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Medicaid: A Primer

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Summary

In existence for 40 years, Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term care to more than 57 million people at an estimated cost to the federal and state governments of roughly \$300 billion. Of all federally supported programs, only Medicare comes close to this level of spending, and only Social Security costs more.

Each state designs and administers its own version of Medicaid under broad federal rules. State variability in eligibility, covered services, and how those services are reimbursed and delivered is the rule rather than the exception.

This report describes the basic elements of Medicaid, focusing on federal rules governing who is eligible, what services are covered, how the program is financed and how beneficiaries share in the cost, how providers are paid, and the role of special waivers in expanding eligibility and modifying benefits. Basic program statistics and citations to in-depth CRS reports on specific topics are provided. This report will be updated as legislative activity warrants.

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Medicaid: A Primer

Medicaid was enacted in 1965 in the same legislation that created the Medicare program (i.e., the Social Security Amendments of 1965; P.L. 89-97). It grew out of and replaced two earlier programs of federal grants to states that provided medical care to welfare recipients and the elderly. It has expanded in additional directions since that time.

In the federal budget, Medicaid is an entitlement program that constitutes a large share of mandatory spending. Two other federally supported health programs — Medicare and the State Children’s Health Insurance Program (SCHIP) — are also entitlements,¹ and are also components of mandatory spending in the federal budget. All three programs finance the delivery of certain health care services to specific populations. While Medicare is financed exclusively by the federal government, both Medicaid and SCHIP are jointly financed by the federal and state governments. Federal Medicaid spending is open-ended, with total outlays dependent on the generosity of state Medicaid programs. In contrast, SCHIP is a capped federal grant to states.

Even though Medicaid is an entitlement program in federal budget terms, states may choose to participate, and all 50 states do so. If they choose to participate, states must follow federal rules in order to receive federal reimbursement to offset a portion of their Medicaid costs.

Who is Eligible for Medicaid?

The federal Medicaid statute (Title XIX of the Social Security Act) defines more than 50 distinct population groups as being potentially eligible. To qualify for Medicaid coverage, applicants’ income (e.g., wages, Social Security benefits) and often their resources or assets (e.g., value of a car, savings accounts) must meet program *financial requirements*. These requirements vary considerably among states, and different rules apply to different population groups within a state. Medicaid eligibility is also subject to *categorical restrictions* — generally, it is available only to the elderly, persons with disabilities (as generally defined under the federal

¹ The term “entitlement” has two meanings in this context. Individuals who meet state eligibility requirements are entitled to Medicaid. Similarly, individuals who meet federal eligibility requirements are entitled to Medicare. In contrast, states that meet certain federal requirements are entitled, or have access to, federal SCHIP grants. All states have qualified for SCHIP. There is no individual entitlement under SCHIP.

Supplemental Security Income Program, or SSI²), members of families with dependent children, and certain other pregnant women and children. In recent years, Medicaid has been extended to additional groups with specific characteristics, including certain women with breast or cervical cancer and uninsured individuals with tuberculosis.

Some eligibility groups are mandatory, meaning that all states must cover them; others are optional. Examples of groups that states *must* provide Medicaid to include:

- poor families that meet the financial requirements (based on family size) of the former Aid to Families with Dependent Children (AFDC) cash assistance program,³
- pregnant women and children under age six with family income below 133% of the federal poverty level (FPL),⁴
- children ages six through 18 with family income below 100% FPL,
- poor individuals with disabilities or poor individuals over age 64 who qualify for cash assistance under the SSI program,⁵ and
- certain groups of legal permanent resident immigrants (e.g., refugees for the first seven years after entry into the U.S.; 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).

Examples of groups that states *may choose* to cover under Medicaid:

- pregnant women and infants with family income exceeding 133% FPL up to 185% FPL,
- individuals with disabilities and people over age 64 whose income exceeds the SSI level (about 75% FPL nationwide) up to 100% FPL,
- individuals who require institutional care (in a nursing facility or other medical institution) whose income exceeds the SSI level up to 300% of the applicable SSI payment standard (based on family size) or roughly 221% FPL,

² SSI provides cash assistance to the elderly and adults with certain disabilities that significantly restrict their ability to be gainfully employed. In the case of children, disabilities must result in marked and severe functional limitations.

