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Medicaid: An Overview

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August 3, 2015

Congressional Research Service
7-....
www.crs.gov
R43357

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term services and supports (LTSS) to an estimated 65 million people at a cost to states and the federal government of $498 billion in FY2014. In comparison, the Medicare program provided health care benefits to nearly 54 million seniors and certain individuals with disabilities in that same year at a cost of roughly $606 billion to the federal government. 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 the territories choose to participate. 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 programs outside of federal rules.

Historically, Medicaid eligibility generally has been limited to low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities; however, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) included the ACA Medicaid expansion, which expands Medicaid eligibility to individuals under the age of 65 with income up to 133% of the federal poverty level (FPL) (effectively 138% of 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 expands Medicaid eligibility for children aged 6 to 18 and former foster care children; transitions to the modified adjusted gross income (MAGI) counting methodology to determine eligibility for most non-elderly 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 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, it 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) requirement 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 long-term services and supports (LTSS), to a diverse low-income population, including children, pregnant women, adults, individuals with disabilities, and people aged 65 and older. In FY2014, Medicaid is estimated to have provided health care services to 65 million individuals[1] at a total cost of $498 billion, with the federal government paying $303 billion 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 calendar year (CY) 2013.[4] For some types of services, Medicaid is a significant payer. For instance, in CY2013, Medicaid accounted for 43% of national spending on LTSS,[5] and Medicaid pays for almost half of all births in the United States.[6]

Medicaid is one of the largest payers in the U.S. health care system, representing 15% of national health care spending in CY2013; in that year, private health insurance and Medicare accounted for 33% and 20%, 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 financed jointly 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. (Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, *2014 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, Centers for Medicare & Medicaid Services [CMS], U.S. Department of Health & Human Services [HHS], 2015.)

[2] This figure includes expenditures for State Medicaid Fraud Control Units, Medicaid survey and certification of nursing and intermediate care facilities, and the Vaccines for Children program. (CMS, CMS-64 data as of March 30, 2015; HHS, *Centers for Medicare & Medicaid Services: Fiscal Year 2016 Justification of Estimates for Appropriations Committees*, 2015.)

[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), *Report to the Congress on Medicaid and CHIP,* March 2014.

[5] Based on Congressional Research Service (CRS) analysis of National Health Expenditure Account (NHEA) data obtained from CMS, Office of the Actuary, prepared December, 2014.

[6] MACPAC, *Report to the Congress on Medicaid and CHIP*, June 2014.

[7] Micah Hartman, Anne B. Martin, and David Lassman, et al., "National Health Spending in 2013: Growth Slows, Remains In Step with the Overall Economy," *Health Affairs*, vol. 34, no. 1 (2015).

[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 states operate their programs within the federal requirements, states are entitled to federal Medicaid matching funds. Medicaid also is an individual entitlement, which means that anyone eligible and enrolled in Medicaid under his or her (continued...)

States must follow broad federal rules to receive federal matching funds, but they have flexibility to design their own versions 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 & Medicaid Services (CMS) for approval.[10]

Medicaid was designed to provide coverage to groups with a wide range of health care needs that historically were excluded from the private health insurance market (e.g., individuals with disabilities 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 typically are not 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 and referred to as *dual-eligible beneficiaries*. For other Medicaid enrollees, out-of-pocket costs generally are nominal, which may not be the case with most employer-sponsored insurance or coverage through health insurance exchanges (also referred to as *marketplaces*).[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 may be 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 that began in 2014. The ACA likely will 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. Under the ACA, Medicaid and the health insurance exchanges are envisioned to work in tandem to provide a continuous source of subsidized coverage for lower-income individuals and families. Medicaid agencies are required to coordinate with the health

(...continued)

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 "Medicaid Program Waivers."

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

[12] Health insurance exchanges were established under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148 as amended) as marketplaces in which certain individuals and businesses can purchase private health insurance. For more information about the health insurance exchanges, see CRS Report R44065, *Overview of Health Insurance Exchanges*, coordinated by (name redacted).

insurance 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 addresses 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) requirement 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 standards. Individuals must meet both *categorical* (e.g., elderly, individuals with disabilities, children, pregnant women, parents, certain non-elderly childless adults) and *financial* (i.e., income and sometimes assets limits) criteria.[13] 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 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).

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

- low-income 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 the age of 18 with family income at or below 133% of the federal poverty level (FPL);[14]
- low-income individuals who are aged 65 and older, or who are blind, or who are under the age of 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 the age of 18) under Title IV–E of the Social Security Act;
- certain individuals who age out of foster care, up to the age of 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 7 years after entry into the United States; asylees for the first 7 years after asylum is

[13] 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 income and assets.

[14] 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 HHS. The guidelines, which are a simplification of the poverty thresholds, are used for administrative purposes—for instance, determining financial eligibility for certain federal programs.

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 to which states *may* provide Medicaid include

- pregnant women and infants with family income between 133% and 185% of 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) and have high medical expense, but have income that exceed the applicable income requirements;[15]
- working people with disabilities; and
- non-elderly adults who otherwise are not eligible for Medicaid with income at or below 133% of FPL (i.e., the ACA Medicaid expansion). (For more information about the ACA Medicaid expansion, see "ACA Medicaid Expansion.")

Modified Adjusted Gross Income

As of January 1, 2014, MAGI rules are used in determining eligibility for most of Medicaid's non-elderly populations, including the ACA Medicaid expansion.[16] This change could mean some individuals who previously were eligible for Medicaid no longer would 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 who previously were eligible for Medicaid ineligible because stepparent income often is excluded from the pre-ACA income counting rules but included for MAGI. By contrast, children previously not eligible might become eligible because MAGI excludes child support income, which generally was included under the pre-ACA income counting rules.[17]

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

[16] Under the ACA, certain groups are exempt from income eligibility determinations for Medicaid based on modified adjusted gross income (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 Supplemental Security Income [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 Children's Health Insurance Program [CHIP] eligibility requirements), for Medicare prescription drug low-income subsidies, or for determinations of eligibility for Medicaid long-term services and supports (LTSS). (For more information about MAGI, see CRS Report R43861, *The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs*, coordinated by (name redacted).)

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

Medicaid's MAGI income-counting rule is set forth in law and regulation.[18] For Medicaid, 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 by certain types of income (e.g., tax-exempt interest income received or accrued during the taxable year and the nontaxable portion of Social Security benefits)[19]. In addition, under Medicaid regulations certain types of income are subtracted (e.g., certain scholarships and fellowships) to arrive at MAGI.[20]

Under the MAGI counting rules, the state looks at each individual's MAGI, deducts 5%, which the law provides as a standard disregard, and compares that income to the new income standards set by the state in coordination with CMS. See **Table A-1** for the state-by-state MAGI-based eligibility levels adjusted for the 5% disregard effective January 1, 2015.

The transition to the MAGI income rules had significant implications for the Medicaid eligibility determination process. It represented 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 stepparent) compared with former Medicaid eligibility rules. These changes necessitated a redesign of the existing Medicaid eligibility and enrollment systems for each state. These systems were integrated with the health insurance 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 FY2023 (see **Table B-1** for state-by-state Medicaid enrollment for FY2012). The figure shows steady enrollment growth, especially among nondisabled children and adults as a result of the recessions.[21] During periods of economic downturns, Medicaid programs face 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.[22]

The ACA Medicaid expansion is projected to add 4.3 million newly eligible adults to Medicaid in FY2014 and 12.0 million newly eligible adults by FY2023.[23] Regardless of whether a state decides to implement the ACA Medicaid expansion, all states are expected to experience an increase in Medicaid enrollment due to the *woodwork* effect. The woodwork effect is the term for

[18] §1902(e)(14)(E) of the Social Security Act and 42 C.F.R. §435.603(e).

[19] While the Internal Revenue Service's definition of MAGI excludes nontaxable social security benefits, P.L. 112-56, enacted on November 21, 2011, changed the definition of income for Medicaid eligibility to include such nontaxable social security benefits.

