rehabilitative and habilitative services and devices, and preventive care.

Rules regarding how states must design their Medicaid ABPs to meet the ACA requirements have been established through regulation.[31] As a part of the benefit design process, CMS established a policy whereby states can use benefit substitution as a tool to fill in coverage gaps to ensure that all EHBs are represented and/or to align their benefit plans with traditional Medicaid state plan coverage and/or with exchange coverage.[32] This substitution policy has the potential to make Medicaid ABP benefit coverage look very different than the benchmark and benchmark-equivalent benefit coverage that existed prior to ABPs.

Medicaid Benefits by Eligibility Classification

Table 1 provides examples of Medicaid benefits available by selected eligibility classifications. As illustrated, different Medicaid subpopulations may have access to quite varied benefit packages.

Table 1. Examples of Medicaid Benefits, by Eligibility Classification

	Eligibility Classification			
Type of Benefit	**Traditional Medicaid Populations[a]**	**Medically Needy**	**Section 1115 Waivers**	**Non-Elderly, Non-Pregnant Adults**
Mandatory	-Inpatient hospital -Nursing facility care (age 21+) -EPSDT (< age 21)	-Prenatal and delivery services -Ambulatory services (< age 18; individuals entitled to institutional care)	-Negotiated between the states and the Secretary of HHS	-ABPs

[29] The 10 essential health benefits required under the ACA include (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services (including behavioral health treatment), (6) prescribed drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.

[30] Health insurance coverage for mental illness had historically been less generous than that for other physical illnesses. Mental health parity is a response to this disparity in insurance coverage, and generally refers to the concept that health insurance coverage for mental health services should be offered on par with covered medical and surgical benefits. For more information about mental health parity, see CRS Report R41249, *Mental Health Parity and the Patient Protection and Affordable Care Act of 2010*, by Amanda K. Sarata.

[31] Centers for Medicare and Medicaid Services (CMS), "Medicaid and Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment," Final Rule, 78 *Federal Register*, July 15, 2013.

[32] For a discussion of the substitution process, see CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*, by Kirsten J. Colello.

	Eligibility Classification			
	-Physicians -Federally qualified health centers -Family planning -Pregnancy-related services	-Home health for those entitled to nursing facility care		
Optional	-Clinic services -Prescribed drugs -Physical, occupational, and speech therapy -Other practitioners -Dental	-Nursing facility care -Clinic services -Physical, occupational, and speech therapy -Other practitioners -Dental	-Negotiated between the states and Secretary of HHS	-For special needs subgroups, option to have same benefits as categorically needy or enroll in an ABP
Traditional Benefits Versus ABPs	Traditional Benefits	Traditional Benefits	Not applicable	ABPs with exceptions

Sources: Title XIX of the Social Security Act and related federal guidance.

Note: With respect to medically needy groups, broader requirements apply if a state has chosen to provide coverage for medically needy individuals in intermediate care facilities for the mentally retarded or in institutions for mental diseases. In these cases, states are required to cover the same services as those which are mandatory for the categorically needy, or alternatively, the care and services described in 7 of the first 24 paragraphs in the federal Medicaid statute defining covered mandatory and optional services.

ABP—Alternative Benefit Plans

EPSDT—Early and Periodic Screening, Diagnostic and Treatment services

HHS—Health & Human Services

a. Traditional Medicaid populations include the elderly, individuals with disabilities, children, and pregnant women.

Service Delivery Models

Benefits are made available to Medicaid enrollees via two alternative service delivery systems: fee-for-service or managed care. Under the "fee for service" (FFS) delivery system, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under the "managed care" delivery system, Medicaid enrollees get most or all of their services from an organization under contract with the state. States have traditionally used the fee-for-service service delivery model for Medicaid, but since the 1990s, the share of Medicaid enrollees covered by the managed care model has increased dramatically. As of July 2011, more than 74% of Medicaid enrollees were covered by some form of managed care.[33]

There are three types of Medicaid managed care:

- **Managed care organizations (MCOs)**—states contract with MCOs to provide a comprehensive package of benefits to certain Medicaid enrollees. States usually

[33] Centers for Medicare & Medicaid Services, *Medicaid Managed Care Enrollment Report*, November 2012.

pay the MCOs on a capitated basis, which means the states prospectively pay the MCOs a fixed monthly rate per enrollee to provide or arrange for most health care services.

- **Primary care case management (PCCM)—**states contract with primary care providers to provide case management services to Medicaid enrollees. Typically, under PCCM, the primary care provider receives a monthly case management fee per enrollee for coordination of care, but the provider continues to receive FFS payments for the medical care services utilized by Medicaid enrollees.
- **Limited benefit plans**—these plans look like MCOs in that states usually contract with a plan and pay them on a capitated basis. The difference is that limited benefit plans provide only one or two Medicaid benefits (i.e., behavioral health or dental services).

While managed care has largely been used for Medicaid subgroups that do not have chronic health care needs, some states are turning to this type of service delivery system for the elderly and individuals with disabilities.

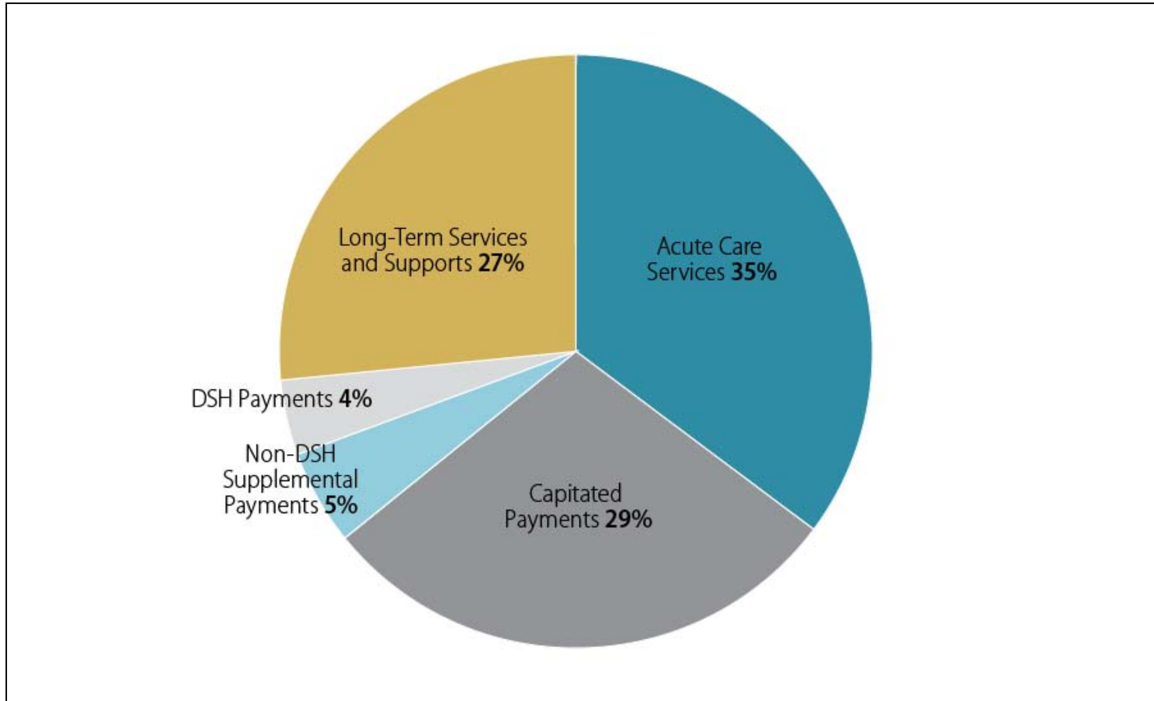
Medicaid Service Spending

Figure 3 below shows the nationwide distribution of Medicaid expenditures across broad categories of service for FY2012. These data illustrate that roughly one-third of benefit spending is for acute care services, while capitated payments under managed care arrangements account for another third, and LTSS represent slightly more than one-fourth of Medicaid benefit payments. In general, when other sources of insurance/payment are available (including Medicare), Medicaid wraps around that coverage.[34]

[34] For related details, see Federal regulations at 42 CFR 433.135, 433.138, and 433.152.

Figure 3. Medicaid Medical Assistance Payments, by Category

FY2012



Source: Centers for Medicare & Medicaid Services, CMS-64 Data (base expenditures), FY2012.

Notes: Medical assistance expenditures exclude Medicaid expenditures for administrative activities. DSH stands for "disproportionate share hospital" payments, which are provided in addition to Medicaid payments otherwise received by certain qualifying hospitals.

Beneficiary Cost-Sharing

Federal statutes and regulations address the circumstances under which enrollees may share in the costs of Medicaid, both in terms of participation-related cost-sharing (e.g., monthly premiums) and point-of-service cost-sharing (e.g., copayments to providers). States can require certain beneficiaries to share in the cost of Medicaid services, but there are limits on (1) the amounts that states can impose, (2) the beneficiary groups that can be required to pay, and (3) the services for which cost-sharing can be charged.