³ AFDC income standards are well below the federal poverty level, but states can modify (liberalize or further restrict) these criteria. Under the 1996 welfare reform law, AFDC was replaced with the Temporary Assistance for Needy Families (TANF) program. Although TANF recipients are not automatically eligible for Medicaid, some states have aligned income rules for TANF and Medicaid, thus facilitating Medicaid coverage for some TANF recipients.

⁴ For example, in 2005, the FPL for a family of four is \$19,350 — 133% of FPL for such a family would equal \$25,736.

⁵ Some states use income, resource and disability standards that differ from current SSI standards.

- “medically needy” individuals who meet categorical requirements (e.g., are over 64 or under 19, have a disability, are pregnant, or are members of families with dependent children) with income up to 133 $\frac{1}{3}$ % of the maximum payment amount applicable under states’ former AFDC programs based on family size.⁶ Unlike most other eligibility groups, medical expenses (if any) may be subtracted from income in determining financial eligibility for medically needy coverage, which is often referred to as “spend down,” and
- legal immigrants after their first five years in this country.

While Medicaid is targeted at individuals with low income, not all of the poor are eligible, and not all those covered are poor. For example, adults without a qualifying disability and no dependent children are *not* eligible for Medicaid, no matter how poor they are (unless a state has a special waiver; see the subsection on waivers below). And, as noted above, the income standards applicable to some Medicaid eligibility groups exceed the poverty level. Moreover, from state to state, applicants with substantial differences in gross income may qualify for Medicaid under the same eligibility group, depending on the income methodology used (i.e., what types of income are counted, and how much, if any, income of a given type is disregarded or ignored).

What Benefits Does Medicaid Cover?

Like eligibility, federal rules require states to cover certain benefits under their Medicaid program. Certain other services may also be offered at state option. 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 categorically needy groups⁷ must be equal in amount, duration, and scope. Likewise, services available to medically needy groups⁸ must be equal in amount, duration, and scope. These requirements are called the “comparability rule.”
- With certain exceptions, the amount, duration, and scope of benefits must be the same statewide, also referred to as the “statewideness rule.”

⁶ This limit can be raised or lowered based on specific provisions in the 1996 welfare reform legislation.

⁷ 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.

⁸ Medically needy groups include individuals meeting the same categorical restrictions, but different (typically somewhat higher) financial standards apply.

- With certain exceptions, beneficiaries must have freedom of choice among health care providers or managed care entities participating in Medicaid.

Benefits identified in the federal statute and regulations include a wide range of medical care and services. Some benefits are specific items, such as eyeglasses and prosthetic devices. Other benefits are defined in terms of specific types of providers (e.g., physicians, hospitals) whose array of services are designated as coverable under Medicaid. Still other benefits define specific types of service (e.g., family planning services and supplies, pregnancy-related services) that may be delivered by any qualified medical provider that participates in Medicaid.

Examples of benefits that are *mandatory* for most Medicaid groups:

- inpatient hospital services (excluding services for mental disease),
- services provided by federally qualified health centers,
- laboratory and X-ray services,
- physician services,
- pregnancy-related services,
- nursing facility services for individuals age 21 and over, and
- home health care for those entitled to nursing home care.

Examples of *optional* benefits for most Medicaid groups that are offered by many states:

- prescribed drugs (covered by all states),
- routine dental care,
- physician-directed clinic services,
- other licensed practitioners (e.g., optometrists, podiatrists, psychologists),
- inpatient psychiatric care for the elderly and for individuals under age 21,
- nursing facility services for individuals under age 21,
- physical therapy,
- prosthetic devices, and
- transportation.

The optional benefits offered vary across states. In addition, 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). Exceptions to stated limits may be permitted under circumstances defined by the state.

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

- 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 optional services that states do not otherwise cover in their Medicaid programs.