[20] For more information, see CRS Report R43861, *The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs*, coordinated by (name redacted).

[21] 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.

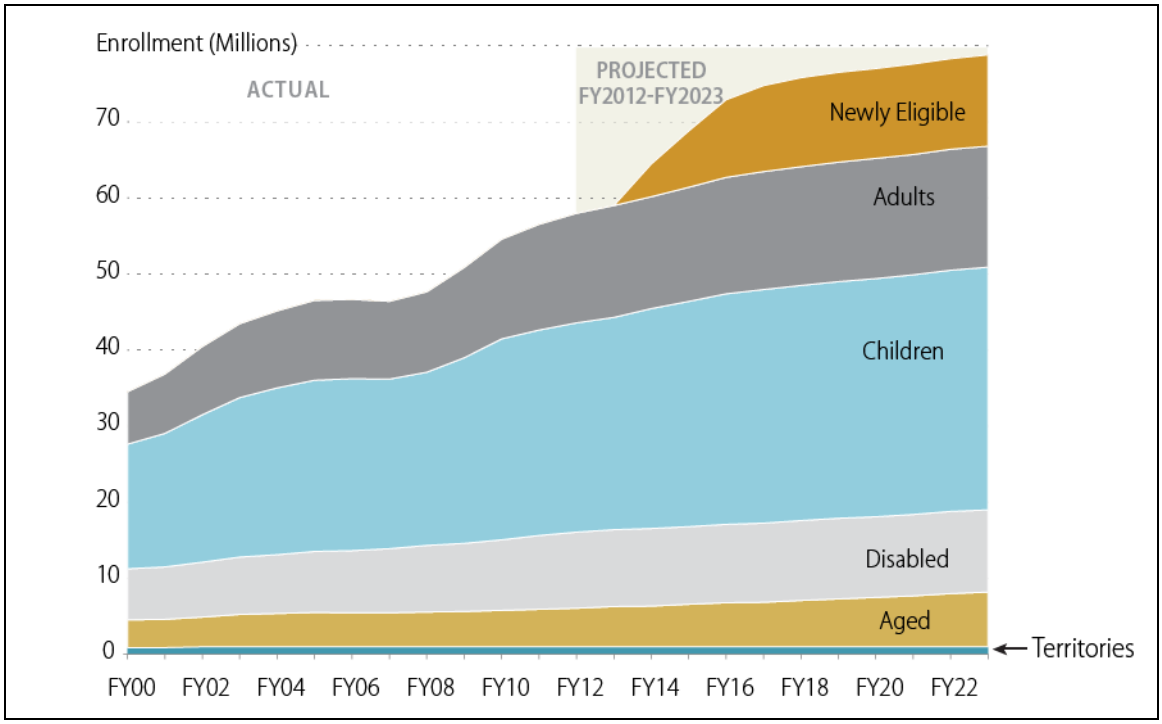
[22] John Holahan and A. Bowen Garrett, *Rising Unemployment, Medicaid and the Uninsured*, Kaiser Commission on Medicaid and the Uninsured, Publication #7850, January 2009.

[23] Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, *2014 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, CMS, HHS, 2015.

uninsured individuals who are eligible for Medicaid without the expansion but decide to enroll in Medicaid due to increased media attention and outreach efforts associated with the ACA.

Figure 1. Past and Projected Medicaid Enrollment, by Population

(FY2000–FY2023)



Source: Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, *2014 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health & Human Services (HHS), 2015.

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

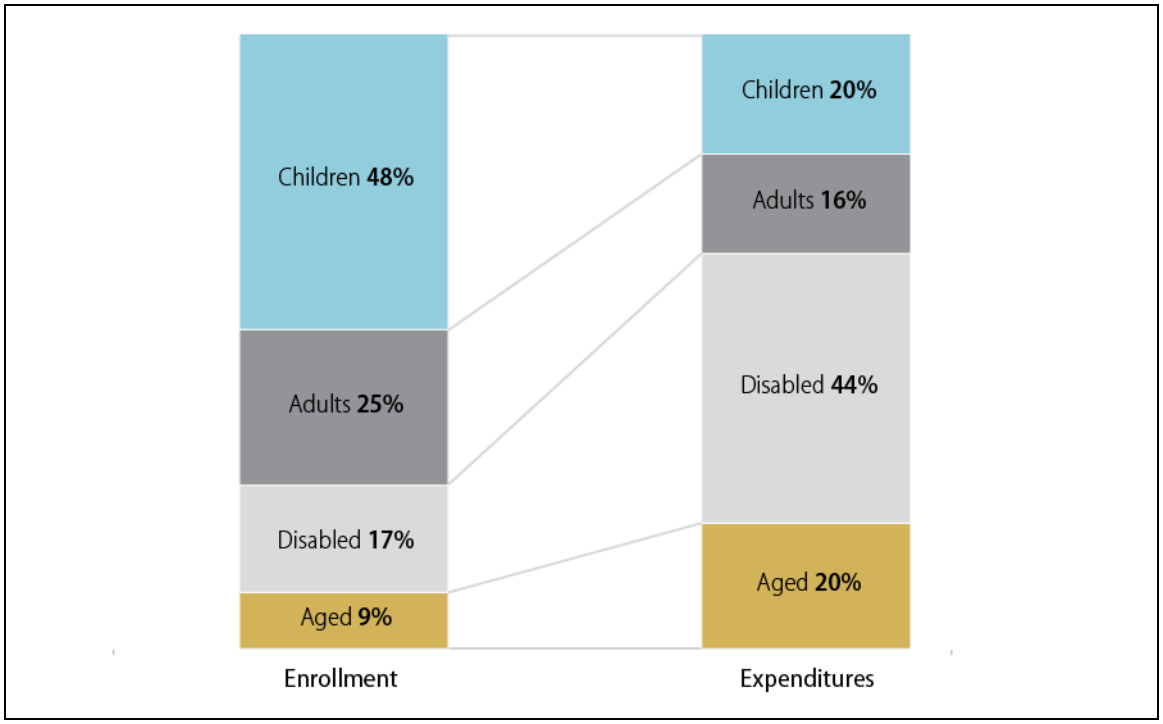
For purposes of this figure, *Newly Eligible Adults* are adult enrollees who are newly eligible in 2014 and later as a result of the expanded eligibility criteria in the Patient Protection and Affordable Care Act (ACA; 111-148, as amended). Other eligible adults who become enrolled as a result of the 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 Medicaid expenditures, while some smaller enrollment groups are responsible for a larger proportion of Medicaid expenditures. As shown in **Figure 2**, for FY2012, 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 25% of all enrollees but only about 16% 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 21% 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.

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

(FY2013)



Source: Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, *2014 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, CMS, HHS, 2015.

Notes: Totals and components exclude disproportionate share hospital expenditures (i.e., payments to hospitals treating large numbers of low-income patients), territory enrollees and expenditures, and other adjustments. May not sum to totals due to rounding.

Benefits

Medicaid coverage includes a wide variety of preventive, primary, and acute care services as well as LTSS (see "Long-Term Services and Supports" for more information about LTSS).[24] Not everyone enrolled in Medicaid has access to the same set of services. Different eligibility classifications determine available benefits. Federal law provides two primary benefit packages for state Medicaid programs: (1) traditional benefits and (2) alternative benefit plans (ABPs).[25] Each of these packages is summarized in **Table 1**. For the medically needy subgroup, states may offer a more restrictive benefit package than is available to other enrollees. In addition, states can use waiver authority (e.g., Section 1115 of the Social Security Act) to tailor benefit packages to specified Medicaid subgroups (see "Medicaid Program Waivers" for more information about Section 1115 waivers).

[24] LTSS benefits include nursing facility services, home health, case management services, personal care services, and private duty nursing.

[25] For more information about traditional Medicaid benefits and alternative benefit plan coverage, see CRS Report R43656, *Traditional Benefits and Alternative Benefit Plans Under Medicaid*, by (name redacted).