In general, premiums and enrollment fees are often prohibited. However, premiums may be imposed on enrollees with incomes above 150% of FPL. In state fiscal year (SFY) 2013, 39 states had at least one group able to participate in Medicaid by paying a premium, with a total of 59 different premium programs.[35]

States can impose cost sharing, such as copayments, coinsurance, deductibles, and other similar charges, on most Medicaid-covered benefits, both inpatient and outpatient services, but cost

[35] Vernon K. Smith, Robin Rudowitz, and Laura Snyder, *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014*, Kaiser Commission on Medicaid and the Uninsured, October 2013

sharing cannot be imposed for emergency services and family planning services and supplies. Some subgroups of beneficiaries are exempt from cost sharing (e.g., children under 18 years of age and pregnant women). The cost-sharing amounts that can be charged vary with income. In SFY2013, 46 states (including the District of Columbia) reported having copayment requirements.[36]

Higher beneficiary cost-sharing is allowed in certain circumstances, and recent ACA regulations modified some of these provisions.[37] For example, for non-emergency care in a hospital emergency department, a maximum $8 payment can be charged to individuals with family income at or below 150% of FPL,[38] and there is no specified limit for individuals with income above 150% of FPL when alternative providers are available.

The aggregate cap on all out-of-pocket cost-sharing is generally up to 5% of monthly or quarterly income.[39]

Financing[40]

The federal government and the states jointly finance Medicaid. The federal government reimburses states for a portion (i.e., the federal share) of each state's Medicaid program costs. Because federal Medicaid funding is an open-ended entitlement to states, there is no upper limit or cap on the amount of federal Medicaid funds a state may receive. In FY2012, Medicaid expenditures totaled $431 billion. The federal share totaled $249 billion and the state share was $182 billion.[41]

Federal Share

The federal government's share of most Medicaid expenditures is established by the federal medical assistance percentage (FMAP) rate, which is generally determined annually and varies by state according to each state's per capita income relative to the U.S. per capita income.[42] The formula provides higher FMAP rates, or federal reimbursement rates, to states with lower per capita incomes and lower FMAP rates to states with higher per capita incomes.

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[36] Vernon K. Smith, Robin Rudowitz, and Laura Snyder, *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014*, Kaiser Commission on Medicaid and the Uninsured, October 2013

[37] Department of Health and Human Services, Centers for Medicare and Medicaid Services, Essential Health Benefits in Alternative Benefit Packages, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges; Eligibility and Enrollment; Final rule, *Federal Register*, Vol. 78, No. 135, July 15, 2013.

[38] Beginning October 1, 2015, such cost-sharing must be increased by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher 5-cent increment.

[39] Section 1916A of the Social Security Act.

[40] For more information about Medicaid financing and expenditures, see CRS Report R42640, *Medicaid Financing and Expenditures*, by Alison Mitchell.

[41] Centers for Medicare & Medicaid Services, CMS-64 data.

[42] For more detail about the FMAP rate, see CRS Report R42941, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2014*, by Alison Mitchell and Evelyne P. Baumrucker.

FMAP rates have a statutory minimum of 50.00% and a statutory maximum of 83.00%.[43] In FY2014, 15 states have the statutory minimum FMAP rate of 50.00% (Rhode Island is slightly above at 50.11%), and Mississippi has the highest FMAP rate of 73.05% (see **Table B-1** for each state's FY2014 FMAP rate).

The FMAP rate is used to reimburse states for the federal share of most Medicaid expenditures, but exceptions to the regular FMAP rate have been made for certain states (e.g., the District of Columbia and the territories), situations (e.g., during economic downturns), populations (e.g., certain women with breast or cervical cancer and individuals in the Qualifying Individuals[44] program), providers (e.g., primary care physicians and Indian Health Service facilities), and services (e.g., family planning and home health services). In addition, the federal share for most Medicaid administrative costs does not vary by state and is generally 50%.

The ACA includes new FMAP exemptions, including the "newly eligible" FMAP rates and the "expansion state" FMAP rates. Under the "newly eligible" FMAP rate, from 2014 through 2016, states receive a 100% FMAP rate for the cost of individuals who are "newly eligible" for Medicaid due to the ACA expansion. This "newly eligible" FMAP rate phases down to 95% in 2017, 94% in 2018, 93% in 2019, and 90% thereafter.[45] The "expansion state" FMAP rate is available for individuals in "expansion states" who were eligible for Medicaid on March 23, 2010, and are in the new eligibility group for nonelderly, nonpregnant adults at or below 133% FPL. The formula[46] used to calculate the "expansion state" FMAP rates is based on a state's regular FMAP rate, so the "expansion state" FMAP rates will vary from state to state until 2019, at which point the "newly eligible" FMAP and the "expansion state" FMAP rates will converge to 93%.

Table 2. FMAP Rates for ACA Medicaid Expansion

	2014	2015	2016	2017	2018	2019	2020+
"Newly eligible" Adults in all States	100%	100%	100%	95%	94%	93%	90%
Certain Individuals in "Expansion states"	75%-92%	80%-93%	85%-95%	86%-93%	90%-93%	93%	90%

Source: Prepared by CRS.

Notes: For the calculation of the "expansion state" FMAP rates, the lower bound is a state with a regular FMAP rate of 50% (which is the statutory minimum), and the upper bound is a state with a regular FMAP rate of 83% (which is the statutory maximum).

[43] Section 1905(b) of the Social Security Act.

[44] States are required to pay Medicare Part B premiums for Medicare beneficiaries with income between 120% and 135% FPL and limited assets (referred to as "qualifying individuals"), up to a specified dollar allotment.

[45] The "newly eligible" FMAP rates are available for these specific years, regardless of whether a state implements the ACA Medicaid expansion in 2014 or a later year.

[46] Expansion state FMAP formula = [regular FMAP + (newly eligible FMAP – regular FMAP) * transition percentage equal to 50% in CY2014, 60% in CY2015, 70% in CY2016, 80% in CY2017, 90% in CY2018, and 100% in CY2019+].

While most federal Medicaid funding is provided on an open-ended basis, certain types of federal Medicaid funding are capped. For instance, federal disproportionate share hospital (DSH)[47] funding to states cannot exceed a state-specific annual allotment. Also, Medicaid programs in the territories (i.e., American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the Virgin Islands) are subject to annual spending caps.

State Share

The federal government provides broad guidelines to states regarding allowable funding sources for the state share (also referred to as the non-federal share) of Medicaid expenditures. However, to a large extent, states are free to determine how to fund their share of Medicaid expenditures. As a result, there is significant variation from state to state in funding sources.

States can use state general funds (i.e., personal income, sales, and corporate income taxes) and "other state funds" (i.e., provider taxes,[48] local government funds, tobacco settlement funds, etc.) to finance the state share of Medicaid.[49] Federal statute[50] allows as much as 60% of the state share to come from local government funding.[51] Federal regulations also stipulate that the state share not be funded with federal funds (Medicaid or otherwise).[52] In SFY2011, on average, 72% of the state share of Medicaid expenditures was financed by state general funds, and the remaining 28% was financed by "other state funds."[53]

A few funding sources have received a great deal of attention over the past couple of decades because states have used these funds in some financing mechanisms designed to maximize the amount of federal Medicaid funds coming to the state. This is referred to as "Medicaid maximization."[54] In general, some states have used "Medicaid maximization" strategies that

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[47] For more information about Medicaid DSH payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*, by Alison Mitchell.

[48] States are able to use revenues from health care provider taxes to help finance their share of Medicaid expenditures as long as the provider tax is broad-based and uniform. Also, states are not allowed to hold the providers harmless for the cost of the provider tax (i.e., they cannot guarantee that providers receive their money back). In addition, provider tax revenue is prohibited from exceeding 25% of the state share of Medicaid expenditures. For more information about provider taxes, see CRS Report RS22843, *Medicaid Provider Taxes*, by Alison Mitchell.

[49] National Association of State Budget Officers, *State Expenditure Report: Examining Fiscal 2011-2013 State Spending*, 2013.

[50] Section 1902(a)(2) of the Social Security Act.

[51] The federal statute allows for the significant use of local funds in financing Medicaid because local governments financed a significant amount of the health care services provided to low-income individuals prior to the enactment of Medicaid. (Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP*, March 2012.)

[52] 42 C.F.R. 433.51(c).

[53] National Association of State Budget Officers, *State Expenditure Report: Examining Fiscal 2011-2013 State Spending*, 2013.

