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How Medicaid Works: Program Basics

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How Medicaid Works: Program Basics

Summary

Medicaid is a means-tested entitlement program that has been in existence for over 35 years. It provides primary and acute care as well as long-term care to over 40 million Americans at a cost to federal and state governments of approximately $258.2 billion in FY2002. Of all federally supported social programs, only Medicare comes close to this level of spending, and only Social Security costs more.

Medicaid is jointly financed by the federal and state governments, but each state designs and administers its own version of the program under broad federal guidelines. The complexity of Medicaid presents an enormous challenge for anyone attempting to generalize about the program. State variability in eligibility, covered services and how those services are reimbursed and delivered is the rule, rather than the exception. Furthermore, Medicaid is targeted at individuals with low income, but not all of the poor are eligible, and not all those covered are poor.

This report summarizes the basic elements of Medicaid. Specifically, it describes federal Medicaid rules governing: (1) who is eligible, (2) what services are covered and how they are delivered, (3) how the program is financed and administered, (4) key provider reimbursement issues, and (5) the significant role of waivers in expanding eligibility and modifying services and health care delivery systems. It concludes with a brief history of Medicaid legislation enacted since 1996. This report will be updated periodically.

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How Medicaid Works: Program Basics

Overview

Medicaid was enacted in 1965, in the same legislation that created the Medicare program, the Social Security Amendments of 1965 (P.L. 89-97). It grew out of and replaced two earlier programs of federal grants to states that provided medical care to welfare recipients and the aged.

Medicaid is a means-tested entitlement program. It is jointly financed by federal and state funds. Federal contributions to each state are based on a state's willingness to finance covered medical services and a matching formula. Each state designs and administers its own program under broad federal rules. The Centers for Medicare and Medicaid Services (CMS), within the U.S. Department of Health and Human Services (HHS), is responsible for federal oversight of the program. In FY2002, total (preliminary) federal and state spending on Medicaid reached $258.2 billion (see **Table 1**), slightly exceeding total outlays for Medicare. No other means-tested cash or noncash program comes close to approaching this spending level. In fact, of all federally supported social programs, only Social Security costs more.

Table 1. Federal Share and Total Medicaid Spending for Last Five Years, 1998-2002

($ in billions)

Year	Total Medicaid spending	Federal share	Percentage change in federal share
1998	$177.3	$100.1	6.6%
1999	$189.9	$107.4	7.3%
2000	$206.1	$116.9	8.8%
2001	$228.0	$129.8	11.0%
2002	$258.2	$146.2	13.0%

Sources: CRS tabulations of preliminary CMS Form 64 data, 1998-2001, CMS summary programdata at [http://www.cms.hhs.gov/medicaid/mbes/sttotal.pdf].

To many, Medicaid is an enigma. The program's complexity surrounding who is eligible, what services are paid for, and how those services are reimbursed and delivered is one source of this confusion. Variability across state Medicaid programs is the rule, not the exception, and adds to the confusion. Income eligibility levels vary, services covered vary, and the method for and amount of reimbursement for services differ from state to state. In addition, more and more states in recent years have implemented a variety of major program changes using special waiver authority.

Furthermore, Medicaid is a program that is targeted at individuals with low-income, but not all of the poor are eligible, and not all those covered are poor. For populations like children and families, primary and acute care are often delivered through managed care, while the elderly and disabled typically obtain such care on a fee-for-service basis. Nationwide, Medicaid finances the majority of long-term care services. Such services include, for example, nursing home care and community-based services designed to support the elderly and disabled in their homes. Recently, some states have begun to integrate Medicare and Medicaid financing and/or coverage of acute and long-term care services for these populations.

The complexity of Medicaid presents an enormous challenge for anyone attempting to make generalizations about the program. This report describes federal Medicaid rules that govern: (1) who is eligible, (2) what services are covered and how they are delivered, (3) how the program is financed and administered, (4) key provider reimbursement issues, and (5) the significant role of waivers in expanding eligibility and modifying services. It concludes with a brief legislative history of major laws affecting Medicaid enacted since 1996.

Eligibility

Federal Medicaid statute defines over 50 distinct population groups as being potentially eligible for states' programs. Some groups are mandatory, meaning that all states that participate in the Medicaid program must cover them; others are optional. Prior to the 1980s, Medicaid eligibility was limited to very low-income families with dependent children, poor elderly and disabled individuals, and the "medically needy." Beginning in the 1980s, additional eligibility pathways were added to the Medicaid statute to allow for the coverage of higher income children and pregnant women as well as other elderly and disabled individuals. Most recently, states were given the option to provide Medicaid to other groups with specific characteristics including certain women with breast or cervical cancer, to uninsured individuals with tuberculosis, and to additional working individuals with disabilities. Not all groups of Medicaid beneficiaries receive the same set of benefits. To understand the different benefits offered to each group, see "Benefits."

