Introduction

This booklet summarizes key elements of the Medicaid program, including basic answers to questions about the design and cost of the Medicaid program, why legislators should care about it, who and what it covers, why the program is costly for states, and what strategies can help improve quality while controlling Medicaid costs. Medicaid has undergone many changes and innovations over its 50-year history. This resource is intended to provide lawmakers with information about the program, so they can make informed decisions. The primer concludes with information about the challenges of getting reliable data on Medicaid programs from around the country, and offer resources and tools that can help state policymakers develop evidence-based, cost-effective policies to support their Medicaid programs.

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What is Medicaid?

Medicaid is a publicly financed program that provides health insurance for millions of low-income Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. In 2016, the Medicaid program covered close to 74.5 million people, or about 20 percent of the population. Many of them have complex and costly needs for health care. Medicaid is a shared program between the federal government and the states. This federal-state partnership program was created by Congress in 1965 (in Title XIX of the Social Security Act).

The Children’s Health Insurance Program (CHIP) provides health coverage to additional lower-income children whose family income is higher than Medicaid’s eligibility threshold. Under CHIP, states can choose to expand their Medicaid program or administer a separate CHIP program. CHIP is also administered by the states in compliance with federal requirements. The program is funded jointly by states and the federal government.

Medicaid is sometimes confused with Medicare, a separate program that is managed and funded exclusively by the federal government—Medicare covers almost all U.S. citizens age 65 and over (57.5 million enrollees in 2016). Medicare relies on Medicaid to cover certain services for low-income older adults, such as long-term care and community-based services. Approximately 10 million people currently qualify for both programs (dual eligible coverage).

While the federal government provides substantial funding and oversight for Medicaid through the Centers for Medicare & Medicaid Services (CMS), each state manages its own Medicaid program. Federal statute establishes the fundamental program parameters. States vary in the amount of legislative oversight they provide to their programs. Although it is an optional program, all 50 states, the District of Columbia, and the commonwealths and territories participate.

The Process for Making Changes to the Medicaid Program Requires State and Federal Partners

State Lawmakers

State Medicaid Agency

Federal Medicaid Agency (CMS)

STATE LAW OR REGULATION
Authorization and appropriations

MEDICAID STATE PLAN
State plan amendment (SPA) or Section 1115 Waiver

Source: Kaiser Commission on Medicaid and the Uninsured.
Why Should Legislators Care About Medicaid?

Medicaid provides health insurance for low-income people who may have complex needs and require expensive care. States bear substantial costs of providing health care for indigent patients. When low-income people have access to care through Medicaid the costs are shared with the federal government rather than being shifted elsewhere, such as to other tax-funded programs, to emergency rooms, or to private insurance plans in the form of higher premiums. Medicaid helps states pay for “uncompensated care” for indigent patients, those who are uninsured and cannot pay for their health care. When people have access to care, chronic conditions can be managed more effectively—possibly preventing a crisis or emergency care, and ultimately reducing costs.

States face difficult choices about their Medicaid programs. They balance resources between providing health care services to low-income citizens and other programs such as education, transportation, corrections and other public assistance programs. Medicaid costs have grown over time as a percent of state budgets, and this impacts other state programs—as shown in this graph of state expenditures over the past 20 years.\(^4\)

Variability exists among states in terms of how fast their Medicaid budgets grow, with an average growth rate of 4.1 percent annually. Some state budgets are growing slowly at 1 percent to 2 percent annually (New Hampshire and Nebraska), while others are growing at 8 percent to 9 percent (Arizona and Delaware).\(^5\)
What Portion of the State Budget Goes to Medicaid?

Medicaid’s share of state budgets varies across states and differs depending on how it is calculated. In 2016, Medicaid accounted for approximately 29 percent of total state expenditures. This includes the federal matching funds that are sent to the states for Medicaid. Spending from state funds alone is a lower percentage of the total—the portion of state funds that supported Medicaid was 16.8 percent in 2016. States receive funding from the federal government to support a variety of programs. Approximately 47.6 percent of all the federal dollars going to the states supports the cost of Medicaid.