[54] National Health Policy Forum at The George Washington University, *The Basics: Medicaid Financing*, February 4, 2011; U.S. Government Accountability Office, *Medicaid Financing: Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight*, testimony of Marjorie Kanof before U.S. Congress, House of Representatives, Committee on Oversight and Government Reform, GAO-08-255T, November 1, 2007; Andy Schneider and David Rousseau, *The Medicaid Resource Book*, The Kaiser Commission on Medicaid and the Uninsured, Publication Number 2236, January 17, 2003; Teresa A. Coughlin and Stephen Zuckerman, *States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences*, The Urban Institute, June 2002.

involve the coordination of fund sources, such as provider taxes and intergovernmental transfers (IGTs),[55] and payment policies, such as DSH and other supplemental payments[56] to draw down federal Medicaid funds without expending many, if any, state general funds.

Expenditures

The cost of Medicaid, like most health expenditures, has generally increased at a rate significantly faster than the overall rate of U.S. economic growth, as measured by Gross Domestic Product (GDP).[57] In the past, much of Medicaid's expenditure growth has been due to federal or state expansions of Medicaid eligibility criteria,[58] but per-enrollee costs for Medicaid have also increased faster than the economy. However, when compared to other forms of health insurance, Medicaid per-enrollee expenditures are relatively low.

One of the major factors impacting Medicaid spending is the economy.[59] Also, state-specific factors, such as policy decisions and demographics, impact Medicaid expenditures and cause Medicaid spending to vary widely from state to state. In 2011 and 2012, Medicaid experienced unusually slow rates of growth, which is the result of improved economic conditions and state efforts to limit the growth of Medicaid expenditures due to the expiration of the temporary increase of the FMAP rate.[60,61]

Figure 4 shows actual Medicaid expenditures from FY1997 to FY2011 and projected Medicaid expenditures from FY2012 through FY2021 (see **Table B-1** for state-by-state expenditures for FY2012). These expenditures are broken down by state and federal expenditures. In FY2012, Medicaid spending on services and administrative activities in the 50 states, the District of Columbia, and the territories totaled $431 billion. Medicaid expenditures are estimated to grow to $795 billion in FY2021.[62]

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[55] IGTs are transfers of public funds between government entities, such as from counties to states or between state agencies. This financing mechanism is commonly used to enable states and local governments to carry out shared functions.

[56] Supplemental payments are Medicaid payments made to providers that are separate from and in addition to the standard payment rates for services rendered to Medicaid enrollees. Often, providers receive supplemental payments in a lump sum.

[57] Christopher J. Truffer, John D. Klemm, and Christian J. Wolfe, et al., 2012 Actuarial Report on the Financial Outlook for Medicaid, Centers for Medicare & Medicaid Services' Office of the Actuary, 2013.

[58] Rachel Garfield, Lisa Clemans-Cope, and Emily Lawton, et al., *Enrollment-Driven Expenditure Growth: Medicaid Spending during the Economic Downturn, FFY2007-2010*, Kaiser Commission on Medicaid and the Uninsured, Publication #8309, May 2012.

[59] Christopher J. Truffer, John D. Klemm, and Christian J. Wolfe, et al., 2012 Actuarial Report on the Financial Outlook for Medicaid, Centers for Medicare & Medicaid Services' Office of the Actuary, 2013.

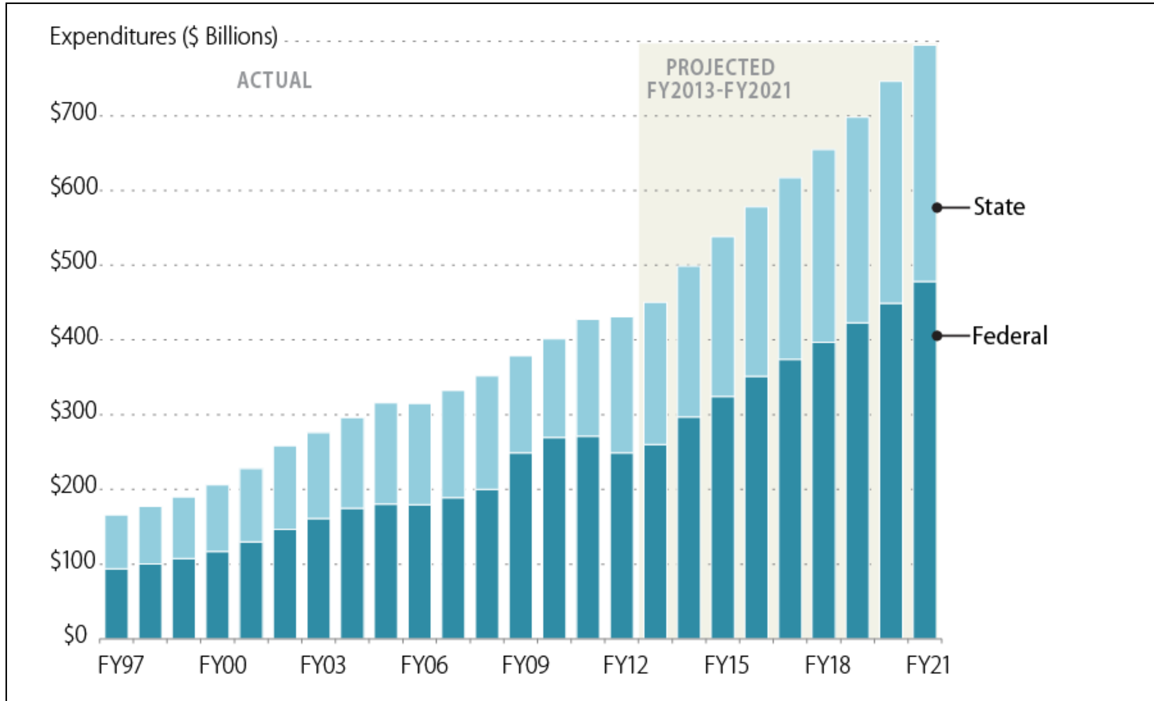
[60] For FY2009 through FY2011, the federal share of Medicaid expenditures was higher than usual due to the temporary FMAP increase provided to states from October 1, 2008, through June 30, 2011. The temporary FMAP increase was originally provided through the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) and extended through P.L. 111-226.

[61] Christopher J. Truffer, John D. Klemm, and Christian J. Wolfe, et al., 2012 Actuarial Report on the Financial Outlook for Medicaid, Centers for Medicare & Medicaid Services' Office of the Actuary, 2013; Anne B. Martin, Micah Hartman, and Lekha Whittle, "National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year," *Health Affairs*, vol. 33, no. 1 (January 2014).

[62] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Form CMS-64 data, April 16, 2012; Christopher J. Truffer, John D. Klemm, and Christian J. Wolfe, et al., *2012 Actuarial Report on the Financial Outlook for Medicaid*, Centers for Medicare & Medicaid Services' Office of the Actuary, 2013.

Figure 4. Federal and State Actual and Projected Medicaid Expenditures

(FY1997 to FY2021; dollars in billions)



Source: Actual expenditures are from Form CMS-64 Data, and the projected expenditures are from the CMS Office of the Actuary's *2012 Actuary Report on the Financial Outlook for Medicaid*.

Notes: The expenditures shown in this figure include all Medicaid expenditures, which include both administrative and benefit spending.

Historically, in a typical year, the average federal share of Medicaid expenditures has been about 57%, which means the average state share is about 43%. However, the federal government's share of Medicaid expenditures is expected to increase with the implementation of the ACA Medicaid expansion because the federal government is funding a vast majority of the cost of the expansion through the "newly eligible" and the "expansion state" FMAP rates. By FY2020, the average federal share of Medicaid is estimated to be 60%.[63]

Provider Payments

For the most part, states establish their own payment rates for Medicaid providers. Federal statute requires that these rates be sufficient to enlist enough providers so that covered benefits will be available to Medicaid enrollees at least to the same extent they are available to the general population in the same geographic area.[64]

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[63] Congressional Budget Office, *An Overview of the Medicaid Program*, September 18, 2013; Christopher J. Truffer, John D. Klemm, and Christian J. Wolfe, et al., *2012 Actuarial Report on the Financial Outlook for Medicaid*, Centers for Medicare & Medicaid Services' Office of the Actuary, 2013.

[64] Section 1902(a)(30)(A) of the Social Security Act.

Low Medicaid physician payment rates in many states and their impact on provider participation have been perennial concerns for policy makers. Still, in recent years, under recessionary budget pressures, many states have reduced Medicaid provider payment rates. Improvements to state finances for SFY2013 resulted in more states enhancing rather than restricting provider rates for the first time since SFY2009.[65]

The ACA requires that Medicaid payment rates for certain primary care services be raised to what Medicare pays for these services for CY2013 and CY2014. The federal government is picking up the entire cost of that increase in primary care rates (i.e., the difference between Medicare payment rates and the existing Medicaid payment rates as of July 1, 2009) for those two years.