Medicaid is a means-tested program. To qualify, applicants' income and resources must be within certain limits. The specific income and resource limitations that apply to each eligibility group are set through a combination of federal parameters and state definitions. Consequently, those standards vary considerably among states, and different standards apply to different population groups within a state. For many of those groups, moreover, states have permission under a special provision, Section 1902(r)(2), to use more liberal standards for computing income and resources than are specified within each of the groups' definitions. Most states use Section 1902(r)(2) to ignore or disregard certain types or amounts of income or assets, thereby extending Medicaid to individuals with earnings or assets too high to otherwise qualify under the specified rules for that eligibility pathway.

Families, Pregnant Women, and Children

The two primary pathways to Medicaid for low-income family members, pregnant women, and children are through (1) Section 1931 of Medicaid statute, for those families who would have been eligible for cash welfare payments under former Aid to Families with Dependent Children (AFDC) program rules, and (2) a series of targeted Medicaid expansions for poor pregnant women and children begun in the 1980s. Other important pathways for low-income family members, including transitional medical assistance, other AFDC-related groups, and children qualifying for the State Children's Health Insurance Program (SCHIP) who are receiving their health coverage under the Medicaid program, are explained below.

Section 1931: Persons Qualifying under the Former AFDC Program Rules. Families who are eligible for Temporary Assistance for Needy Families (TANF), the welfare program enacted in 1996 to replace AFDC, are not automatically eligible for Medicaid. Medicaid's Section 1931, however, preserves Medicaid entitlement for individuals who meet the requirements of the former AFDC programs in effect in their states on July 16, 1996. This categorical group was created when TANF replaced AFDC to ensure that low-income families do not lose Medicaid as a result of welfare reform. States have significant flexibility in defining the income and resource standards for those families qualifying for Medicaid under Section 1931: (1) income standards may be reduced below those in effect in 1996, but they cannot be lower than those used on May 1, 1988; (2) income and resource standards may be increased for any period after 1996, but by no more than the percentage increase in the Consumer Price Index (CPI) for the same period; and (3) states may use less restrictive methods for counting income and resources than those in effect on July 16, 1996.

Certain individuals qualifying under the Section 1931 pathway may be denied Medicaid coverage if they refuse to cooperate with states' TANF work requirements. States are permitted to deny Medicaid benefits to nonpregnant adults and heads of households who lose TANF benefits because of refusal to work, but must continue to provide Medicaid coverage to their children.

In 2002, 39 states had taken advantage of the flexibility of Section 1931 to expand eligibility for working families by disregarding some earned income, thereby allowing families with higher total income to qualify for the program. Other states eliminated various income and assets rules, again for low-income working families, thus expanding their access to Medicaid.[1]

Poverty-related Pregnant Women and Children. Between 1986 and 1991, Congress gradually extended Medicaid to new groups of pregnant women and children. Under these provisions, states are required to cover pregnant women and children under age 6 with family incomes below 133% of the federal poverty income

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[1] K.A. Maloy , K.A. Kenney, J. Darnell, S. Cyprien, *Can Medicaid Work for Low-Income Working Families?*, Kaiser Commission on the Future of Medicaid and the Uninsured, Apr. 2002.

guidelines.[2] Coverage for pregnant women qualifying through this pathway is limited to services related to the pregnancy or complications of the pregnancy and extends to 60 days after termination of the pregnancy. Children receive full Medicaid coverage.

States are required to cover all children over the age of five and under 19 who are in families with income below 100% of the federal poverty level. This requirement has been phased-in since July 1, 1991, and was fully implemented in 2002.

States have the option to go beyond the above mandatory groups to include pregnant women and infants under one year of age whose family income is over 133 and up to 185% of the FPL. In 2002, 36 states and the District of Columbia extended coverage to some or all pregnant women and infants in this category.

Transitional Medical Assistance. Transitional medical assistance (TMA) was established prior to the 1996 welfare reform to address the concern that individuals receiving AFDC payments would not seek work or would turn down work opportunities for fear of losing Medicaid. TMA requires states to continue providing Medicaid for six months to families that were receiving Medicaid under Section 1931 in at least three of the last six months. The extended Medicaid coverage is available to individuals (and their families) who would otherwise have lost such assistance due to increased work hours, increased earnings of the caretaker relative, or the loss of one of the time-limited earned income disregards. In addition, states are required to extend Medicaid coverage for a second six months to families that were covered during the entire first six-month TMA period, and whose earnings are below 185% of poverty. The provisions authorizing TMA are due to sunset at the end of March, 2004, although this date has been repeatedly extended. A small additional group of mandatory TMA-eligible persons are those who would otherwise lose Medicaid coverage under Section 1931 because of increased child or spousal support. Families eligible for this four-month extension must have been receiving Medicaid under Section 1931 in at least three of the preceding six months.