- While all women who qualify for Medicaid are eligible for pregnancy-related services, women who qualify under one of the *pregnancy-related eligibility groups* are eligible for *only* pregnancy-related services (including treatment of conditions that may complicate pregnancy) through a period of 60 days postpartum.
- Under Section 1915(c) of the federal Medicaid statute, the Secretary of Health and Human Services (HHS) may waive certain Medicaid requirements allowing states to cover a broad range of *home and community-based services (HCBS)* for persons who would otherwise be eligible for Medicaid-funded institutional care. Waiver participants must be members of targeted groups (as designated by the state), including the aged, persons with physical disabilities, persons with mental retardation or developmental disabilities (MR/DD), and persons with mental illness. Benefits may include, for example, personal care (e.g., assistance with eating/drinking, toileting, medication management, or ventilators); habilitation services (e.g., assistance with socialization and adaptive skills) for individuals with MR/DD; transportation; case management; psychosocial rehabilitation and clinic services for persons with chronic mental illness. A cost-effectiveness test, which must be met, requires that expenditures for HCBS not exceed the cost of institutional care that would have otherwise been provided to waiver participants. Thus, states may cap enrollment and/or set expenditure limits on a per capita or aggregate basis to meet this requirement.
- Special benefit rules apply to optional *medically needy populations*. States may offer a more restrictive benefit package than is provided to categorically needy populations, but at a minimum, must offer (1) prenatal and delivery services for pregnant women, (2) ambulatory services for individuals under 18 and those entitled to institutional services, and (3) home health services for individuals entitled to nursing facility care.⁹
- State Medicaid programs must pay Medicare cost-sharing expenses (e.g., Medicare premiums and, in some cases, deductibles and co-insurance) for certain low-income individuals eligible for both programs, often called “dual eligibles.”

⁹ 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.

How Is Medicaid Financed?

The federal and state governments share the cost of Medicaid. States are reimbursed by the federal government for a portion (the “federal share”) of a state’s Medicaid program costs. Because Medicaid is an open-ended entitlement, there is no upper limit or cap on the amount of federal funds a state may receive. Medicaid costs in a given state and year are primarily determined by the expansiveness of eligibility rules and beneficiary participation rates, the breadth of benefits offered, and the generosity of provider reimbursement rates.

The state-specific federal share for benefit costs is determined by a formula set in law that establishes higher federal shares for states with per capita personal income levels lower than the national average (and vice versa for states with per capita personal income levels that are higher than the national average).¹⁰ The federal share, called the federal medical assistance percentage (FMAP) is at least 50% of state Medicaid benefit costs, and can be as high as 83% (statutory maximum). For FY2006, the federal share for benefit costs ranges from 50% (in 12 states) up to 76% (in one state).

The federal match for administrative expenditures does not vary by state and is generally 50%, but certain administrative functions have a higher federal matching rate. Functions with a 75% federal match include, for example, survey and certification of nursing facilities, operation of a state Medicaid fraud control unit (MFCU), and operation of an approved Medicaid management information system (MMIS) for claims and information processing. The implementation and operation of immigration status verification systems by each state is fully financed by the federal government. Overall, administrative costs represent about 5% of total Medicaid spending in a given year.

Do Beneficiaries Pay for Medicaid Services?

State Medicaid programs are allowed to require certain beneficiaries to share in the cost of Medicaid services, although 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. The rules for service-based cost-sharing (e.g., copayments paid to a provider at the time of service delivery) are different from those for participation-related cost-sharing (e.g., premiums paid by beneficiaries typically on a monthly basis independent of any services rendered).

¹⁰ For one benefit, family planning services and supplies, the federal share is 90% for all states. In addition, the federal share is 100% for Medicaid services provided by an Indian Health Service facility (whether operated by the IHS or certain Indian tribes or tribal organizations) to Medicaid beneficiaries.

Service-Based Cost-Sharing

For some groups of beneficiaries, all service related cost-sharing is prohibited unless the prohibitions are lifted under a special waiver (see the subsection on waivers below). All service related cost-sharing is prohibited for children under 18 years of age. Service related cost-sharing is prohibited for pregnant women for any services that relate to the pregnancy or to any other medical condition which may complicate pregnancy. In addition, such cost-sharing cannot be charged for:

- services furnished to individuals who are inpatients in a hospital, or are residing in a long term care facility or in another medical institution if the individual is required to spend most of their income for medical care;
- services furnished to individuals receiving hospice care;
- emergency services; and
- family planning services and supplies.

For most other beneficiaries and services, Medicaid programs are allowed to establish “nominal” service related cost-sharing requirements. Nominal amounts are defined in regulations and are generally between \$0.50 and \$3, depending on the cost of the service provided. For working individuals with disabilities who qualify for Medicaid under eligibility pathways established by the Balanced Budget Act of 1997 (BBA97) and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), service related cost-sharing charges may be required that exceed nominal amounts as long as they are set on a sliding scale based on income.