In some cases, states make supplemental payments to Medicaid providers that are separate from and in addition to, the standard payment rates for services rendered to Medicaid enrollees. Often, providers receive supplemental payments in a lump sum. States are permitted to make supplemental payments to providers, but federal regulations specify upper payment limit (UPLs), which prohibit using federal matching funds for Medicaid fee-for-service payments in excess of what would have been paid under Medicare payment principles.[66] The institutions subject to the UPL requirement are hospitals (separated into inpatient services and outpatient services), nursing facilities, intermediate care facilities for the intellectually disabled, and freestanding non-hospital clinics.

Medicaid DSH payments are one type of supplemental payment, and federal statute requires that states make Medicaid DSH payments to hospitals treating large numbers of low-income patients. In FY2012, federal DSH allotments totaled $11.4 billion.[67] The ACA makes aggregate reductions in Medicaid DSH allotments for FY2014 through FY2020. The Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96) and the American Taxpayer Relief Act of 2012 (P.L. 112-240) extended these DSH reductions to FY2021 and FY2022. In FY2023, DSH allotments are scheduled to rebound to the pre-ACA reduced levels.

Medicaid Program Waivers

The Social Security Act authorizes several waiver and demonstration authorities to provide states with the flexibility to operate their Medicaid programs. Each waiver authority has a distinct

[65] Vernon K. Smith, Robin Rudowitz, and Laura Snyder, *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014*, Kaiser Commission on Medicaid and the Uninsured, October 2013; Vernon K. Smith, Robin Rudowitz, and Laura Snyder, *Medicaid Today; Preparing for Tomorrow A Look at Medicaid Spending, Enrollment and Policy Trends: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013*, Kaiser Commission on Medicaid and the Uninsured, October 2012; and Vernon K. Smith, Robin Rudowitz, and Laura Snyder, *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012*, Kaiser Commission on Medicaid and the Uninsured, October 2011.

[66] In practice, the UPL rules simply ensure that Medicaid does not pay a class of providers in the aggregate more than Medicare would have paid for the same or comparable services delivered by those same institutions. (Medicaid and CHIP Payment and Access Commission, *Medicaid UPL Supplemental Payments*, November 2012.)

[67] DSH allotments are different from DSH payments. Allotments reflect the maximum amount of federal DSH funding available to states, and DSH payments are the amounts paid to hospitals. Each state receives an annual DSH allotment, which is the maximum amount of federal matching funds that each state is permitted to claim for Medicaid DSH payments. For more information about Medicaid DSH payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*, by Alison Mitchell.

purpose and specific requirements. Under the various waiver authorities, states may try new or different approaches to the delivery of health care services or adapt their programs to the special needs of particular geographic areas or groups of Medicaid enrollees. The primary Medicaid waiver authorities include:

- **Section 1115 Research and Demonstration Projects**—Under Section 1115 of the Social Security Act, the Secretary of HHS may waive Medicaid requirements contained in Section 1902 (including, but not limited to, what is known as "freedom of choice" of provider, "comparability" of services, and "statewideness"). States use this waiver authority to change eligibility criteria in order to offer coverage to new groups of people, to provide services that are not otherwise covered, to offer different service packages or a combination of services in different parts of the state, to cap program enrollment, and to implement innovative service delivery systems, among other purposes.
- **Section 1915(b) Managed Care/Freedom of Choice Waivers**—Section 1915(b) of the Social Security Act permits states to establish mandatory managed care programs or otherwise limit enrollees' choice of providers.[68]
- **Section 1915(c) Home- and Community-Based Services Waivers (HCBS)**—Section 1915(c) authorizes the Secretary of HHS to waive certain requirements of Medicaid law allowing states to cover a broad range of HCBS (including services not available under the Medicaid state plan) for certain persons with long-term care needs. Specifically, under Section 1915(c) states can waive rules regarding "statewideness" and "comparability" of services. States may also apply certain income counting rules to persons in HCBS waivers that allow an individual to be eligible for Medicaid who might not otherwise qualify.
- **Section 1915(b) and (c) Waivers**—Section 1915(b) and (c) waivers allow states to provide HCBS to disabled and elderly populations in a managed care setting or within a limited pool of providers. States must apply for each waiver authority concurrently and comply with the individual requirements of each waiver.

States often operate multiple waiver programs with their state plan. Key characteristics of these primary Medicaid waiver authorities compared to state plan requirements are summarized in **Table 2**. The statutory requirements that may be waived under each type of waiver are different, but all types of waivers are time limited and approvals are subject to reporting and evaluation requirements. In addition, all types of waivers must comply with various financing requirements (i.e., budget neutrality,[69] cost-effectiveness,[70] or cost-neutrality).[71]

[68] There are four types of authorities under Section 1915(b) that states may request: (b)(1) allows states to require Medicaid beneficiaries to enroll in managed care; (b)(2) allows states to designate a "central broker" to assist Medicaid beneficiaries in choosing among competing health care plans; (b)(3) allows states to use cost savings made possible through the recipients' use of more cost-effective medical care to provide additional services; and (b)(4) allows states to limit the beneficiaries' choice of providers (except in emergency situations, for recipients residing in a long term care facility, and with respect to family planning services).

[69] Budget neutrality means that the estimated spending under the waiver cannot exceed the estimated cost of the state's Medicaid program without the waiver.

[70] Cost effectiveness means the cost of payments under managed care cannot exceed the cost of fee-for-service absent the waiver.

[71] Under the cost-neutrality test, expenditures under the waiver may not exceed the cost of institutional care that would have been provided to waiver recipients absent the waiver.

Table 3. Key Characteristics of the Primary Medicaid Waiver Authorities Compared to State Plan Requirements

Key Characteristic	Sec. 1115 Research and Demonstration Waivers[a]	Sec. 1915(b) Managed Care/Freedom of Choice Waivers	Sec. 1915(c) Home and Community Based Services (HCBS) Waivers	Sec. 1915(b)/(c) Concurrent Waivers	Medicaid State Plan
Number of Waivers[b]	73 waivers (in 41 states and DC)	22 waivers (in 18 states)	321 waivers (in 47 states and the District of Columbia)	2 waivers (in 2 states)	N/A
Statutory requirements that may be waived					
"Statewideness"[c]	X	X	X	X	N/A
"Comparability" of Services[d]	X	X	X	X	N/A
"Freedom of Choice" of Provider[e]	X	X		X	N/A
Income and Resource Rules[f]			X	X	N/A
Federal Matching Funds for Costs Not Otherwise Matchable	X	X	X	X	N/A
Evaluations	X	X	X	X	N/A
Duration	5 year initial, renewed for up to 3-year intervals	2 year initial, renewed for up to 2-year intervals	3 year initial, renewed for up to 5-year intervals	Must prepare separate renewal requests	Once approved duration indefinite
Financing	Budget neutral over the life of the program	Must meet cost-effectiveness test	Must meet cost-neutrality test	Must meet cost-effectiveness neutrality and cost-effectiveness tests	Open-ended mandatory entitlement
Enrollment caps and waiting lists	X		X	X	Individual entitlement

Source: Prepared by CRS based in program rules and regulations.

a. The number of Section 1115 waivers includes only those under the oversight of CMS's Children and Adults Health Programs Group. This count includes standalone family planning waivers.

b. Data for number of waivers from lists of operational waivers posted on the CMS website as of 12/4/13.

c. Waiving the "statewideness" requirement (as permitted under Section 1902[a][1] of the Social Security Act) allows states to target waivers to particular areas of the state where the need is greatest, or where certain types of providers are available, for example.

d. Waiving "comparability" of services (Section 1902[a][10][B] of the Social Security Act) allows states to target waiver services to particular groups of individuals or to target services on the basis of disease or condition.

e. Waiving the "freedom of choice" requirement (Section 1902[a][23] of the Social Security Act) allows states to implement managed care delivery systems or otherwise limit choice of provider.

f. Institutional deeming rules (Section 1902[a][10][C][i][II]) of the Social Security Act) means that income and resources are not deemed to the recipient from a spouse or parent. This allows states to cover medically needy individuals under home and community-based service waivers who would not be eligible for waiver services under the community rules, but would be eligible under institutional rules.

Program Integrity

Program integrity initiatives are designed to combat fraud, waste, and abuse in the Medicaid program. Some oversight efforts focus on preventing fraud and abuse through effective program management, while others focus on addressing problems after they occur through investigations, recoveries, and enforcement activities. Areas such as eligibility determination have multiple program integrity initiatives, while other areas, such as managed care, receive comparatively little attention.[72]

Multiple agencies at the federal and state levels are involved in program integrity. The federal agencies are CMS, the Office of the Inspector General for the Department of HHS, the Department of Justice, and the Government Accountability Office. The state agencies involved with program integrity activities include the state Medicaid agencies and the federally required Medicaid Fraud Control Units (MFCUs). Coordination of Medicaid program integrity activities can be a problem because there are so many agencies working on program integrity initiatives and each state develops its own approach to program integrity.