As health care costs rise faster than other sectors of the economy, states struggle to keep costs down while preserving other programs and safety-net services for their citizens. Current federal statute requires that state Medicaid programs must cover all people who meet eligibility requirements. The federal government reimburses states a certain percentage of Medicaid costs (which varies by state) for serving all people who qualify. The matching federal funding for state Medicaid costs is called the Federal Medical Assistance Percentage (FMAP).

Expenditures by Budget Category
Estimated fiscal 2016

**TOTAL STATE EXPENDITURES**
Total state expenditures are all federal and state funds.

- Medicaid: 29.0%
- K-12: 19.4%
- Higher ed.: 10.2%
- Trans.: 7.9%
- All other: 29.2%
- Public assistance: 1.4%
- Corrections: 3.0%

**STATE GENERAL FUND EXPENDITURES**

- K-12: 24.7%
- Medicaid: 16.8%
- Higher ed.: 13.4%
- Trans.: 7.5%
- All other: 32.4%
- Public assistance: 0.9%
- Corrections: 4.4%

Source: National Association of State Budget Officers
Who Receives Health Coverage Through the Medicaid Program?

To qualify for Medicaid, individuals must first meet two basic criteria: they must be U.S. citizens (or certain qualified non-citizens such as lawful permanent residents), and they must be residents of the states where they are applying. Federal law requires state Medicaid programs to cover certain populations and allows states the option of covering others. Medicaid is called an “entitlement program” because states must provide coverage to certain groups or “categories” of people. These groups are entitled to services through the Medicaid program (they are sometimes referred to as “categorically eligible”):

- Low-income infants and children who qualify for Medicaid and/or the CHIP program based on income or other guidelines;
- Low-income pregnant women and certain parents of qualified children;
- Low-income individuals of all ages with disabilities;
- Low-income seniors, most of whom are also covered by Medicare (“dual eligible” for both programs).

Recent expansion of the Medicaid programs under the Affordable Care Act in some states provides coverage to additional low-income adults who would not otherwise qualify under a “categorical group.” There are different requirements for this population and they are considered a special “expansion population.” Information on each state’s eligibility levels is available on the website for the Centers for Medicare & Medicaid Services.

Even though people with disabilities and the elderly comprise only 24 percent of the Medicaid population, they account for 63 percent of all Medicaid costs. In contrast, the mostly healthy populations (children, younger adults and pregnant women) account for 75 percent of Medicaid enrollment, but only 36 percent of all Medicaid spending (see more on page 9).

Minimum income guidelines are set by the federal government. The table at right provides general federal guidelines from 2015; eligibility is based on household income as a percent of the federal poverty level.

### Median Medicaid/CHIP Income Eligibility Thresholds, April 2015

Based on federal poverty level.

<table>
<thead>
<tr>
<th>Category</th>
<th>Eligibility Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>Adopting: 30% ($61,247) Not adopting: 49% ($8,840)</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>Adopting: 199% ($39,979) Not adopting: 138% ($16,242)</td>
</tr>
<tr>
<td>Parents</td>
<td>Adopting: 138% ($27,724) Not adopting: 44% ($8,840)</td>
</tr>
<tr>
<td>Childless Adults</td>
<td>0% ($0)</td>
</tr>
</tbody>
</table>

**NOTE:** State-reported eligibility levels as of January 2015, updated to reflect Medicaid expansion decisions as of April 2015. Eligibility levels are based on 2015 federal poverty levels (FPLs) for children, pregnant women and parents in a family or three or four childless adults. In 2015, the FPL was $20,090 for a family of three and $11,770 for an individual.

*Source: Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015*
Which States Have Expanded Medicaid?

As of March 2017, approximately 74.5 million people were enrolled in Medicaid (and/or CHIP); this is an increase from 56 million in 2014, when some states expanded their Medicaid programs with significant initial support from the federal government under provisions of Public Law 111-148, also known as the Affordable Care Act. The expansion populations have primarily included eligible low-income adults with incomes up to 138 percent of the federal poverty level. Thirty-one states plus D.C. have decided to proceed with the expansion, while 19 states declined to expand. Six states proceeded with expansion through waivers—“waiver applications” request permission from the federal government to design alternative expansion opportunities. More information about waivers is included on page 8.

Medicaid Expansion
State decisions regarding Medicaid expansion as of March, 2017.