Table 1. Examples of Mandatory and Optional Benefits for Traditional Benefits and Alternative Benefit Plans (ABPs)

Type of Benefit	Traditional Benefits	ABPs
Mandatory	• Inpatient hospital services • Nursing facility care (aged 21+) • EPSDT (< the age of 21) • Physician services • FQHC services • Family planning services • Pregnancy-related services • Home health	• Hospitalization services • EPSDT (< the age of 21) • Preventive services • FQHC services • Family planning services • Maternity and newborn care • Prescription drugs • Rehabilitative services • Mental health services
Optional	• Clinic services • Prescription drugs • Physical, occupational, and speech therapy services • Dental services for adults	For special-needs subgroups, option to receive traditional benefits or enroll in an ABP plan.

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

Notes: ABP—Alternative Benefit Plans

EPSDT—Early and Periodic Screening, Diagnostic and Treatment services

FQHC—Federally qualified health center

Traditional Medicaid Benefits

The traditional Medicaid program requires states to cover a wide array of mandatory services (e.g., inpatient hospital care, lab and x-ray services, physician care, nursing facility services for individuals aged 21 and older). In addition, states may provide optional services, some of which commonly are covered (e.g., personal care services, prescription drugs, clinic 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 population groups must be equal in amount, duration, and scope. This requirement is 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. (See "Service Delivery Models" for information about managed care.)

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; sufficiency of amount, duration, and scope; and freedom of choice. Exceptions to state limits may be permitted under circumstances defined by the state.

Alternative Benefit Plans

As an alternative to providing all the mandatory and selected optional benefits under traditional Medicaid, the Deficit Reduction Act of 2005 (DRA; P.L. 109-171) gave states the option to enroll state-specified groups in what was referred to as benchmark or benchmark-equivalent coverage but currently are called ABPs. The ACA made significant changes to both ABP design and requirements.[26]

Under ABPs, states may waive the statewideness and comparability requirements that apply to traditional Medicaid benefits. This flexibility permits the state to define populations that are served and the specific benefit packages that apply. In general, ABPs may cover fewer benefits than traditional Medicaid, but there are some requirements, such as coverage of EPSDT services (for children under the age of 21), family planning services and supplies, and both emergency and nonemergency 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 ABP coverage to the individuals eligible for Medicaid through the expansion (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 health insurance exchanges.[27] In addition, ABP coverage must comply with the federal requirements for mental health parity,[28] and special rules also apply with regard to prescription drugs, rehabilitative and habilitative services and devices, and preventive care. Medicaid beneficiaries enrolled in such coverage must have access to services provided by rural health clinics and federally qualified health centers.

[26] Existing benchmark and benchmark-equivalent plans prior to the ACA also have to conform to ACA requirements.

[27] 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) prescription 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.

[28] Health insurance coverage for mental illness historically had 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.

Long-Term Services and Supports

LTSS refers to a broad range of health and health-related services and supports needed by individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or condition. Among the Medicaid LTSS benefits, the only state plan benefits that participating states are required by federal law to cover are nursing facility services and home health. States may cover other types of LTSS, including case management services, personal care services, and private duty nursing.[29]

As the largest single payer of LTSS in the United States, Medicaid plays a key role in providing these services. In FY2014, Medicaid LTSS accounted for 26% of all Medicaid spending despite the fact that LTSS recipients represent a relatively small share of the total Medicaid population (See **Figure 3**).[30] An estimated 4.2 million Medicaid beneficiaries (or 6.4%) of the 66 million total enrolled Medicaid population received LTSS in FY2010.[31]

Medicaid funds LTSS for eligible beneficiaries in both institutional and home- and community-based settings, though the services offered differ substantially by state. Moreover, states are required to offer certain Medicaid institutional services to eligible beneficiaries, while the majority of Medicaid home- and community-based services (HCBS) are optional for states. In recent decades, federal authority has expanded to assist states in increasing and diversifying their Medicaid LTSS coverage to include HCBS. As a result, the share of Medicaid LTSS spending for HCBS has increased considerably, from 33% of Medicaid LTSS spending in 2003 to 51% of Medicaid LTSS spending in 2013.[32]

Medicaid Service Spending

Figure 3 below shows the nationwide distribution of Medicaid expenditures across broad categories of service for FY2014. These data illustrate that 37% of benefit spending is for capitated payments under managed care arrangements (see "Service Delivery Models" for information about managed care), while LTSS account for a little more than a quarter and acute care services represent another quarter of Medicaid benefit payments. In general, when other sources of insurance/payment are available (including Medicare), Medicaid wraps around that coverage (i.e., additional coverage for services covered under Medicaid but not under the other source of coverage).[33]

[29] For more information about these benefits and Medicaid LTSS, see CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*, by (name redacted).

[30] CRS analysis of CMS, CMS-64 Data (base expenditures), FY2014 as of March 30, 2015. This estimate does not include Medicaid LTSS expenditures financed under capitated arrangements.

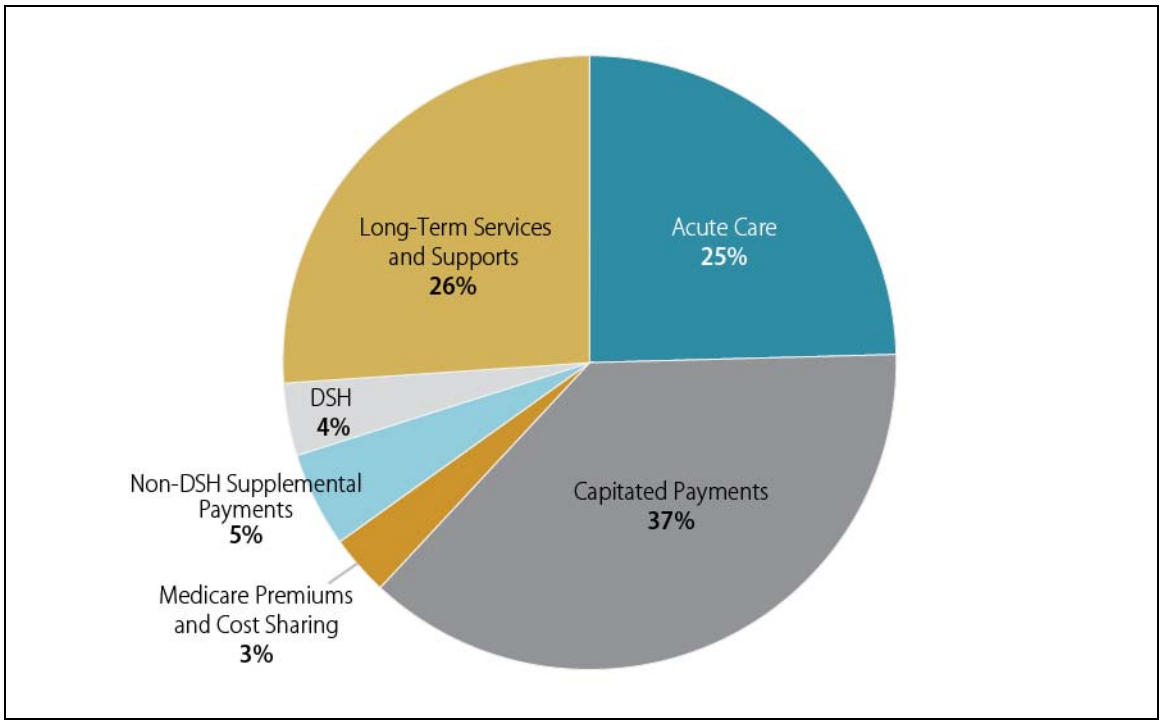
[31] These enrollment figures are measured according to "ever enrolled" counts that measure the number of people covered by Medicaid for any period of time during the year, which provides a higher count than enrollment measured according to person-year equivalents or average monthly enrollment. (MACPAC, *Report to the Congress on Medicaid and CHIP*, June 2014.)

