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Updated: June 2017 | Fact Sheet

Medicaid Pocket Primer

What is Medicaid?

Medicaid is the nation's public health insurance program for people with low income. The Medicaid program covers more than 70 million Americans, or 1 in 5, including many with complex and costly needs for care. The vast majority of Medicaid enrollees lack access to other affordable health insurance. Medicaid covers a broad array of health services and limits enrollee out-of-pocket costs. The program is also the principal source of long-term care coverage for Americans. As the nation's single largest insurer, Medicaid provides significant financing for hospitals, community health centers, physicians, and nursing homes, and jobs in the health care sector. The Medicaid program finances over 16% of all personal health care spending in the U.S.

How is the Medicaid program structured?

Medicaid is a federal-state program. Subject to federal standards, states design and administer their own Medicaid programs. Beyond the federal requirements, states have extensive flexibility to determine covered populations, covered services, health care delivery models, methods for paying physicians and hospitals, and many other aspects of their Medicaid programs. States can also get Section 1115 waivers to test and implement approaches that diverge from federal Medicaid rules but that the Secretary of Department of Health and Human Services (HHS) determines advance program objectives. All Americans who meet Medicaid eligibility requirements are guaranteed coverage.

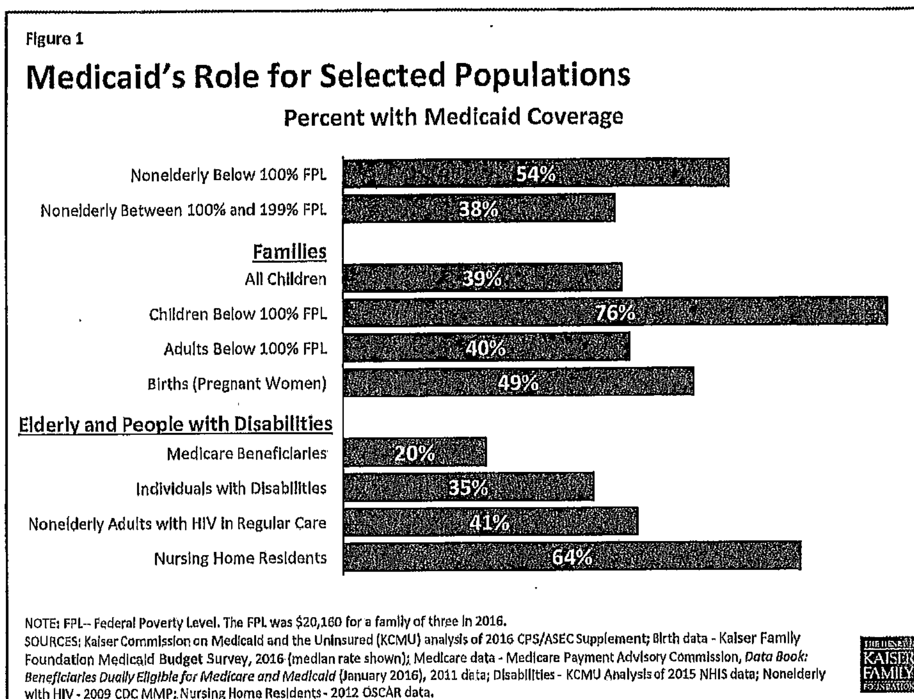
The federal government matches state Medicaid spending on an open-ended basis. The guarantee of federal matching funds increases state resources for coverage of their low-income residents and also permits state Medicaid programs to respond to demographic and economic shifts, changing coverage needs, technological innovations, public health emergencies such as the opioid addiction crisis, and disasters and other events beyond states' control. Medicaid is a complex program because it has evolved over time to serve diverse populations with a wide range of needs, including many individuals who are very poor and very frail, and because of wide variation across state Medicaid programs. The Centers for Medicare and Medicaid Services (CMS) within HHS is the federal agency responsible for Medicaid. Title XIX of the Social Security Act and a large body of federal regulations govern the program, defining federal Medicaid requirements and state options and authorities.

Who has Medicaid coverage?

Medicaid and the Children's Health Insurance Program (CHIP) currently cover over 74 million low-income Americans, who fall into four main groups: infants and children; pregnant women, parents, and other nonelderly adults; individuals of all ages with disabilities; and very low-income seniors, most of whom are also covered by Medicare. Three-quarters of nonelderly adult Medicaid enrollees are working. Children make up

about half of all Medicaid enrollees, nonelderly adults make up one-quarter, and seniors and people with disabilities make up one-quarter.