More at ncsl.org
This map on the NCSL website also provides overview information on the breakdown of insurance coverage for each state’s population. The categories include: percent of the population covered by Medicaid, Medicare, private insurance, and the percent uninsured.
What Services Does Medicaid Cover?

Federal Medicaid law requires states to cover certain services and allows states to select from a menu of other optional services. Because Medicaid covers so many low-income elderly people and people with disabilities who cannot obtain private sector coverage, its benefits package reflects these special needs. For example, Medicaid covers some services that most private insurance plans do not cover, such as nursing home and other long-term care services, which can be costly.

Mandatory Benefits/Services

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services (for individuals under 21)
- Nursing Facility Services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

Optional Benefits/Services

- Prescription Drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing and language disorder services
- Respiratory care services
- Other diagnostic, screening, preventive and rehabilitative services
- Podiatry services
- Optometry services
- Dental Services
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Other practitioner services
- Private duty nursing services
- Personal Care
- Hospice
- Case management
- Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
- Services in an intermediate care facility for Individuals with Intellectual Disability
- State Plan Home and Community Based Services-1915(i)
- Self-Directed Personal Assistance Services- 1915(j)
- Community First Choice Option- 1915(k)
- TB Related Services
- Inpatient psychiatric services for individuals under age 21
- Other services approved by the Secretary
- Health Homes for Enrollees with Chronic Conditions – Section 1945
What is a Medicaid “Waiver”?

States seeking additional flexibility to design their Medicaid programs may apply for formal waivers of some of the statutory requirements from the secretary of the U.S. Department of Health and Human Services (HHS).

A Medicaid waiver is a written approval from the federal government (reviewed and determined by the Centers for Medicare & Medicaid Services) that allows states to differ from the rules of the standard federal program. In other words, the state is allowed a “waiver” from some of the requirements of the federal program. This means that they can test and develop how to deliver services in their state-based program in a way that differs from federal guidelines.

For example, certain eligibility and benefit provisions of the Medicaid statute may be waived in order to explore new approaches to the delivery of and payment for acute care and long-term services and supports (LTSS). States can use waivers to offer a specialized benefit package to a subset of Medicaid beneficiaries, to restrict enrollees to a specific network of providers, or to extend coverage to groups beyond those defined in Medicaid law.

All states operate one or more Medicaid waivers, which are generally referred to by the section of Social Security Act granting the waiver authority and are categorized either as program waivers or research and demonstration projects. Approval of states’ waiver applications is at the discretion of the secretary of Health and Human Services.

There are four types of Medicaid waivers:

- **Section 1115 waivers** allow for research and demonstration projects designed to temporarily test expanded eligibility or coverage options, as well as methods for financing and delivering Medicaid.

- **Section 1915(b) waivers** allow states to develop Medicaid managed care plans. Currently, a large majority of Medicaid beneficiaries are covered through managed care organizations (MCOs). While the MCOs can also be established through a state plan amendment, a waiver is needed for mandatory managed care coverage. State Medicaid agencies can contract with MCOs to help manage quality, utilization, and costs, while also working to improve plan performance and patient outcomes. MCOs provide health care services to Medicaid beneficiaries and receive payment for these services from the state Medicaid fund.

- **Section 1915(c) Home and Community-Based Services (HCBS) waivers** allow beneficiaries to receive long-term health care benefits at home or in community settings outside of institutional settings, such as nursing homes.

- **Combined or concurrent Section 1915(b) and 1915(c) waivers** allow a state to provide services identified in Section 1915(c) by contracting with managed care organizations defined in Section 1915(b). The contracted managed care organizations deliver home and community-based health care services.
What About the High Cost of Medicaid?

Concerns about Medicaid costs mirror those about overall health care costs. In fact, Medicaid spends about 25 percent less than private insurance on an average per person basis.