Other AFDC-Related Groups. While the AFDC program no longer exists, a number of Medicaid eligibility groups tied to states' former AFDC rules remain. States must provide Medicaid to recipients of adoption assistance and foster care (who are under age 18) under Title IV — E of the Social Security Act. In 1999 states were given the option to extend Medicaid to former foster care recipients who are aged 18, 19, or 20.

Ribicoff children, a pathway named for the former Senator who sponsored legislation authorizing this group, are those under age 21 who meet income and resource requirements for the former AFDC Program but who do not meet other categorical requirements for AFDC. States have the option to cover Ribicoff children and have a great deal of flexibility in defining the specific group of children to be covered under this category. Often states use this authority to cover children in state-

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[2] 100% of FPL is equal to $15,260 and 133% of FPL is equal to $20,256 for a family of three in 2003.

sponsored foster care, children who are institutionalized, or who are inpatients in psychiatric facilities. Although many of the children who have traditionally been covered under Ribicoff are now eligible under other poverty-related groups, Ribicoff remains an important pathway to eligibility for some small groups of older adolescents in foster care and children in two-parent families.

Targeted Low-income Children. Section 4911 of the Balanced Budget Act of 1997 (BBA 1997, P.L. 105-33) established an additional coverage group for low-income children. This provision establishes a Medicaid coverage group that is parallel to the group of children eligible for health coverage under another provision of BBA 97, the State Children's Health Insurance Program (Section 4901). The two provisions allowed states to choose, after the passage of BBA 97, to either extend Medicaid for targeted low-income children, to create a new SCHIP program for those children, or coordinate both programs to cover the target population.

Targeted low-income children are those who are not otherwise eligible for Medicaid, are not covered under a group health plan or other insurance, and are living in families with income that is either: (1) above the state's Medicaid financial eligibility standard in effect in June 1997 but less than 200% of the FPL; or (2) in states with Medicaid income levels for children already at or above 200% of the poverty level as of June 1997, within 50 percentage points over this income standard. States can either establish a specific coverage group for targeted low-income children or they can build upon other existing Medicaid coverage groups for children. As of February 2003, 37 states cover targeted low-income children under Medicaid.

The Aged and Persons with Disabilities

Persons Who Qualify for Supplemental Security Income (SSI). With one important exception, states are required to provide Medicaid coverage to recipients of SSI. SSI, authorized under Title XVI of the Social Security Act, is a means-tested cash assistance program for aged, blind, and disabled individuals whose income falls below the federal maximum monthly SSI benefit and whose resources are limited. To qualify for SSI, a person must satisfy the program criteria for age or disability and meet certain citizenship or United States residency requirements. Eligibility for SSI is restricted to otherwise qualified individuals whose resources do not exceed $2,000 for an individual and $3,000 for a couple; certain resources, such as a person's home, are exempt. Income cannot exceed the maximum federal SSI benefit of $552 per month in 2003 for an individual living independently, and $829 for a couple living independently. The SSI benefit level of $552 per month for an individual is 74% of the FPL.

The major exception to Medicaid coverage of SSI recipients is in states that exercise the so-called "209(b)" option described in Section 209(b) of the Social Security Amendments of 1972 (P.L. 92-603). Such states may use income, resource and disability standards that are no more restrictive than those in place on January 1, 1972. As of 2001, there were 11 Section 209(b) states: Connecticut, Illinois, Hawaii, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma and Virginia. Each of these has at least one eligibility standard that is more restrictive than current SSI standards and some have certain standards that are more liberal. States that use more restrictive eligibility rules under Section 209(b) must also allow

applicants to deduct medical expenses from their income when determining financial eligibility for Medicaid. This process is sometimes referred to as "spend-down."[3]

Recipients of State Supplemental Payment (SSP) Benefits. Many states provide SSP benefits with state-only dollars on a monthly basis. These payments are intended to cover such items as food, shelter, clothing, utilities, and other daily necessities. The amount of the benefit is determined by the individual states. States may provide supplemental payments to all persons who receive SSI, and/or to individuals who meet all SSI criteria, other than income. States may also choose to provide SSP benefits only to particular groups, such as elderly persons living independently in the community without special needs, or elderly individuals who require in-home personal care assistance or home-delivered meals. In all of these cases, states decide whether to extend Medicaid coverage to all SSP recipients, to only some of these recipients, or to none at all. When a state provides Medicaid eligibility to persons receiving only SSP — and not SSI — then the maximum income eligibility standard for Medicaid is an amount equivalent to the combined federal SSI payment and the SSP benefit. For 209(b) states, however, the effective maximum financial eligibility standard for these individuals is the 209(b) categorical eligibility standard plus the SSP payment.