The federal government and states contribute equally to fund most Medicaid activities to combat waste, fraud, and abuse, although for some activities, the federal government provides additional funds through enhanced FMAP rates. As mentioned earlier, all states receive the same FMAP rate for administrative expenditures, including most program integrity activities, which is generally 50%. States receive higher FMAP rates for selected administrative activities such as 90% for the startup of MFCUs and 75% for ongoing MFCU operation.

The ACA included some provisions to increase uniformity among Medicare, Medicaid, and CHIP program integrity activities. For instance, the ACA introduced additional provider screening requirements that are applicable to Medicare, Medicaid, and CHIP. The ACA also created an integrated Medicare and Medicaid data repository to enhance program integrity data sharing to be available to federal and state agencies and law enforcement officials. Moreover, the ACA established a recovery audit contractor (RAC) requirement for Medicaid, under which state Medicaid agencies contract with a RAC to identify and recover overpayments and identify underpayments.

Beyond the ACA requirements, states report implementing a number of new and enhanced Medicaid program integrity activities in SFY2013. For example, 26 states reported implementing or enhancing analytical technologies used to prevent improper payments, 11 states implemented or expanded an enhanced provider screening initiatives, 14 states reported new or enhanced

[72] Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2013.

public/private data sharing initiatives, and 18 states reported a wide range of other program integrity efforts or initiatives.[73]

Selected Issues

Currently, the Medicaid program is dealing with several major issues, which mostly stem from the implementation of the ACA. First, the ACA Medicaid expansion began on January 1, 2014. Since the expansion is optional for states, some are implementing the expansion, some states are still deciding, and other states have chosen not to implement the expansion. Second, the coordination of care for dual-eligible beneficiaries is a focus of federal and state policy makers. Also, a new ACA health insurance annual fee may increase Medicaid expenditures through higher Medicaid MCO rates. Finally, the ACA included a Medicaid MOE provision, which expired on January 1, 2014, for adults but continues until 2019 for children.

ACA Medicaid Expansion

The primary goal of the ACA is to increase access to affordable health insurance for the uninsured and to make health insurance more affordable for individuals who already have such coverage. The ACA Medicaid expansion is one of the major insurance coverage provisions included in the law.

As enacted, beginning in 2014, the ACA Medicaid expansion created a new mandatory Medicaid eligibility group: all adults under age 65 with income up to 133% of FPL (effectively 138% FPL) (see "Eligibility" for more information). The ACA requires most of the individuals covered under the ACA Medicaid expansion to receive ABP coverage (see "Benefits" for more information), and the law provides enhanced federal matching rates for coverage of this new eligibility group (see "Federal Share" for more information).

The ACA provided states with the option to implement the ACA Medicaid expansion earlier than 2014. Between April 1, 2010, and January 1, 2014, states had the option to expand Medicaid to individuals up to 133% of FPL, so long as the state did not extend coverage to (1) individuals with higher income before those with lower incomes or (2) parents unless their children are enrolled in the state plan, a waiver, or in other health coverage. Eight states[74] and the District of Columbia elected to implement the ACA Medicaid expansion early.

Originally, it was assumed that all states would implement the ACA Medicaid expansion in 2014 as required by statute because implementation was required in order for states to receive any federal Medicaid funding. However, on June 28, 2012, the United States Supreme Court issued its decision in *National Federation of Independent Business (NFIB) v. Sebelius*[75] finding that the

[73] Vernon K. Smith, Robin Rudowitz, and Laura Snyder, *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014*, Kaiser Commission on Medicaid and the Uninsured, October 2013.

[74] The eight states that implemented the ACA Medicaid expansion early were California, Colorado, Connecticut, Illinois, Minnesota, New Jersey, Ohio, and Washington.

[75] 132 S. Ct. 2566 (2012).

federal government cannot terminate the federal Medicaid funding a state receives for its current Medicaid program if a state refuses to implement the ACA Medicaid expansion.[76]

State Decisions

Since the federal government cannot terminate current Medicaid federal matching funds if a state refuses to implement the Medicaid expansion required by the ACA, the Supreme Court's ruling in *NFIB* effectively made state participation in the ACA Medicaid expansion voluntary. However, if a state accepts the ACA Medicaid expansion funds, it must abide by the new expansion coverage rules.

CMS informed states that they face no deadline for deciding whether to implement the ACA Medicaid expansion, and according to CMS, states can also discontinue the expansion at any time.[77] If states want to take full advantage of the 100% federal financing for the "newly eligible" enrollees, however, they need to implement the expansion on January 1, 2014. The statute explicitly provides the 100% federal funding for the "newly eligible" enrollees for 2014, 2015, and 2016, rather than for the first three years a state implements the expansion.

As of December 19, 2013, 24 states and the District of Columbia were planning to implement the ACA Medicaid expansion on January 1, 2014, and Michigan is planning to implement the expansion on April 1, 2014.[78] Among the remaining states, 5 are still considering the expansion, and 21 states are not implementing the expansion at this time.[79] **Figure 5** shows state decisions about implementing the ACA Medicaid expansion.

[76] For a discussion of the Supreme Court's decision on the Medicaid expansion, see CRS Report R42367, *Medicaid and Federal Grant Conditions After NFIB v. Sebelius: Constitutional Issues and Analysis*, by Kenneth R. Thomas.

[77] Centers for Medicare & Medicaid Services, *Frequently Asked Questions on the Exchanges, Market Reforms and Medicaid*, December 10, 2012.

[78] The Medicaid expansion for Iowa and Michigan is subject to CMS approval of those states' 1115 Waiver applications. (CMS, *State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014,* October 24, 2013.)

[79] States' decisions are based on CRS's monitoring of state activity through media outlets and state tracking of decisions done by CMS, State Refor(u)m, the Kaiser Family Foundation, the Advisory Board Company, and Avalere.

Figure 5. State Decisions Whether to Implement the ACA Medicaid Expansion

As of December 19, 2013

Source: States' decisions are based on CRS's monitoring of state activity through media outlets and state tracking of decisions done by CMS, State Refor(u)m, the Kaiser Family Foundation, the Advisory Board Company, and Avalere.

Notes: All states (except Michigan) are supposed to implement the ACA Medicaid expansion on January 1, 2014. Michigan is planning to implement the expansion on April 1, 2014.

While there are some exceptions, most of the states implementing the ACA Medicaid expansion tend to have low rates of uninsured individuals (relative to the national average) and traditionally have provided Medicaid coverage to more nondisabled adults through relatively higher Medicaid income eligibility levels. Also, in general, the states *not* implementing the ACA Medicaid expansion have relatively higher rates of uninsured and traditionally have covered fewer nondisabled adults under Medicaid.[80]

Premium Assistance Model

Most states implementing the ACA Medicaid expansion are doing so through an expansion of their current Medicaid program. However, some states are using a premium assistance model for their ACA Medicaid expansion, which means Medicaid funding is used to purchase health

[80] U.S. Census Bureau, American Community Survey, 2012; Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP*, March 2013.

insurance coverage for the ACA Medicaid expansion population through qualified health plans[81] in the exchanges.

HHS approved Arkansas's waiver to use a premium assistance model for its ACA Medicaid expansion on September 27, 2013, and Iowa's waiver was approved December 10, 2013. Other states (including Florida, Ohio, Pennsylvania, and Tennessee) have expressed interest in the premium assistance model for the ACA Medicaid expansion.[82]

States *Not* Expanding

States have chosen *not* to implement the ACA Medicaid expansion for various reasons, including not wanting to expand Medicaid because they view the expansion as unaffordable to the state and the Medicaid program as "broken."[83] State decisions *not* to implement the ACA Medicaid expansion could have implications for low-income individuals, large employers with low wage workers, and hospitals.

Low-Income Individuals

Even if a state does *not* implement the ACA Medicaid expansion, some of the individuals that would have been covered by the Medicaid expansion may still gain health insurance coverage under the ACA health insurance coverage provisions. The ACA provides premium tax credits and cost-sharing subsidies to individuals with household income between 100% and 400% of FPL who do not have access to minimum essential coverage.[84] As a result, most uninsured individuals with incomes between 100% and 133% of FPL living in states that decide *not* to implement the ACA Medicaid expansion may become eligible for premium tax credits and cost-sharing subsidies to purchase insurance through the health insurance exchanges. However, most uninsured individuals with incomes under 100% of FPL living in states that decide *not* to implement the ACA Medicaid expansion will likely remain uninsured because these individuals are *not* eligible for premium tax credits or the cost sharing subsidies to purchase health insurance through the exchanges.