The most notable reason Medicaid costs so much is because it covers many people with complex health care needs such as multiple chronic conditions and serious disabilities, and it pays for high-cost services such as long-term care. Even though people with disabilities and the elderly comprise only 24 percent of the Medicaid population, they account for 63 percent of all Medicaid costs. In contrast, the mostly healthy populations (children, younger adults and pregnant women) account for 75 percent of Medicaid enrollment, but only 36 percent of all Medicaid spending. Costs for care per beneficiary vary widely across states, influenced by a number of factors including what benefits are available, and the cost of that care. Average spending for individuals with disabilities was highest in New York, at $33,808 (in 2011), and lowest in Alabama, at $10,142 (in 2011). Texas represents the average, where individuals with disabilities cost an average of $17,709 per person in 2011. Legislators can influence costs by emphasizing health care management in their state; options include implementing managed care and reforming payment strategies.
How can States Manage Medicaid Costs and Improve Quality?

As Medicaid costs consume a larger share of state budgets, policymakers seek ways to make sure their state’s program is managed as efficiently and effectively as possible. It is important to remember that health care costs have risen in response to several factors, including the rising cost of health services in a fee-for-service payment system, growing numbers of people with complex needs for care and expensive services, and the choice by states to expand their programs to cover more people who would otherwise not have health coverage.

The quickest ways for states to trim Medicaid costs involve changing program eligibility, services, or payments to service providers, which states typically turn to during a budget crisis. Each of these options has its drawbacks.

- Changing or restricting eligibility shifts costs elsewhere, such as to other state or locally funded programs, to emergency rooms, to private insurance plans in the form of higher premiums, and to providers in the form of debt or charity care.
- Imposing stringent restrictions on services such as prescription drugs may result in higher costs associated with sicker patients, including expensive hospital or long-term care.
- Reducing provider payments can result in fewer providers participating in Medicaid, making it difficult to ensure that patients receive needed care.

In the longer term, states have undertaken innovations to help control Medicaid costs, and many are related to increasing value and improving quality. Some involve innovations such as value-based purchasing and bundled payments, providing alternatives to the traditional fee-for-service model. Other innovations focus on reducing hospital visits (such as unnecessary trips to emergency rooms, or readmissions after leaving the hospital) by providing coordinated care through use of care managers who help complex patients navigate the health care system. Other innovations focus on preventing costly medical errors. Some states provide care for Medicaid clients through Accountable Care Organizations, which are designed to help states get the most value for their Medicaid dollars.

All of these innovations tend to rely on a robust and high functioning Health Information Technology system which connects patients, services and payment through a computerized network.

Taking the longest view, states are also considering the programs that address health disparities. Living in poverty is one of the things that predisposes many people to illness and poor health. State Medicaid programs are working to reduce the cost of care for high-needs high-cost patients by considering the cross-sectoral programs that support these families and individuals. For example, some states provide supportive housing services to individuals with disabilities, and others refer Medicaid beneficiaries to programs that help them find and maintain employment in their community.
Why are Medicaid Data so Important?

States need fast, reliable data in order to make decisions about their Medicaid programs. Capturing information on enrollment and service delivery is difficult because each state Medicaid program has varying capacity for producing timely data through their Medicaid Statistical Information System (MSIS). This makes it difficult to collect (aggregate) data from across the country. A new generation of data systems in the states called the T-MSIS (Transformed Medicaid Statistical Information System) has the potential to improve the completeness, accuracy, and timeliness of state data available to CMS and to policymakers. Implementation has been delayed for several years due to the complexity of establishing large database systems that collect information from different states.9

Many states have improved their data information systems by establishing All Payer Claims Databases (APCDs). Most APCDs gather claims and eligibility data from medical, pharmacy, and dental payers to create a comprehensive collection of information on things like cost of care, utilization, patient demographics, and quality of health care. The public and private payers that submit information to APCDs vary by state, but often include voluntary and mandated submissions from Medicaid, state employee health benefits programs, some commercial insurers and self-insured employer plans. This gives state lawmakers the cross-cutting information they need to compare Medicaid to the private sector, and discover inefficiencies.

All-Payer Claims Databases

Source: www.acpdcouncil.org
Online Tools and Resources at NCSL.org

Additional resources on the topics and questions covered in this booklet are listed below in the order in which they were described in this document. In addition, NCSL health program staff members are available to provide customized research support and provide or arrange for technical assistance for legislators and legislative staff. Contact NCSL’s health program staff for assistance via email at Health-info@ncsl.org or at 1-303-364-7700.

<table>
<thead>
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<th>Topic</th>
<th>Resources</th>
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