Participation-Related Cost-Sharing

Premiums and enrollment fees are prohibited under Medicaid except for the following groups:

- For certain families that qualify for transitional Medicaid (originally created to support welfare to work transitions), states may charge premiums but only for the final six months of receiving transitional Medicaid coverage.
- For pregnant women and infants with family income that exceeds 150% of the FPL, states are allowed to implement nominal premiums or enrollment fees between \$1 and \$19 per month depending on family income.
- For individuals who qualify for Medicaid through the medically needy pathway, states may implement a monthly fee as an alternative to meeting the financial eligibility thresholds by deducting medical expenses from income (i.e., the “spend down” method).
- For individuals who qualify under pathways for working individuals with disabilities, states may charge premiums or enrollment fees. Those fees are not capped when charged to individuals with a disability qualifying under the provisions of BBA97 whose family income does not exceed 250% FPL. Premiums charged to those

who qualify under TWWIIA, whose income is between 250% and 450% FPL, cannot exceed 7.5% of income.

How are Providers Paid Under Medicaid?

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

Providers cannot deny care or services based on an individual's ability to pay Medicaid cost-sharing amounts. However, this requirement does not eliminate the liability of a Medicaid beneficiary for payment of such amounts. In practice, some states have allowed providers to refuse to provide services to Medicaid beneficiaries who have failed to make copayments in the past, but most states do not have specific policies on this issue.¹¹

Medicaid regulations place restrictions on how Medicaid cost-sharing may be used in determining provider reimbursement. States are prohibited from increasing the payments they make to providers to offset uncollected amounts for deductibles, co-insurance, co-payments or similar charges that the provider has waived or are uncollectable (with the exception of providers reimbursed by the state under Medicare reasonable cost reimbursement principles¹²). In addition, if a state contracts with certain managed care organizations that do not impose the state's Medicaid cost-sharing requirements on their Medicaid members, the state must calculate payments to such organizations as if those cost-sharing amounts were collected.

How Do Medicaid Research and Demonstration Waivers Work?

Section 1115 of the Social Security Act provides the Secretary of HHS with broad authority to conduct research and demonstration projects that further the goals of the Medicaid program (as well as other programs, such as SCHIP). Some policy makers at both the federal and state level view Section 1115 authority as a means to restructure Medicaid coverage, control costs, and increase state flexibility in a variety

¹¹ U.S. Department of Health and Human Services, Office of Inspector General, *Medicaid Cost Sharing*, OEI-03-91-01800 (July 1993), available at [<http://oig.hhs.gov/oei/reports/oei-03-91-01800.pdf>].

¹² For providers reimbursed under such principles, the state may increase its payment to offset uncollected Medicaid cost-sharing amounts that are bad debts for such providers. See Medicare Payment Advisory Commission, Report to the Congress: Selected Medicare Issues (June 2000), pp. 112-113, available at [http://www.medpac.gov/publications/congressional_reports/Jun00%20Entire%20report.pdf].

of ways. To obtain such a waiver, a state must submit proposals outlining the terms and conditions of its waiver for approval by the federal agency that oversees and administers the Medicaid program — the Centers for Medicare and Medicaid Services (CMS).

Under this authority, the Secretary may waive any Medicaid requirements contained in Section 1902 of the federal Medicaid statute, including but not limited to, freedom of choice of provider, and comparability and statewideness of benefits (as described above in the benefits section). For example, states may obtain waivers that allow them to provide services to individuals who would not otherwise meet Medicaid eligibility rules (e.g., childless adults without a disability), cover non-Medicaid services, limit benefit packages for certain groups, adapt programs to the special needs of particular geographic areas or groups of recipients, or accomplish a policy goal such as to temporarily extend Medicaid in the aftermath of a disaster (as was done in New York City after the September 11 terrorist attacks and in Gulf Coast states after Hurricane Katrina).

Approved waivers are deemed to be part of a state's Medicaid plan, and thus, the federal share of the costs for such waivers is determined by the FMAP formula (described earlier). Unlike regular Medicaid, waiver guidance¹³ specifies that the costs of 1115 waivers must be *budget neutral* over the life of the program. To meet this requirement, estimated spending under the waiver cannot exceed the estimated cost of the state's existing Medicaid program under current law requirements. For example, states may move certain existing Medicaid populations into managed care arrangements and use the savings accrued from that action to finance coverage of otherwise ineligible individuals under an approved waiver.