[32] Steve Eiken, et al., *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY2013: Home and Community-Based Services were a Majority of LTSS Spending*, Truven Health Analytics, June 30, 2015.

[33] For related details, see federal regulations at 42 C.F.R. 433.135, 433.138, and 433.152.

Figure 3. Medicaid Medical Assistance Payments, by Service Category

(FY2014)



Source: CRS analysis of CMS, CMS-64 Data (base expenditures), FY2014 as of March 30, 2015.

Notes: Medical assistance expenditures exclude Medicaid expenditures for administrative activities. DSH stands for *disproportionate share hospital* payments, which are one type of supplemental payments. 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. Acute care services include prescription drugs. Capitated payments are those payments made under managed care arrangements (see "Service Delivery Models" for information about managed care).

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., co-payments [i.e., flat dollar amounts paid directly to providers for services rendered]).[34] 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 often are prohibited. However, premiums may be imposed on certain enrollees, such as individuals with incomes above 150% of FPL, certain working individuals with disabilities, and certain children with disabilities.

[34] For more information about Medicaid cost sharing, see CRS Report R43850, *Out-of-Pocket Costs for Medicaid Beneficiaries: In Brief*, by (name redacted).

States can impose cost sharing, such as co-payments,[35] coinsurance,[36] deductibles,[37] and other similar charges, on most Medicaid-covered benefits up to federal limits that vary by income. Some subgroups of beneficiaries are exempt from cost sharing (e.g., children under 18 years of age and pregnant women).

The aggregate cap on all out-of-pocket cost sharing is generally up to 5% of monthly or quarterly household income.[38]

Service Delivery Models

In general, benefits are made available to Medicaid enrollees via two service delivery systems: *fee-for-service* or *managed care*. Under the fee-for-service 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 through an organization under contract with the state.[39] States traditionally have 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. In FY2011, about 72% of Medicaid enrollees were covered by some form of managed care and all but four states (Alaska, Idaho, New Hampshire, and Wyoming) used managed care coverage to some extent.[40]

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 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. MCOs then pay providers for services to enrollees.
- **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 fee-for-service 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 it on a capitated basis. The difference is that limited benefit

[35] A *co-payment* is a specified dollar amount for each item or service delivered.

[36] *Coinsurance* is a specified percentage of the cost or charge for a specific service delivered.

[37] A *deductible* is a specified dollar amount paid for certain services rendered during a specific time period (e.g., per month or quarter) before health coverage (e.g., Medicaid) begins to pay for care.

[38] §1916A of the Social Security Act.

[39] On May 26, 2015, CMS released a proposed rule laying out the agency's plan to update the federal regulations pertaining to Medicaid managed care. The proposed rule would be the first major federal regulation impacting Medicaid managed care since 2002. (See CRS Report R44105, *Centers for Medicare & Medicaid Services (CMS) Proposed Rule on Medicaid Managed Care: Frequently Asked Questions*, by Kirstin B. Blom.)

[40] Data from Maine, Tennessee, and Vermont were excluded due to spending anomalies and reporting differences. All three of these states use managed care in their Medicaid programs. (MACPAC, *Report to the Congress on Medicaid and CHIP*, June 2014.)

plans provide only one or two Medicaid services (e.g., behavioral health or dental services).

While managed care has been used largely for healthier Medicaid subgroups (i.e., children and parents), some states are turning to this type of service delivery model for the elderly and individuals with disabilities.

In addition to these two main types of service delivery models, some states use alternative models, such as premium assistance[41] and health savings accounts.[42] Some states are using these alternative models for their ACA Medicaid expansion. For example, Arkansas uses premium assistance through the *private option*[43] for the ACA Medicaid expansion and Michigan uses health savings accounts.

Financing

The federal government and the states jointly finance Medicaid.[44] 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 FY2014, Medicaid expenditures totaled $498 billion. The federal share totaled $303 billion and the state share was $195 billion.[45]

Federal Share

The federal government's share of most Medicaid expenditures is established by the federal medical assistance percentage (FMAP) rate, which generally is determined annually and varies by state according to each state's per capita income relative to the U.S. per capita income.[46] The formula provides higher FMAP rates, or federal reimbursement rates, to states with lower per capita incomes, and it provides lower FMAP rates to states with higher per capita incomes.

[41] States have several options to pay premiums for adults and children to purchase coverage through private group health plans and, in some cases, individual plans.

[42] *Health savings accounts* (HSAs) are accounts with funding available to cover the cost of health care services. An HSA, in and of itself, is not a health insurance plan. Instead, it is an investment account in which contributions earn interest-tax free. In the private market, consumers, their employers, or both may make contributions to HSAs. Consumers withdraw funds on a tax-free basis to cover medical expenses not covered by health insurance. Unused contributions roll over to the next year.

[43] Under the *private option*, the state provides premium assistance to purchase health insurance coverage under the qualified health plans offered through the health insurance exchanges.

[44] For more information about Medicaid financing and expenditures, see CRS Report R42640, *Medicaid Financing and Expenditures*, by (name redacted).

[45] These figures include expenditures for State Medicaid Fraud Control Units, Medicaid survey and certification of nursing and intermediate care facilities, and the Vaccines for Children program. (CMS, CMS-64 data as of March 30, 2015; HHS, *Centers for Medicare & Medicaid Services: Fiscal Year 2016 Justification of Estimates for Appropriations Committees*, 2015.)

[46] For more detail about the federal medical assistance percentage (FMAP) rate, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2016*, by (name redacted).

FMAP rates have a statutory minimum of 50% and a statutory maximum of 83%.[47] In FY2015, 13 states have the statutory minimum FMAP rate of 50%, and Mississippi has the highest FMAP rate of 74% (see **Table B-1** for each state's FY2015 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 Individual[48] program), providers (e.g., 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 included FMAP exceptions, including the *newly eligible* federal matching rates and the *expansion state* federal matching rates. Under the newly eligible federal matching rate, from 2014 through 2016, states receive a 100% federal matching rate for the cost of individuals who are newly eligible for Medicaid due to the ACA expansion. As shown in **Table 2**, this newly eligible federal matching rate phases down to 95% in 2017, 94% in 2018, 93% in 2019, and 90% thereafter.[49] The expansion state federal matching rate is available for individuals in expansion states[50] who were eligible for Medicaid on March 23, 2010, and are in the new eligibility group for non-elderly, nonpregnant adults at or below 133% of FPL. The formula[51] used to calculate the expansion state federal matching rates is based on a state's regular federal matching rate, so the expansion state federal matching rates will vary from state to state until 2019, at which point the newly eligible and the expansion state federal matching rates will converge at 93% and phase down to 90% for 2020 and subsequent years.

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.

[47] §1905(b) of the Social Security Act.

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

[49] 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.

[50] This definition of expansion state was established prior to the Supreme Court decision making ACA Medicaid expansion optional for states. In this context, *expansion state* refers to states that already had implemented (or partially implemented) the ACA Medicaid expansion at the time the ACA was enacted. Specifically, expansion states are defined as those that, as of March 23, 2010 (the ACA's enactment date), provided health benefits coverage meeting certain criteria statewide to parents with dependent children and adults without dependent children up to at least 100% of FPL.

[51] 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+].

Notes: For the calculation of the expansion state federal matching 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).

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)[52] 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 *nonfederal 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 (e.g., provider taxes,[53] local government funds, tobacco settlement funds, etc.) to finance the state share of Medicaid.[54] Federal statute[55] allows as much as 60% of the state share to come from local government funding.[56] Federal regulations also stipulate that the state share not be funded with federal funds (Medicaid or otherwise).[57] In state fiscal year 2013, on average, 73% of the state share of Medicaid expenditures was financed by state general funds, and the remaining 27% was financed by other state funds.[58]

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 process is referred to as *Medicaid maximization*.[59] In general, some states have used Medicaid maximization strategies that involve

[52] For more information about Medicaid DSH payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*, by (name redacted).