Regardless of whether a state decides to implement the ACA Medicaid expansion or not, all states are expected to experience an increase in Medicaid enrollment, due to the "woodwork" effect. This is the term for uninsured individuals who without the expansion are eligible for Medicaid deciding to enroll in Medicaid due to increased media attention and outreach efforts associated

[81] In general, exchanges offer comprehensive coverage that meets the standards to be certified as "qualified health plans" (QHPs), provided it meets requirements related to marketing, choice of providers, plan networks, and other features, or is recognized by each exchange through which such plan is offered. In addition, all QHPs are required to comply with benefit, cost-sharing, and generosity components of the essential health benefits package (described above). In addition to qualified health plans, exchanges also offer multi-state QHPs, child-only QHPs, and CO-OP QHPs.

[82] "Health Policy Brief: Premium Assistance in Medicaid," *Health Affairs*, June 6, 2013.

[83] State Refor(u)m, *Governors Address Medicaid Expansion in "State of the State" Speeches*, March 2013.

[84] The definition of minimum essential coverage is broad. It includes Medicare Part A, Medicaid, the State Children's Health Insurance Program (CHIP), Tricare, the TRICARE for Life program, the veteran's health care program, the Peace Corps program, a government plan (local, state, federal) including the Federal Employees Health Benefits Program (FEHBP) and any plan established by an Indian tribal government, any plan offered in the individual, small group or large group market, a grandfathered health plan, and any other health benefits coverage, such as a state health benefits risk pool, as recognized by the Secretary of HHS in coordination with the Treasury Secretary.

with the ACA. The impact of the woodwork effect depends on the percentage of a state's population that is eligible but not enrolled in Medicaid. Nationally, an estimated 7.3 million to 9.0 million uninsured children and adults were eligible but not enrolled in Medicaid prior to the implementation of the expansion.[85]

Large Employers with Low-Wage Workers

Large employers with low-wage workers in states that do *not* implement the ACA Medicaid expansion might have greater exposure to employer penalties included in the ACA when the penalty goes into effect in 2015.[86] The ACA imposes penalties on "large" employers[87] if at least one of their full-time employees obtains a premium credit through the exchange. Individuals who are not offered employer-sponsored coverage and who are not eligible for Medicaid or other programs may be eligible for premium tax credits for coverage through an exchange. As mentioned above, to receive premium tax credits, individuals must have income of at least 100% and up to 400% of FPL.

In states that do *not* implement the ACA Medicaid expansion, large employers with low income workers could be at greater risk of paying the ACA employer penalty. That is because more low-income workers could qualify for premium tax credits.[88]

Hospitals

Hospitals in states that are *not* expanding Medicaid are concerned because DSH allotments will be reduced by the same across the nation whether or not states implement the expansion. If a state implements the expansion, uncompensated care for hospitals should decline along with the DSH allotments (though not proportionally). However, if a state chooses not to implement the expansion, the demand for uncompensated hospital care is expected to persist but the amount of Medicaid DSH payments hospitals receive to subsidize such care may be reduced.[89] As a result, hospitals have been encouraging states to implement the ACA Medicaid expansion in order to reduce uncompensated care for hospitals. Even though Medicaid provider rates are generally

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[85] Genevieve M. Kenney, Lisa Dubay, Stephen Zuckerman, and Michael Huntress, *Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would not Be Eligible for Medicaid?*, The Urban Institute Health Policy Center, July 5, 2012; Benjamin D. Sommers and Arnold M. Epstein, "Perspective: Why States Are So Miffed about Medicaid - Economics, Politics, and the "Woodwork Effect"," *The New England Journal of Medicine*, vol. 365, no. 2, pp. 100-102 (July 14, 2011).

[86] The employer penalty was supposed to go into effect in 2014, but on July 2, 2013, the Obama Administration announced that it is delaying, until 2015, the enforcement and associated reporting requirements related to the employer penalty. For more information about the delay to the employer penalty, see CRS Report R43150, *Delay in Implementation of Potential Employer Penalties Under ACA*, by Bernadette Fernandez and Annie L. Mach.

[87] A "large employer" is defined in the ACA (as related to the employer penalty) as an employer who employed an average of at least 50 full-time equivalent employees (FTEs) on business days during the preceding calendar year.

[88] For more information about the employer penalty, see CRS Report R41159, *Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA)*, by Julie M. Whittaker.

[89] Toluse Olorunnipa, "Obamacare Cutbacks Shut Hospitals Where Medicaid Went Unexpanded," *Bloomberg Government*, November 25, 2013. Letter from the Republican Governors Public Policy Committee to President Barack Obama dated July 10, 2012, available at http://www.scribd.com/doc/99730375/Medicaid-and-Exchange-Letter-Final. Sarah Kliff, "The super wonky reason states may join the Medicaid expansion," *The Washington Post*, July 8, 2012. Bob Neal, The Fiscal and Economic Impacts of Medicaid Expansion in Mississippi, 2014-2025, Mississippi Public Universities University Research Center, October 2012.

lower than the rates paid by private insurance or Medicare, hospitals are likely better off with payment for a Medicaid patient than no payment for an uninsured patient.

Dual-Eligible Beneficiaries

In FY2010, there were 9.8 million dual-eligible beneficiaries, who are individuals enrolled in both Medicare and Medicaid,[90] which is almost 15% of Medicaid enrollment. Individuals qualify for Medicare because they are either age 65 or older, or under age 65 and have a disability and have been receiving Social Security Disability Insurance for two years.[91] As mentioned previously, individuals qualify for Medicaid because they meet both the categorical (i.e., are a member of a covered group, such as children, pregnant women, families with dependent children, the elderly, or the disabled) and financial eligibility requirements, which vary by state.

Although commonly addressed as a single population, dual-eligible individuals are a diverse population. While dual-eligible beneficiaries tend to be sicker and poorer than the Medicaid population as a whole, not all dual-eligible beneficiaries are in poor health. Individuals receive different types of Medicaid coverage (i.e., full benefits or financial assistance with Medicare premiums and cost sharing).

There are numerous Medicaid eligibility pathways for dual-eligible beneficiaries,[92] but the two main categories of dual-eligible individuals are full dual-eligible beneficiaries and partial dual-eligible beneficiaries. Full dual-eligible beneficiaries receive full benefits from Medicare, and Medicaid provides them with full benefits in addition to financial assistance with their Medicare premiums and cost sharing. Partial dual-eligible beneficiaries receive full benefits from Medicare and financial assistance from Medicaid for Medicare premiums and cost sharing. In FY2010, there were 7.4 million full duals with Medicaid spending totaling $135.4 billion, while the 2.4 million partial duals had $5.2 billion in Medicaid spending.[93]

Because Medicare and Medicaid are different programs, coordinating care and services for dual-eligible beneficiaries presents challenges. Medicare is a national program administered by CMS, while Medicaid is a federal-state partnership under which each state designs and administers its own version of Medicaid under broad federal rules. Coordination of benefits between these distinct programs is administratively complex. Dual-eligible beneficiaries and their service providers must comply with Medicare and Medicaid program rules and processes, which are not always aligned. In addition, delivery of uncoordinated or poorly coordinated health care and related services can be costly and inefficient, affecting dual-eligible beneficiaries' quality of care and increasing Medicare and Medicaid spending. To reduce spending on dual-eligible

[90] This enrollment figure is measured by individuals who were "ever enrolled" in the Medicaid program throughout the year. (Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2013.)

[91] Also qualifying for Medicare are persons who have End-Stage Renal Disease (ESRD). For more information about the Medicare program, see CRS Report R40425, *Medicare Primer*.

[92] The common Medicaid eligibility pathways for Medicare beneficiaries are Supplemental Security Income (SSI) cash assistance, poverty, medically needy, special income rules for nursing home residents, home and community based services waivers, Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, Qualified Disabled Work Individuals, and Qualifying Individuals.

[93] This expenditure figure includes both federal and state Medicaid expenditures. (Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, June 2013.)

beneficiaries and improve the quality of their care, federal and state policy makers are focusing on coordinating care for dual-eligible beneficiaries.[94]

The ACA established the Medicare-Medicaid Coordination Office within CMS in order to improve care coordination for dual-eligible beneficiaries. In addition, the ACA provided CMS the ability to test innovative payment and service delivery models to improve coordination of care and reduce the cost of dual-eligible beneficiaries. With this new authority, CMS is funding demonstration projects to develop approaches to coordinate care for full duals and also to integrate Medicare and Medicaid financing for these individuals.