Medicaid covers many but not all poor Americans (Figure 1). It covers nearly half of all births in the median state, 40% of all children, and 75% of poor children. Reflecting more restrictive state eligibility rules for adults, Medicaid covers 40% of poor nonelderly adults. Medicaid covers 60% of children with disabilities and 30% of nonelderly adults with disabilities, including individuals with severe physical disabilities, developmental disabilities such as autism and traumatic brain injury, serious mental illness, Alzheimer's disease, and other chronic conditions. States can opt to provide Medicaid for children with significant disabilities in higher-income families to fill gaps in private health insurance and limit out-of-pocket burden. Medicaid also assists 1 in 5 Medicare beneficiaries with their Medicare premiums and cost-sharing and provides many of them with benefits not covered by Medicare, especially long-term care, dental care, and vision care.



How did the Affordable Care Act change Medicaid?

Before the Affordable Care Act (ACA), most low-income adults did not qualify for Medicaid because income eligibility for parents was very limited in most states – well below the federal poverty level (FPL) in most states ($11,880 in 2016) – and federal law excluded adults without dependent children from the program. These rules left many poor and low-income adults uninsured. As part of the broader framework the ACA established to cover uninsured Americans, the law expanded Medicaid to nonelderly adults with income up to 138% FPL – $16,394 for an individual in 2016. The ACA provided federal funding for the vast majority of the cost of the Medicaid expansion. In addition, the ACA modernized and steamlined Medicaid eligibility and enrollment and gave states new options and funding for delivery system innovation, including expanded options for community-based long-term care.

Under a 2012 Supreme Court ruling, the ACA Medicaid expansion is effectively optional for states. As of January 2017, 32 states including DC had expanded Medicaid and 19 states had not. In the non-expansion states, 2.6 million adults with income below 100% FPL fall into a "coverage gap" because their income exceeds their state's cutoff for Medicaid but is too low to qualify for subsidies for private coverage in the ACA marketplaces. Between Summer 2013, just prior to the ACA coverage expansions, and October 2016, Medicaid and CHIP enrollment rose by nearly 17 million. In 2015, an estimated 11 million enrollees were adults newly

eligible for Medicaid under the ACA expansion and this number has likely grown as enrollment has continued to rise and additional states have expanded Medicaid. The Medicaid expansion has contributed to a decline in the uninsured rate among nonelderly individuals, which fell from 16.6% in 2013 to an historic low of 10% in early 2016.

What Services does Medicaid cover?

Medicaid covers a broad range of services to address the diverse needs of the populations it serves. In addition to covering the services required by federal Medicaid law, many states elect to cover optional services such as prescription drugs, physical therapy, eyeglasses, and dental care. Coverage for Medicaid expansion adults contains the ACA's ten "essential health benefits," which include preventive services and expanded mental health and substance use treatment services. Medicaid provides comprehensive benefits for children, known as "EPSDT," that are considered a model of developmental pediatric coverage. EPSDT is especially important for children with disabilities because private insurance, which is designed for a generally healthy population, is often inadequate to their needs.

Unlike commercial health insurance and Medicare, Medicaid also covers long-term care, including both nursing home care and many home and community-based long-term services and supports. More than half of all Medicaid spending for long-term care is now for services provided in the home or community that enable seniors and people with disabilities to live independently rather than in institutions.

How do Medicaid enrollees get care?

Medicaid enrollees get their care largely from private, office-based physicians. Community health centers are also a key source of primary care. Enrollees receive specialty care from private physicians and hospital outpatient clinics, and safety-net hospitals, including public hospitals and academic medical centers, provide most of their emergency and inpatient hospital care. More than 60% of Medicaid beneficiaries are enrolled in private managed care plans that contract with states to provide comprehensive services and others receive their care in the fee-for-service system. Managed care plans are responsible for ensuring access to Medicaid services through their networks of providers and are at financial risk for their costs. In the past, states largely limited managed care to children and families, a relatively healthy Medicaid population, but they are increasingly expanding managed care to individuals with disabilities and others with complex needs. In addition, close to half the states now cover long-term services and supports through risk-based managed care arrangemetns.

Delivery system and payment reform are common among state Medicaid programs, as states have a stake in improving the quality of care for Medicaid enrollees and reducing preventable costs. The majority of states have implemented patient-centered medical homes that involve team-based care, and many are taking steps to integrate physical and behavioral health care. In 20 states, Medicaid "health homes" provide comprehensive care coordination for beneficiaries with chronic conditions. Numerous states are implementing "value-based purchasing" approaches that tie Medicaid provider payment to health outcomes and other performance metrics.

HOW IS MEDICAID FINANCED?

Medicaid is financed jointly by the federal government and states. The federal government matches state Medicaid spending; the federal match rate varies by state based on a federal formula and ranges from a minimum of 50% to nearly 75% in the poorest state. Under the ACA, the federal match rate for adults newly eligible for Medicaid due to the expansion is 95% in 2017, phasing down gradually to 90% in 2020 and thereafter. The guaranteed availability of federal Medicaid matching funds eases budgetary pressures on states during recessionary periods, when enrollment rises. Federal matching rates do not adjust to economic shifts, but Congress has twice raised them temporarily during downturns to strengthen support for states. Federal Medicaid matching funds are the largest source of federal revenue in state budgets.