[53] 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 (name redacted).

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

[55] §1902(a)(2) of the Social Security Act.

[56] 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. (MACPAC, *Report to the Congress on Medicaid and CHIP*, March 2012.)

[57] 42 C.F.R. 433.51(c).

[58] National Association of State Budget Officers, *State Expenditure Report: Examining Fiscal 2012-2014 State Spending*, 2014.

[59] 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, managing director of health care, in 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 (continued...)

the coordination of fund sources, such as provider taxes and intergovernmental transfers,[60] and payment policies, such as DSH and other supplemental payments[61] to draw down federal Medicaid funds without expending many, if any, state general funds.

Expenditures

The cost of Medicaid, like most health expenditures, generally has increased at a rate significantly faster than the overall rate of U.S. economic growth, as measured by gross domestic product. In the past, much of Medicaid's expenditure growth has been due to federal or state expansions of Medicaid eligibility criteria,[62] but per enrollee costs for Medicaid also have increased faster than the economy. However, when compared to other forms of health insurance, Medicaid per enrollee expenditures are relatively low.

Medicaid expenditures are influenced by economic, demographic, and programmatic factors. Economic factors include health care prices, unemployment rates (see the "Medicaid Enrollment Trends" section for a discussion of the impact of the unemployment rate on Medicaid enrollment, which also impacts expenditures), and individuals' wages. Demographic factors include population growth and the age distribution of the population. Programmatic factors include state decisions regarding optional eligibility groups, optional services, and provider payment rates. Other factors include the number of eligible individuals who enroll, utilization of covered services, and enrollment in other health insurance programs (including Medicare and private health insurance).

Figure 4 shows actual Medicaid expenditures from FY1997 to FY2014 and projected Medicaid expenditures from FY2015 through FY2023 (see **Table B-1** for state-by-state expenditures for FY2014). These figures are broken down by state and federal expenditures. In FY2014, Medicaid spending on services and administrative activities in the 50 states, the District of Columbia, and the territories totaled $494 billion.[63] Medicaid expenditures are estimated to grow to $835 billion in FY2023.[64]

(...continued)

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*, Urban Institute, June 2002.

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

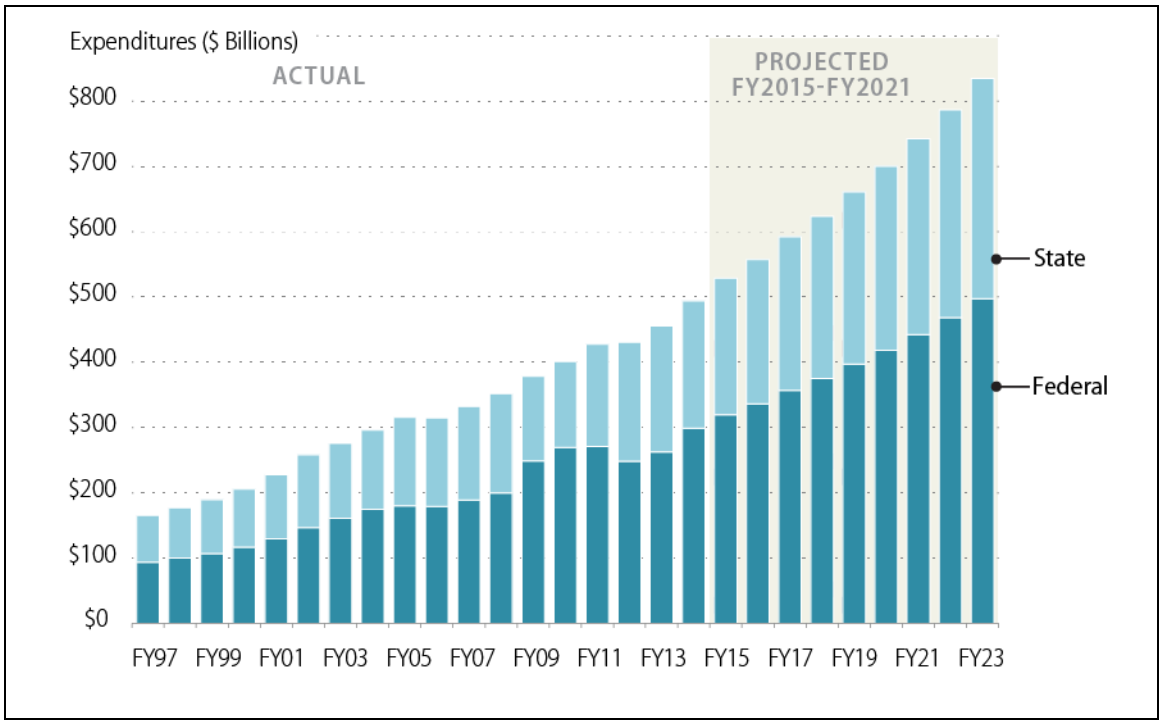
[61] *Supplemental payments* are Medicaid payments made to providers that are separate from and in addition to the standard payment rates for services rendered to Medicaid enrollees. Often, providers receive supplemental payments in a lump sum.

[62] 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.

[63] This figure excludes expenditures for State Medicaid Fraud Control Units, Medicaid survey and certification of nursing and intermediate care facilities, and the Vaccines for Children program. (CMS, CMS-64 Data, as of March 30, 2015.)

[64] Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, *2014 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, CMS, HHS, 2015.

Figure 4. Federal and State Actual and Projected Medicaid Expenditures
(FY1997-FY2023)



Sources: Actual expenditures are from Form CMS-64 Data as of March 30, 2015, and projected expenditures are from Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, *2014 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, CMS, HHS, 2015.

Note: The expenditures shown in this figure are total Medicaid expenditures, which include both administrative and benefit spending.

Historically, in a typical year, the average federal share of Medicaid expenditures was about 57%, which means the average state share is about 43%. However, the federal government's share of Medicaid expenditures increased 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 expansion state federal matching rates. In FY2014, the average federal share of Medicaid increased to 60%, and the federal share of Medicaid is expected to remain at that level through FY2023.[65]

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.[66]

[65] Ibid.

[66] §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 policymakers. Still, during the most recent recession, which ended in 2009, many states reduced Medicaid provider payment rates due to budget pressures. However, over the past couple years, more states have been enhancing rather than reducing provider rates overall due to improvements in state finances.[67]

The ACA required 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 picked 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. While the ACA requirement and the enhanced federal funding have expired, one survey found that 15 states planned to continue the higher payment rates at least partially, 24 states did not plan to continue the higher rates, and the remaining states had not made a decision at the time the survey was conducted.[68]

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.[69] 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 nonhospital 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 FY2014, federal DSH allotments totaled $11.7 billion.[70] The ACA made aggregate reductions in Medicaid DSH allotments for FY2014 through FY2020, but multiple subsequent laws have amended these reductions. Under current law, the aggregate reductions to the Medicaid DSH allotments are to impact FY2018 through FY2025 and in FY2026 states' DSH allotments are to rebound to their pre-reduced levels with the annual inflation adjustments for FY2018 to FY2025.

[67] Vernon K. Smith, Kathleen Gifford, Eileen, et al., *Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and* 2015, Kaiser Commission on Medicaid and the Uninsured, October 2014.

[68] Ibid.

[69] In practice, the upper payment limit (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. (MACPAC, *Medicaid UPL Supplemental Payments*, November 2012.)

[70] 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 (name redacted).