In current law, there are specific limits and restrictions on how a state may operate a waiver program. For example, such waivers must not limit mandatory services for the mandatory pregnant women and children eligibility groups. Another provision specifies restrictions on cost-sharing that may be imposed under waivers.

Some Medicaid Statistics

In FY2005, there were a total of 57.3 million people enrolled in Medicaid at some time during the year. Nearly one-half of these beneficiaries (28.2 million) were children and 15.6 million were adults in families with dependent children. There were also 8.6 million individuals with disabilities, and 4.9 million people over the age of 65 enrolled in Medicaid that year.¹⁴ The latest published estimate of total Medicaid spending available from CMS, including the costs of benefits and program

¹³ Medicaid Program; Demonstration Proposals Pursuant to Section 1115(a) of the Social Security Act; Policies and Procedures, 59 *Federal Register* 49249, Sept. 27, 1994.

¹⁴ Beneficiary statistics for FY2005 were taken from Table 11, *2005 CMS Statistics*, U.S. Department of Health and Human Services. See [<http://www.cms.hhs.gov/researchers/pubs/CMSstatistics/2005CMSstat.pdf>].

administration for the federal and state governments combined, was \$297.5 billion for FY2004.¹⁵

Across the nation, Medicaid covers a very diverse population, and compared to both Medicare and employer-sponsored health care plans, offers the broadest array of medical care and related services available in the United States today. Different groups under Medicaid have very different service utilization patterns. These patterns result in large differences in the proportion of total benefit expenditures by group. For example, based on detailed data for FY2002:

- While the majority of beneficiaries were children without disabilities (roughly 49%), such children accounted for only about 18% of Medicaid's total expenditures on benefits. Most of the expenditures for these children were for acute care in the fee-for-service setting¹⁶ (about 40%) and for managed care premiums¹⁷ (about 36%).
- The next largest beneficiary group — adults without disabilities in families with dependent children — accounted for about 26% of all beneficiaries but only about 12% of benefit expenditures. Like children, acute fee-for-service care (about 54%) and managed care premiums (about 32%) accounted for the majority of these costs.
- In contrast, individuals with disabilities represented about 16% of Medicaid beneficiaries, but this group accounted for the largest share of Medicaid expenditures for benefits (about 45%) of all groups. Most of the costs for persons with disabilities were for long-term care services¹⁸ (47%), acute fee-for-service care (26%), and outpatient prescription drugs (18%).
- Finally, the elderly represented about 9% of Medicaid beneficiaries, but about 26% of all expenditures for benefits. For the aged, the vast majority of costs were for long-term care (74%), and outpatient prescription drugs (14%).

While these statistics vary somewhat from year to year and state to state, the patterns described above generally hold true.

Beginning in 2006, Medicaid beneficiaries who are also eligible for Medicare (i.e., the elderly and certain individuals with disabilities) will receive their outpatient prescription drugs through the new Medicare prescription drug benefit (known as

¹⁵ Total Medicaid spending for FY2004 was taken from Table 26, *2005 CMS Statistics*, U.S. Department of Health and Human Services.

¹⁶ The acute fee-for-service category includes inpatient hospital, physician, dental, other practitioner (e.g., psychologists, chiropractors, optometrists), outpatient hospital, clinic, lab and x-ray, sterilization, abortion, therapy, midwife and nurse practitioner services.

¹⁷ The managed care category includes capitated payments for health maintenance organizations, prepaid health plans, and primary care case management services.

¹⁸ The long-term care category includes care in mental health facilities for persons over age 65 or under 21, care in intermediate care facilities for the mentally retarded, nursing facility care, home health services, personal care, targeted case management, rehabilitation, hospice care, private duty nursing, and home and community-based waiver services.

Medicare Part D) instead of through Medicaid. While the precise impact of the Part D program on Medicaid is unclear at this point in time, Medicaid's coverage of drugs for these populations is to be considerably reduced.

Where is Medicaid Headed?