Impact of ACA Health Insurance Annual Fee on Medicaid

The ACA imposes an annual fee on certain for-profit health insurers, starting in 2014.[95] The ACA health insurance annual fee applies to Medicaid MCOs with the exception of non-profit insurers incorporated under state law that receive more than 80% of their gross revenues from government programs that target low-income, elderly, or disabled populations (such as CHIP, Medicare, and Medicaid).[96] According to one estimate, approximately 80% of Medicaid enrollees covered by managed care receive coverage from a plan impacted by the ACA fee.[97]

Some insurance plans have informed shareholders and state insurance regulators that they intend to pass on the cost of the fee to businesses and enrollees in the form of higher premiums.[98] Medicaid MCOs do not have the ability to pass the cost of the fee on to enrollees through higher premiums because few Medicaid enrollees pay premiums and when premiums are charged the federal government requires the premiums to be nominal.

A number of state governors caution that the ACA health insurance annual fee will result in higher costs to Medicaid. Federal regulations require that the capitated amounts paid to Medicaid MCOs be "actuarially sound," which means the state must consider MCOs' costs, including health benefits, marketing and administrative expenses, and taxes.[99] For this reason, some states have indicated they are willing to include the cost of the ACA fee in the capitation rates,[100] which will likely increase Medicaid expenditures.

[94] Congressional Budget Office, *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies,* June 2013.

[95] The aggregate amount of the ACA fee, to be collected across all covered insurers, will be $8.0 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017, and $14.3 billion in 2018. After 2018, the aggregate fee will be indexed to the overall rate of annual premium growth, as calculated by the Internal Revenue Service. (For more information about the annual fee on health insurers, see CRS Report R43225, *Patient Protection and Affordable Care Act: Annual Fee on Health Insurers*, by Suzanne M. Kirchhoff.)

[96] The following are other types of health insurers or insurance arrangements not subject to the fee: entities that fully self-insure, government-run insurance programs, voluntary employees' beneficiary associations, and student health insurance coverage that educational institutions purchase through a separate, unrelated insurer.

[97] Marwood Group, *Impact of the Annual Health Insurance Tax on State Medicaid Programs*, Prepared for Molina and Amerigroup, October 2011.

[98] Ralph Giacobbe, Chris Carter, and Allison Ryne, et al., *Managed Care: Health Insurance Tax - The $8B Question*, Credit Suisse, November 8, 2013.

[99] American Academy of Actuaries, Practice Note, "Actuarial Certification of Rates for Medicaid Managed Care Programs," 2005, http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.

[100] Ralph Giacobbe, Chris Carter, and Allison Ryne, et al., *Managed Care: Health Insurance Tax - The $8B Question*, Credit Suisse, November 8, 2013.

Maintenance of Effort (MOE)

In response to the economic recession (December 2007 through June 2009),[101] Congress enacted the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5; extended in P.L. 111-226). ARRA included a temporary increase in FMAP rates. In order to receive federal Medicaid matching funds under ARRA, states were required to maintain the same Medicaid eligibility standards, methodologies, and procedures in effect on July 1, 2008, through June 30, 2011. This provision is referred to as the ARRA MOE requirement.

The ARRA MOE provisions were extended and expanded under the ACA. The ACA MOE provisions were designed to ensure that individuals eligible for Medicaid or CHIP did not lose coverage between the date of enactment of ACA (March 23, 2010) and the implementation of the exchanges. Under the ACA MOE provisions, states were required to maintain their Medicaid programs with the same eligibility standards, methodologies, and procedures until the exchanges were operational. Additionally, the ACA MOE continues for Medicaid-eligible children up to age 19 until September 30, 2019. Failure to comply with the ACA MOE requirements means a state loses all of its federal Medicaid matching funds.

The MOE provision did not prohibit states from cutting Medicaid in other ways, such as by reducing provider rates or by eliminating optional benefits. In addition, states were not prohibited from expanding Medicaid coverage during the MOE period.

The ACA provided an exemption to the MOE requirement for states that had a budget deficit, but only with respect to adults who are non-pregnant and non-disabled adults who are eligible for Medicaid under a state plan or waiver and whose income exceeded 133% of FPL. CMS reports that four states (Hawaii, Illinois, Maine, and Wisconsin) reduced coverage for adults under the ACA MOE exemption authority. Other states, such as Minnesota and Arizona, permitted certain adult populations covered under their Section 1115 waiver programs to end (as permitted through guidance and final regulation) without constituting violation of the ACA MOE requirements.

Under both the ARRA and ACA MOEs, states have not been able to restrict the income eligibility for their Medicaid programs generally speaking from July 1, 2008, through January 1, 2014. With the exception of eligibility standards for children, states now have the ability to reduce the cost of Medicaid through reductions to Medicaid eligibility standards. While state finances are improving, state budgets have not quite recovered from the effects of the recession, and some states welcome an additional budget tool (i.e., reducing Medicaid eligibility thresholds) to reduce the cost of Medicaid.

Eleven states (Illinois, Indiana, Louisiana, Maine, Minnesota, New Mexico, New York, Oklahoma, Rhode Island, Vermont, and Wisconsin) reported plans to tighten eligibility for their adult population groups in 2014.[102] Most of the adults who will lose Medicaid eligibility in these states will be eligible for subsidized coverage through the exchanges.[103] States may be financially

[101] As measured by the National Bureau of Economic Analysis.

[102] Vernon K. Smith, Robin Rudowitz, and Laura Snyder, *Medicaid in a Historic Time of Transformation: Results form a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014*, Kaiser Commission on Medicaid and the Uninsured, October 2013.

[103] For more information on the potential implications for these individuals, see CRS Report R42978, *Comparing Medicaid and Exchanges: Benefits and Costs for Individuals and Families*.

better off shifting Medicaid enrollees to the exchanges because the federal government fully funds the cost of premium tax credits and cost-sharing subsidies in the exchanges, whereas states and the federal government share the cost of Medicaid coverage. For the federal government, it is more expensive to cover these individuals through exchanges rather than Medicaid.[104]

Medicaid Resources

For more information on Medicaid, below is a selection of CRS reports that may be of interest.

- CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*
- CRS Report R42640, *Medicaid Financing and Expenditures*
- CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*
- CRS Report R42978, *Comparing Medicaid and Exchanges: Benefits and Costs for Individuals and Families*
- CRS Report R42893, *Proposals to Reduce Federal Medicaid Expenditures*

[104] In July 2012, the Congressional Budget Office estimated that for the average person who does not enroll in Medicaid as a result of their state not implementing the ACA Medicaid expansion and enrolls in an exchange instead, estimated federal spending will rise by roughly $3,000 in 2022—the difference between estimated additional exchange subsidies of about $9,000 and estimated Medicaid savings of roughly $6,000. (Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, July 2012).

Appendix A. State Medicaid and CHIP Income Eligibility Standards

Table A-1 depicts the new MAGI-based eligibility levels for Medicaid beginning on January 1, 2014. The table expresses these standards as a percentage of the federal poverty level (FPL).[105]

CMS worked with states to "convert" their Medicaid income eligibility levels to be based on MAGI as required by the ACA. This table provides the Medicaid MAGI income eligibility levels by FPL for the key groups—children, pregnant women, parents/caretaker relatives and other adults—whose eligibility will be MAGI-based beginning in 2014.

Table A-1. Selected State Medicaid MAGI Income Eligibility Standards Expressed as a Percentage of the Federal Poverty Level

Effective January 1, 2014

	Children				Adults	
State	Ages 0-1[a]	Ages 1-5[a]	Ages 6-18[a]	Pregnant Women	Parents[b]	Other Adults
Alabama	141%	141%	141%	141%	13%	0
Alaska[c]	203%	203%	203%	200%	129%	0%[d]
Arizona	147%	141%	133%	156%	133%	133%
Arkansas	211%	211%	211%	209%	133%	133%
California	261%	261%	261%	208%	133%	133%
Colorado	142%	142%	142%	195%	133%	133%
Connecticut	196%	196%	196%	258%	196%	133%
Delaware	209%	142%	133%	209%	133%	133%
District of Columbia	319%	319%	319%	319%	216%	210%
Florida	206%	140%	133%	191%	31%	0%[d]
Georgia	205%	149%	133%	220%	36%	0%
Hawaii[c]	308%	308%	308%	191%	133%	133%
Idaho	141%	141%	133%	133%	24%[e]	[f]
Illinois	142%	142%	142%	208%	133%	133%
Indiana	208%	158%	158%	208%	20%[e]	[f]
Iowa	375%	167%	167%	375%	133%	133%
Kansas	166%	149%	133%	166%	33%	0%

[105] The poverty guidelines (also referred to as the federal poverty level) are a version of the federal poverty measure. They are issued each year in the *Federal Register* by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds for use for administrative purposes—for instance, determining financial eligibility for certain federal programs.