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 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 the following:

- **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 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.[71]
- **Section 1915(c) Home- and Community-Based Services (HCBS) Waivers—** 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 LTSS needs. Specifically, under Section 1915(c) states can waive rules regarding statewideness and comparability of services. States also may apply certain income counting rules to persons in HCBS waivers that allow an individual who otherwise might not qualify to be eligible for Medicaid.
- **Section 1915(b)/(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 plans. Key characteristics of these primary Medicaid waiver authorities compared with state plan requirements are summarized in **Table 3**. 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

[71] There are four types of authorities under §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).

requirements. In addition, all types of waivers must comply with various financing requirements (e.g., budget neutrality,[72] cost-effectiveness,[73] or cost-neutrality).[74]

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

Key Characteristic	§1115 Research and Demonstration Waivers[a]	§1915(b) Managed Care/Freedom of Choice Waivers	§1915(c) Home and Community Based Services (HCBS) Waivers	§1915(b)/(c) Concurrent Waivers	Medicaid State Plan
Number of Waivers[b]	53 waivers (in 37 states and DC)	52 waivers (in 30 states and DC)	272 waivers (in 48 states and DC)	N/A	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-neutrality and cost-effectiveness tests	Open-ended mandatory entitlement
Enrollment caps and waiting lists	X	—	X	X	Individual entitlement

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

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

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

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

[74] 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.

b. Data for number of waivers from lists of operational waivers posted on the CMS website as of May 2015.

c. Waiving the statewideness requirement (as permitted under §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 (§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 (§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 (§1902[a][10][C][i][II]) of the Social Security Act) mean that income and resources are not deemed to the recipient from a spouse or parent.

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, whereas other areas, such as managed care, have received comparatively little attention in the past.[75]

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 such 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 generally is 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 among 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 an RAC to identify and recover overpayments and identify underpayments.

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

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 states are implementing the expansion, some are still deciding, and others have chosen not to implement the expansion. Second, the coordination of care for dual-eligible beneficiaries is a focus of federal and state policymakers. Third, a new ACA health insurance annual fee may increase Medicaid expenditures through higher Medicaid MCO rates. Finally, the ACA included a Medicaid maintenance of effort (MOE) provision, which expired on January 1, 2014, for adults but continues until September 30, 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 the age of 65 with income up to 133% of FPL (effectively 138% of FPL; see "Eligibility" for more information).[76] 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).

Originally, it was assumed that all states would implement the ACA Medicaid expansion in 2014 as required by statute because implementation was required for states to receive any federal Medicaid funding. However, on June 28, 2012, the U.S. Supreme Court issued its decision in *National Federation of Independent Business (NFIB) v. Sebelius*[77] finding that the federal government cannot terminate the federal Medicaid funding a state receives for its current Medicaid program if a state does not implement the ACA Medicaid expansion.[78]

State Decisions

Since the federal government cannot terminate current Medicaid federal matching funds if a state does not 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.

[76] For more information about the ACA Medicaid expansion, see CRS Report R43564, *The ACA Medicaid Expansion*, by (name redacted).

[77] 132 S. Ct. 2566 (2012).

[78] 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 (name redacted).

CMS informed states that they face no deadline for deciding whether to implement the ACA Medicaid expansion and, according to CMS, states also can discontinue the expansion at any time.[79] If states want to take full advantage of the 100% federal financing for the newly eligible enrollees, however, they must have implemented 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.

On January 1, 2014, when the ACA Medicaid expansion went into effect, 24 states and the District of Columbia included the ACA Medicaid expansion as part of their Medicaid programs. The following states implemented the expansion on later dates: Michigan (April 1, 2014), New Hampshire (August 15, 2014), Pennsylvania (January 1, 2015), and Indiana (February 1, 2015). In addition, Montana Governor Bullock signed the bill adopting the ACA Medicaid expansion on April 29, 2015, but the law directs the state to apply for a Section 1115 waiver to implement the expansion that requires federal government approval. In July 2015, the governor of Alaska informed the legislature of his intent to accept federal Medicaid funding for the ACA Medicaid expansion.[80] In addition, Utah currently is debating the ACA Medicaid expansion.[81] **Figure 5** shows state decisions about implementing the ACA Medicaid expansion as of July 2015.

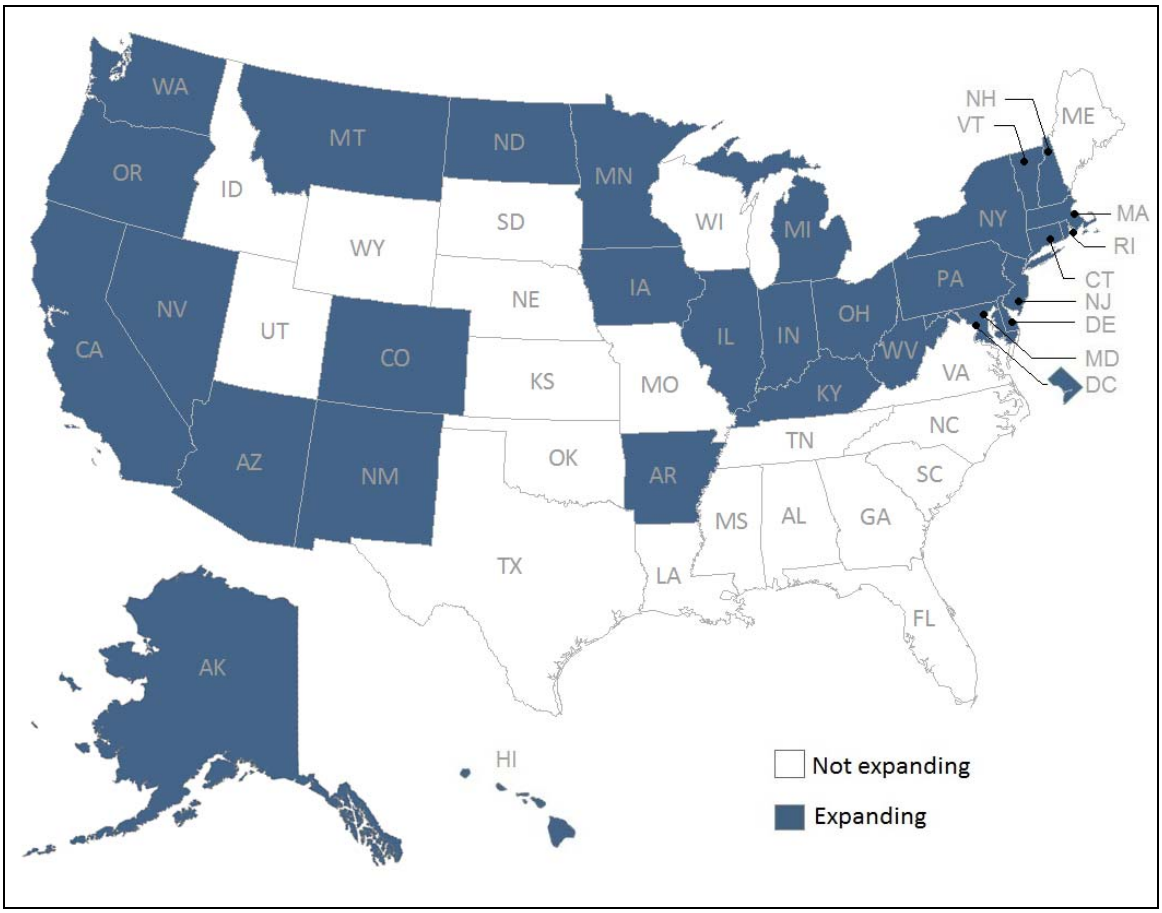
[79] CMS, *Frequently Asked Questions on the Exchanges, Market Reforms and Medicaid*, December 10, 2012.

[80] Sara Hansard, "Alaska Expanding ACA Medicaid Under Governor's Action," *Bloomberg BNA*, July 17, 2015; Rachana Pradhan, "Alaska to expand Medicaid," *Politico Pro,* July 17, 2015.

[81] Rachana Pradhan, "Utah leaders reach agreement on Medicaid expansion," *Politico Pro,* July 18, 2015.

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

(as of July 2015)



Source: CRS.

Notes: Most states implemented the ACA Medicaid expansion on January 1, 2014, but the following states implemented the expansion on later dates: Michigan (April 1, 2014), New Hampshire (August 15, 2014), Pennsylvania (January 1, 2015), and Indiana (February 1, 2015). Montana Governor Bullock signed the bill adopting the ACA Medicaid expansion on April 29, 2015, but the law directs the state to apply for a Section 1115 waiver to implement the expansion.