Medicaid's role in providing access to health care for millions of Americans has been regularly scrutinized by Congress, resulting in important legislative changes. For example, in the 1980s, eligibility expansions for pregnant women and children were adopted. In the mid-1990s, welfare reform included provisions that restricted access to Medicaid for new immigrants, and removed the automatic link between receipt of cash assistance and Medicaid for low-income families. In the late 1990s, managed care was expanded significantly as was coverage for workers with disabilities. Largely because of concerns about questionable financing practices at the state level, on several occasions, Congress has restricted supplemental Medicaid payments made to hospitals serving a disproportionate share of Medicaid and uninsured patients (also called DSH payments). Similarly, in 2000, Congress also required new, more restrictive upper payment limit rules for institutional providers. And the formula used to determine the federal share of Medicaid costs has frequently been the subject of proposed reform, but with little federal action.

Today, Congress is in the midst of federal budget reconciliation for FY2006. And once again, Medicaid reform proposals are in both the House- and Senate-passed bills, setting up a conference on the Senate-numbered bill.¹⁹ The House passed this conference agreement on December 19, 2005. Among several Medicaid changes, the conference agreement includes provisions to change rules regarding asset transfers that affect eligibility for Medicaid long-term care services, reimbursement for prescription drugs, and beneficiary cost-sharing and covered benefits.

In addition, the House-passed conference agreement stipulates that no hospital or physician who imposes cost-sharing for non-emergency care in an emergency room would be liable in any civil action or proceeding, absent a finding by clear and convincing evidence of gross negligence. Liabilities related to the provision of emergency care or other applicable state laws regarding delivery of care would not be affected. On December 21, 2005, the Senate passed an amended conference agreement that, through a point of order, struck this Medicaid provision. The amended conference agreement must go back to the House for a new vote, which may happen on December 22, 2005, or could be postponed, perhaps to late January when Congress is back in session.

¹⁹ H.R. 4241 as amended was incorporated into the Senate passed bill, S. 1932, as a substitute amendment.

CRS Medicaid Resources

Below is a list of selected CRS reports on various issues that provide additional detail on the topics summarized in this report.

General

CRS Report RL32277, *How Medicaid Works: Program Basics*, by Elicia Herz, coordinator, et al.

Eligibility

CRS Report RL31413, *Medicaid-Eligibility for the Aged and Disabled*, by Julie M. Stone.

CRS Report RL33019, *Medicaid Eligibility for Adults and Children*, by Jean Hearne.

CRS Report RL31698, *Transitional Medical Assistance (TMA) Under Medicaid*, by April Grady.

Benefits

CRS Report RL32977, *Dual Eligibles: A Review of Medicaid's Role in Providing Services and Assistance*, by Karen Tritz.

CRS Report RS21837, *Implications of the Medicare Prescription Drug Benefit for Dual Eligibles and State Medicaid Programs*, by Karen Tritz.

CRS Report RL32362, *Key Benefits Under Medicaid and SCHIP for Children with Mental Health and Substance Abuse Problems*, by Elicia J. Herz.

CRS Report RL32219, *Long-Term Care: Consumer-Directed Services Under Medicaid*, by Karen Tritz.

CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne and April Grady.

Financing

CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by Christine Scott.

CRS Report RL31773, *Medicaid and the State Fiscal Crisis of 2000 - 2003*, by Christine Scott.

CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne.

CRS Report RL31021, *Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action*, by Elicia J. Herz.

CRS Report RS22101, *State Medicaid Program Administration: A Brief Overview*, by April Grady.

Provider Reimbursement

CRS Report RL32644, *Medicaid Reimbursement Policy*, by Mark Merlis.

Waivers

CRS Report RS21054, *Medicaid and SCHIP Section 1115 Research and Demonstration Waivers*, by Evelyne P. Baumrucker.

CRS Report RL33083, *Hurricane Katrina: Medicaid Issues*, by Evelyne Baumrucker, et al.

Statistics

CRS Report 97-975, *Health Insurance Coverage of Children, 2004*, by Chris L. Peterson.

CRS Report RL32555, *Medicaid/SCHIP as Primary Source of Health Insurance During the Year*, by Chris L. Peterson.

CRS Report RS21071, *Medicaid Expenditures, FY2002 and FY2003*, by Karen L. Tritz.

Policy Considerations

CRS Report RL33121, *Medicaid Issues for the 109th Congress*, by Jean Hearne.

CRS Report RL33131, *Budget Reconciliation FY2006: Medicaid, Medicare and State Children's Health Insurance Program (SCHIP) Provisions*, by Evelyne Baumrucker, et al.

CRS Report RL32771, *Medicaid and SCHIP: The President's FY2006 Budget Proposals*, by April Grady, et al