State	Children			Pregnant Women	Adults	
	Ages 0-1[a]	Ages 1-5[a]	Ages 6-18[a]		Parents[b]	Other Adults
Kentucky	195%	159%	159%	195%	133%	133%
Louisiana	212%	212%	212%	209%	19%[e]	[f]
Maine	191%	157%	157%	209%	100%	[d,f]
Maryland	317%	317%	317%	259%	133%	133%
Massachusetts	200%	150%	150%	200%	133%	133%[d]
Michigan	195%	160%	160%	195%	133%	133%
Minnesota	283%	275%	275%	278%	200%	200%
Mississippi	194%	143%	133%	194%	24%	0%
Missouri	205%	150%	150%	205%	20%[e]	[f]
Montana	159%	143%	143%	159%	48%	[f]
Nebraska	213%	213%	213%	194%	63%	0%
Nevada	159%	159%	133%	159%	133%	133%
New Hampshire	318%	318%	318%	196%	70%	0%
New Jersey	194%	142%	142%	194%	133%	133%
New Mexico	300%	300%	240%	250%	133%	133%
New York	218%	149%	149%	218%	133%	133%[d]
North Carolina	210%	210%	133%	196%	46%	0%[d]
North Dakota	147%	147%	133%	147%	133%	133%
Ohio	206%	206%	206%	200%	133%	133%
Oklahoma	205%	205%	205%	133%	43%[e]	[f]
Oregon	185%	133%	133%	185%	133%	133%
Pennsylvania	215%	157%	133%	215%	33%	0%[d]
Rhode Island	261%	261%	261%	190%	133%	133%
South Carolina	208%	208%	208%	194%	62%	0%
South Dakota	182%	182%	182%	133%	54%	0%
Tennessee	195%	142%	133%	195%	106%	0%
Texas	198%	144%	133%	198%	15%	0%
Utah	139%	139%	133%	139%	46%[e]	[f]
Vermont	313%	313%	313%	208%	133%	133%
Virginia	143%	143%	143%	143%	49%	0%
Washington	207%	207%	207%	193%	133%	133%
West Virginia	158%	141%	133%	158%	133%	133%
Wisconsin	301%	186%	151%	301%	95%[e]	95%
Wyoming	154%	154%	133%	154%	57%	0%

Source: Centers for Medicare and Medicaid Services. Eligibility levels in effect based on information current as of September 30, 2013, provided to CMS by states either for purposes of FFM programming of state-specific Medicaid/CHIP rules, through state plan amendments, or by direct request from CMS. These levels are subject to change.

Notes: For these eligibility groups, an individual's income, computed based on the new modified adjusted gross income (MAGI)-based income rules and adjusted by a 5% disregard, is compared to the income standards identified in this table to determine if they are income eligible for Medicaid or CHIP. Other eligibility criteria also apply, for example, with respect to citizenship, immigration status and residency. Note that this table reflects the principal but not all MAGI coverage groups.

a. These eligibility standards include CHIP-funded Medicaid expansions.

b. In states that use dollar amounts rather than percentages of the federal poverty level (FPL) for 2013 to determine eligibility for parents, CMS has converted those amounts to a percent of the FPL and selected the highest percentage to reflect the eligibility level for the group. In addition, for states that are adopting the Medicaid expansion, CMS has indicated the upper income limit for parents will also be 133% of the FPL, since parents can be eligible for coverage under the new ACA Medicaid expansion group. The actual dollar standards that states will use to determine eligibility are quoted in the monthly income tables available at http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-levels.html.

c. The dollar values that represent the FPLs in Alaska and Hawaii are higher than for the contiguous 48 states. For example, as of 2013, 100% of the FPL for a family of four is equal to $29,440 in Alaska and $27,090 in Hawaii, compared to $23,550 in the other 48 states.

d. The state covers some 19 and 20 year olds—AK (129%), FL (31%), ME (156%), MA (150%), NY (150%), NC (46%), and PA (33%).

e. Reflects parent coverage under the Medicaid state plan. The state has some additional coverage above state plan eligibility standards through a section 1115 demonstration or a pending demonstration proposal. The demonstration includes limitations on eligibility and/or benefits, is not offered to all residents of the state, and/or includes an enrollment cap.

f. The state has a Section 1115 demonstration or a pending demonstration proposal that provides Medicaid coverage to some low-income adults. The demonstration includes limitations on eligibility and/or benefits, is not offered to all residents of the states, and/or includes an enrollment cap.

Appendix B. State-by-State Medicaid Data

Table B-1 provides the most recent available data for state-by-state Medicaid enrollment, expenditures (including both the federal and state shares), and FMAP rates.

Table B-1. State-by-State Medicaid Enrollment, Expenditures, and FMAP Rates

		FY2012 Medicaid Expenditures[a] ($ in millions)			
State	**FY2010 Enrollment[b] (in thousands)**	**State**	**Federal**	**Total**	**FY2014 FMAP Rates**
Alabama	1,016	$1,613	$3,589	$5,202	68.12
Alaska	126	$587	$854	$1,441	50.00
Arizona	1,531	$2,528	$5,639	$8,167	67.23
Arkansas	699	$1,288	$3,074	$4,362	70.10
California	11,335	$25,749	$27,522	$53,271	50.00
Colorado[c]	632	$2,428	$2,488	$4,916	50.00
Connecticut	712	$3,331	$3,366	$6,696	50.00
Delaware	225	$707	$866	$1,573	55.31
District of Columbia	213	$681	$1,544	$2,224	70.00
Florida	3,703	$8,112	$10,535	$18,647	58.79
Georgia	1,870	$2,976	$5,819	$8,795	65.93
Hawaii	261	$749	$763	$1,512	51.85
Idaho[c]	223	$466	$1,050	$1,516	71.64
Illinois	2,780	$6,891	$7,105	$13,995	50.00
Indiana	1,174	$2,627	$5,264	$7,891	66.92
Iowa	555	$1,384	$2,190	$3,574	57.93
Kansas	394	$1,204	$1,631	$2,834	56.91
Kentucky	907	$1,665	$4,094	$5,759	69.83
Louisiana	1,177	$2,277	$5,077	$7,354	60.98
Maine[c]	352	$913	$1,652	$2,565	61.55
Maryland	952	$3,907	$3,998	$7,904	50.00
Massachusetts	1,654	$6,595	$6,731	$13,326	50.00
Michigan	2,257	$4,381	$8,560	$12,941	66.32
Minnesota	936	$4,460	$4,544	$9,004	50.00
Mississippi	772	$1,181	$3,438	$4,618	73.05
Missouri[c]	1,033	$3,261	$5,743	$9,004	62.03
Montana	133	$336	$695	$1,031	66.33
Nebraska	250	$768	$1,024	$1,792	54.74

State		FY2012 Medicaid Expenditures[a] ($ in millions)			
Nevada	340	$787	$1,045	$1,832	63.10
New Hampshire	167	$614	$637	$1,251	50.00
New Jersey	1,026	$5,404	$5,567	$10,971	50.00
New Mexico	576	$1,063	$2,541	$3,604	69.20
New York	5,570	$26,305	$26,769	$53,074	50.00
North Carolina	1,876	$4,458	$8,418	$12,876	65.78
North Dakota	82	$342	$446	$788	50.00
Ohio	2,246	$6,058	$10,768	$16,826	63.02
Oklahoma	829	$1,639	$3,005	$4,644	64.02
Oregon	644	$1,819	$3,103	$4,922	63.14
Pennsylvania	2,417	$9,466	$11,684	$21,150	53.52
Rhode Island	205	$912	$1,032	$1,944	50.11
South Carolina	909	$1,434	$3,381	$4,815	70.57
South Dakota	131	$293	$492	$786	53.54
Tennessee	1,502	$3,115	$6,135	$9,250	65.29
Texas	4,844	$11,998	$16,936	$28,934	58.69
Utah	352	$593	$1,410	$2,003	70.34
Vermont	196	$570	$792	$1,362	55.11
Virginia	1,007	$3,511	$3,579	$7,089	50.00
Washington	1,353	$3,949	$4,171	$8,120	50.00
West Virginia	430	$810	$2,121	$2,931	71.09
Wisconsin[c]	1,139	$2,898	$4,566	$7,464	59.06
Wyoming	87	$270	$296	$566	50.00
National Total	**65,804**	**$181,370**	**$247,748**	**$429,118**	

Source: Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, March 2013; Centers for Medicare & Medicaid Services, CMS-64 data; Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2013 Through September 30, 2014," 77 *Federal Register* 71420, November 30, 2012.

Notes: May not sum to totals due to rounding.

a. Medicaid expenditures include benefit and administrative expenditures but exclude expenditures in the territories and spending for State Medicaid Fraud Control Units, Medicaid survey and certification of nursing and intermediate care facilities, and the Vaccines for Children program.

b. Enrollment numbers generally include individuals ever enrolled in Medicaid-financed coverage during the year, even if for a single month. Numbers exclude enrollees in the territories.

c. Enrollment data for FY2010 was not available for Colorado, Idaho, Maine, Missouri, and Wisconsin, and this table show FY2009 for these states.

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