Dual-Eligible Beneficiaries

In FY2011, there were 10.2 million dual-eligible beneficiaries, who are individuals enrolled in both Medicare and Medicaid,[82] which is almost 15% of Medicaid enrollment. Individuals qualify for Medicare either because they are aged 65 or older or because they are under the age of 65, have a disability, and have been receiving Social Security Disability Insurance for two years.[83] As mentioned previously, individuals qualify for Medicaid because they meet both the categorical requirement (i.e., are a member of a covered group, such as children, pregnant women, families

[82] This enrollment figure is measured by individuals who were "ever enrolled" in the Medicaid program throughout the year. (MACPAC, *Report to Congress on Medicaid and CHIP*, June 2014.)

[83] 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*, coordinated by (name redacted) and (name redacted).

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 diverse. 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/or cost sharing).

There are numerous Medicaid eligibility pathways for dual-eligible beneficiaries,[84] 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 FY2011, there were 7.5 million full duals, with Medicaid spending totaling $134.3 billion, and 2.6 million partial duals with $6.0 billion in Medicaid spending.[85]

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 beneficiaries and improve the quality of their care, federal and state policymakers are focusing on coordinating care for dual-eligible beneficiaries.[86]

The ACA established the Medicare-Medicaid Coordination Office within CMS to improve care coordination for dual-eligible beneficiaries. In addition, the ACA provided CMS with 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.

[84] 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 working individuals, and qualifying individuals.

[85] This expenditure figure includes both federal and state Medicaid expenditures. (MACPAC, *Report to Congress on Medicaid and CHIP*, June 2014.)

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

Impact of ACA Health Insurance Annual Fee on Medicaid

The ACA imposes an annual fee on certain for-profit health insurers, starting in 2014.[87] The ACA health insurance annual fee applies to Medicaid MCOs with the exception of nonprofit 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).[88] According to one estimate, approximately 80% of Medicaid enrollees covered by managed care receive coverage from a plan impacted by the ACA fee.[89]

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.[90] Medicaid MCOs do not have the ability to pass on the cost of the fee 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.[91] For this reason, some states have indicated they are willing to include the cost of the ACA fee in the capitation rates,[92] which likely will increase Medicaid expenditures.

Maintenance of Effort

In response to the economic recession (December 2007 through June 2009),[93] 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. 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.

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[87] The aggregate amount of the ACA fee, to be collected across all covered insurers, was estimated to 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 (name redacted).)

[88] 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.

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

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

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

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

[93] According to the National Bureau of Economic Analysis, the United States was in recession from December 2007 through June of 2009.

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 the ACA (March 23, 2010) and the implementation of the health insurance exchanges. Under the ACA MOE provisions, states were required to maintain their Medicaid programs with the same eligibility standards, methodologies, and procedures in place on the date of enactment until the health insurance exchanges were operational. Additionally, the ACA MOE continues for Medicaid-eligible children up to the age of 19 until September 30, 2019. Failure to comply with the ACA MOE requirements means a state loses all its federal Medicaid matching funds.

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

Under both the ARRA and ACA MOEs, states were not able to restrict income eligibility for their Medicaid programs, generally speaking, from July 1, 2008, through January 1, 2014 (i.e., when health insurance exchanges were operational). States now have the ability to reduce the cost of Medicaid through reductions to Medicaid eligibility standards for adult populations. However, under current law, the ACA MOE for children is to remain in place until September 30, 2019.

Medicaid Resources

For more information on Medicaid, the following CRS reports may be of interest.

- CRS Report R42640, *Medicaid Financing and Expenditures*
- CRS Report R43656, *Traditional Benefits and Alternative Benefit Plans Under Medicaid*
- CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*
- CRS Report R43778, *Medicaid Prescription Drug Pricing and Policy*
- CRS Report R43564, *The ACA Medicaid Expansion*
- CRS Report R43850, *Out-of-Pocket Costs for Medicaid Beneficiaries: In Brief*
- CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*
- CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*
- CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2016*

Appendix A. State Medicaid and CHIP Income Eligibility Standards

Table A-1 depicts the modified adjusted gross income (MAGI)-based eligibility levels for Medicaid as of January 1, 2015, based on findings from a 50-state survey.[94] The table expresses these standards as a percentage of the federal poverty level (FPL).[95]

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

(effective January 1, 2015)

	Children[a]				Adults[b]	
State	Aged 0-1	Aged 1-5	Aged 6-18	Pregnant Women	Parents[c]	Other Adults
Alabama	146%	146%	105%	146%	18%	0%
Alaska	182%	182%	182%	205%	146%	0%
Arizona	152%	146%	109%	161%	138%	138%
Arkansas	147%	147%	112%	214%	138%	138%
California	213%	147%	138%	213%	138%	138%
Colorado	147%	147%	113%	200%	138%	138%
Connecticut	201%	201%	201%	263%	201%	138%
Delaware	199%	147%	105%	217%	138%	138%
District of Columbia	211%	151%	117%	211%	221%	215%
Florida	197%	145%	117%	196%	34%	0%
Georgia	210%	154%	118%	225%	38%	0%
Hawaii	196%	144%	138%	196%	138%	138%
Idaho	147%	147%	138%	138%	27%	0%
Illinois	147%	113%	113%	213%	138%	138%
Indiana	213%	146%	111%	213%	24%	0%
Iowa	245%	172%	127%	380%	138%	138%
Kansas	171%	154%	118%	171%	38%	0%
Kentucky	200%	147%	147%	200%	138%	138%
Louisiana	147%	147%	147%	138%	24%	0%

[94] Tricia Brooks, Joe Touschner, and Samantha Artiga, et al., *Modern Era Medicaid: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP as of January 2015*, The Kaiser Commission on Medicaid and the Uninsured, January 2015.

[95] 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 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[a]			Pregnant Women	Adults[b]	
	Aged 0-1	Aged 1-5	Aged 6-18		Parents[c]	Other Adults
Maine	196%	162%	162%	214%	105%	0%
Maryland	199%	138%	138%	264%	138%	138%
Massachusetts	190%	138%	119%	205%	138%	138%
Michigan	200%	148%	115%	200%	138%	138%
Minnesota	280%	280%	280%	283%	138%	138%
Mississippi	199%	148%	112%	199%	28%	0%
Missouri	201%	153%	153%	201%	23%	0%
Montana	148%	148%	148%	162%	51%	0%
Nebraska	167%	150%	138%	199%	55%	0%
Nevada	165%	165%	127%	165%	138%	138%
New Hampshire	201%	201%	201%	201%	138%	138%
New Jersey	199%	147%	112%	199%	138%	138%
New Mexico	245%	245%	195%	255%	138%	138%
New York	223%	154%	115%	223%	138%	138%
North Carolina	199%	146%	112%	201%	45%	0%
North Dakota	152%	152%	116%	152%	138%	138%
Ohio	161%	161%	161%	205%	138%	138%
Oklahoma[d]	174%	156%	120%	138%	46%	0%
Oregon	190%	138%	105%	190%	138%	138%
Pennsylvania	220%	162%	124%	220%	138%	138%
Rhode Island	195%	147%	114%	195%	138%	138%
South Carolina	199%	148%	138%	199%	67%	0%
South Dakota	152%	145%	116%	138%	53%	0%
Tennessee	200%	147%	138%	200%	103%	0%
Texas	203%	149%	114%	203%	19%	0%
Utah[e]	144%	144%	110%	144%	46%	0%
Vermont	242%	242%	242%	213%	138%	138%
Virginia	148%	148%	114%	148%	45%	0%
Washington	215%	215%	215%	198%	138%	138%
West Virginia	163%	146%	113%	163%	138%	138%
Wisconsin	306%	191%	138%	306%	100%	100%
Wyoming	159%	159%	124%	159%	58%	0%

Source: Tricia Brooks, Joe Touschner, and Samantha Artiga, et al., *Modern Era Medicaid: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP as of January 2015*, The Kaiser Family Foundation, The Kaiser Commission on Medicaid and the Uninsured, January 2015.

Notes: This table reflects modified adjusted gross income (MAGI) income standards in effect as of January 1, 2015 (based on 2014 federal poverty levels, or FPL), for selected MAGI coverage groups, and it includes a disregard equal to 5 percentage points. For these eligibility groups, an individual's MAGI income is compared with the income standards identified in this table to determine if the individual is income eligible for Medicaid. Other eligibility criteria also apply, for example, with respect to citizenship, immigration status, and residency.

a. These child-related eligibility standards do not include Children's Health Insurance Program (CHIP)-funded expansions of Medicaid, including the group of *stair-step* children between the ages of 6 and 18 in families with annual income less than 133% of FPL who were required to transition from CHIP to Medicaid under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), beginning January 1, 2014. The purpose of this transition was to ensure uniform child coverage under Medicaid up to 133% of FPL (effectively 138% after adjustment for the 5% disregard) across all states.

b. This table reflects state decisions on the ACA Medicaid expansion, which impacts eligibility levels for non-elderly adults. As of January 1, 2015. Since that time, Indiana implemented the expansion on February 1, 2015. In addition, Montana Governor Bullock signed the bill adopting the ACA Medicaid expansion on April 29, 2015, but the law directs the state to apply for a Section 1115 waiver to implement the expansion.

c. In states that use dollar amounts rather than percentages of FPL to determine eligibility for parents, the Kaiser Family Foundation converted the amounts to a percentage of the FY2014 FPL for a family of three and included a disregard equal to 5 percentage points of the FPL applied to the highest income limit for the group.

d. In Oklahoma, individuals working for certain qualified employers with incomes at or below 200% of FPL are eligible for premium assistance (i.e., Medicaid funds to subsidize the cost of private health insurance coverage) for employer-sponsored insurance. Individuals without a qualifying employer with incomes up to 100% of FPL are eligible for more limited subsidized insurance through the Insure Oklahoma Section 1115 waiver program.

e. In Utah, adults with incomes up to 150% of FPL are eligible for coverage of primary care services under the Primary Care Network Section 1115 waiver program; enrollment is closed. The state also provides premium assistance for employer-sponsored coverage to working adults with incomes up to 200% of FPL under the Utah Premium Partnership Health Insurance Section 1115 waiver program.

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 federal medical assistance percentage (FMAP) rates.

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

State	FY2012 Enrollment[b] (in thousands)	FY2014 Medicaid Expenditures[a] ($ in millions)			FY2015 FMAP Rates
		State	Federal	Total	
Alabama	1,104	$1,690	$3,735	$5,425	68.99%
Alaska	139	$630	$917	$1,547	50.00%
Arizona[c]	1,713	$2,693	$6,760	$9,453	68.46%
Arkansas	695	$1,328	$3,826	$5,154	70.88%
California[d]	12,005	$29,769	$38,480	$68,248	50.00%
Colorado[d]	826	$2,706	$3,559	$6,265	51.01%
Connecticut	823	$3,074	$4,094	$7,168	50.00%
Delaware	255	$721	$1,084	$1,805	53.63%
District of Columbia	225	$704	$1,821	$2,524	70.00%
Florida	4,145	$8,428	$12,623	$21,050	59.72%
Georgia[c]	1,640	$3,199	$6,659	$9,858	66.94%
Hawaii	296	$848	$1,201	$2,050	52.23%
Idaho	279	$478	$1,214	$1,692	71.75%
Illinois	3,005	$8,114	$9,609	$17,723	50.76%
Indiana	1,228	$3,131	$6,469	$9,600	66.52%
Iowa	622	$1,513	$2,597	$4,110	55.54%
Kansas	430	$1,234	$1,699	$2,933	56.63%
Kentucky	926	$1,924	$6,092	$8,016	69.94%
Louisiana	1,311	$2,752	$4,586	$7,338	62.05%
Maine	446	$941	$1,587	$2,529	61.88%
Maryland	1,098	$4,102	$5,523	$9,626	50.00%
Massachusetts	1,549	$7,209	$7,743	$14,952	50.00%
Michigan	2,297	$4,439	$9,709	$14,148	65.54%
Minnesota	1,145	$4,663	$5,851	$10,513	50.00%
Mississippi	781	$1,330	$3,687	$5,016	73.58%
Missouri	1,135	$3,423	$5,816	$9,239	63.45%
Montana	136	$363	$781	$1,145	65.90%

State		FY2014 Medicaid Expenditures[a] ($ in millions)			
Nebraska	264	$838	$1,070	$1,907	53.27%
Nevada	405	$734	$1,698	$2,432	64.36%
New Hampshire	168	$677	$744	$1,421	50.00%
New Jersey	1,184	$5,687	$7,507	$13,194	50.00%
New Mexico	652	$1,088	$3,261	$4,349	69.65%
New York	5,865	$24,903	$28,696	$53,599	50.00%
North Carolina	1,976	$4,269	$8,386	$12,655	65.88%
North Dakota[d]	87	$212	$239	$451	50.00%
Ohio	2,474	$6,653	$13,570	$20,223	62.64%
Oklahoma	931	$1,710	$3,215	$4,925	62.30%
Oregon	751	$2,058	$5,233	$7,291	64.06%
Pennsylvania	2,562	$11,109	$13,306	$24,415	51.82%
Rhode Island[d]	185	$1,069	$1,498	$2,566	50.00%
South Carolina	1,044	$1,640	$3,956	$5,597	70.64%
South Dakota[d]	134	$344	$497	$841	51.64%
Tennessee	1,545	$3,308	$6,346	$9,654	64.99%
Texas[c]	4,641	$13,157	$19,674	$32,831	58.05%
Utah	388	$652	$1,583	$2,235	70.56%
Vermont	205	$630	$940	$1,570	54.01%
Virginia	1,093	$3,838	$4,142	$7,980	50.00%
Washington	1,408	$4,051	$6,794	$10,846	50.03%
West Virginia	439	$929	$2,559	$3,488	71.35%
Wisconsin	1,264	$3,094	$4,689	$7,783	58.27%
Wyoming	89	$281	$313	$595	50.00%
National Total	**68,680**[e]	**$194,340**	**$297,636**	**$491,976**	

Sources: Medicaid and CHIP Payment and Access Commission (MACPAC), *MACStats*, Updated March 25, 2015; CMS, CMS-64 data, as of March 30, 2015; HHS, "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, 2014 Through September 30, 2015," 79 *Federal Register* 3385, January 21, 2014.

Notes: May not sum to totals due to rounding. FMAP = Federal medical assistance percentage.

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; however, in the event individuals also were enrolled in CHIP-financed Medicaid coverage (e.g., CHIP Medicaid expansion program) during the year, they are excluded if their most recent enrollment month was in the CHIP Medicaid expansion program. These enrollment numbers exclude individuals in the territories and in CHIP Medicaid expansion programs only.

c. MACPAC noted that these states had a change in total enrollment of 10% or more over the prior year. This change may reflect data anomalies in the submission of Medicaid Statistical Information System (MSIS) data and may be updated in these states' future MSIS data submissions.

d. Not all states had certified their CMS-64 Financial Management Report submissions as of February 25, 2015. California and Colorado's second, third, and fourth quarter submissions are not certified; North Dakota's third and fourth quarter submissions are not certified; South Carolina's second quarter submission is not certified; and Rhode Island's fourth quarter submission is not certified. Figures presented in this table may change if states revise their expenditure data after this date.

e. The national total is less than the sum of the state enrollment amounts. Both the national total and each state's enrollment figures are unduplicated counts (i.e., an individual is counted as one person even if he or she may have been enrolled in Medicaid for two or more periods of time throughout the year), but individuals may have moved from state to state and been counted in the enrollment for two or more states.

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