Poverty-related Group for the Aged and Disabled. The enactment of the Omnibus Budget Reconciliation Act of 1986 (OBRA 86) offered states an option for covering persons whose income exceeds SSI or 209(b) levels. This option allows states to cover aged and disabled individuals with incomes *up to* 100% of FPL. In 2001, there were 21 states using this option.[4]

Coverage for Institutionalized Individuals and Related Groups Under the Special Income Rule. States may extend Medicaid to certain individuals with incomes too high to qualify for SSI, and who are eligible for nursing facility or other institutional care. Under the special income rule, also referred to as "the 300% rule," such persons must (1) require care provided by a nursing home or other medical institution for no fewer than 30 consecutive days, (2) meet the resource standard determined by the state, and (3) have income that does not exceed a specified level — *no greater than* 300% of the maximum SSI payment applicable to a person living at home. For 2003, this limit is $1,656 per month (3 times the

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[3] An example of spend-down is as follows: if an applicant has a monthly income of $700 (not including any SSI or State Supplemental Payments (SSP)) and the state's maximum allowable income standard for spend-down eligibility is $600, the applicant would qualify for Medicaid after incurring $100 in medical expenses in that month.

[4] A survey by the American Public Human Services Association reported that the District of Columbia (up to 100%) and the following states had implemented this option as of October 2001: California (up to 100%), Florida (90%), Georgia (100%), Illinois (85%), Maine (100%), Massachusetts (100%), Michigan (100%), Minnesota (95%), Mississippi (100%), Nebraska (100%), New Jersey (100%), North Carolina (100%), Pennsylvania (100%), Rhode Island (100%), South Carolina (100%), Utah (100%), Vermont (100%), Virginia (80%). In a separate survey, CRS determined that Oklahoma (100%) and Hawaii (100%) also used this option in 2001.

monthly SSI payment of $552). States may use a level that is lower than the maximum of 300% of SSI, if they wish.

Since 1993 (OBRA 93), states that use only the special income rule for institutional eligibility, and do not use the medically needy option (described below), must allow applicants to place income in excess of the special income level in a special trust, often called a Miller Trust, and receive Medicaid coverage for their care.[5] Following the individual's death, the state becomes the beneficiary of amounts in the trust.

Working Individuals with Disabilities. Concern that many workers with disabilities would lose eligibility for Medicaid as a result of increased earnings and yet not have access to affordable or adequate health insurance through their jobs, prompted Congress to establish a variety of special rules that would protect working individuals with disabilities from losing their Medicaid benefits. One rule does so by changing SSI program rules for working persons with disabilities. In order for disabled persons to qualify for SSI and, thus become eligible for Medicaid, applicants must establish disability status under the criteria determined by the Secretary of the Department of Health and Human Services (DHHS). These criteria are linked to an individual's ability to work or earn income from work, commonly referred to as an individual's ability to "engage in substantial gainful activity" (SGA). Current regulations provide that an individual is able to engage in SGA if his or her earnings exceed $800 per month, as of January 2003. For persons who are blind, SGA is $1,330 per month for 2003. SGA is defined in federal regulations as paid work involving significant and productive physical or mental duties.[6] Section 1619(a) of SSI law permits those states that extend Medicaid to SSI recipients to allow certain persons with a disability who had been eligible for an SSI payment for at least one month and who meet all other eligibility rules, to continue receiving Medicaid even when they are working at the SGA level. The amount of their SSI special cash benefits is gradually reduced as their earnings increase under an income disregard formula[7] until their countable earnings reach the SSI benefit standard or what is known as the *breakeven point* ($552 per month in 2003).

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[5] OBRA 1993 codified a 1990 ruling from the United States District Court for the District of Colorado which first coined the term "Miller Trust." See *Miller v. Ybarra*, 746 F.Supp. 79 (E. Colo 1990).

[6] The inability to engage in SGA must be a result of a medically determined physical or mental impairment expected to result in death or that has lasted, or can be expected to last, for a continuous period of at least 12 months. A child under age 18 may qualify as disabled if he or she has an impairment that results in "marked and severe" functional limitations.

[7] Not all income is counted for SSI purposes. Different exemptions, or disregards, apply for the different types of income. Earned income that is exempt from being counted includes the first $65 per month in wages; one-half of all wages over $65; impairment-related expenses necessary for blind and disabled workers; and income used for a plan for achieving self support (PASS). Unearned income exclusions include the first $20 per month of non-needs tested benefits and all of the following: Food Stamps; housing and energy assistance; state and local needs-based assistance; in-kind support and maintenance payments from non-profit organizations; and student grants and scholarships.

In addition, individuals who are blind or have a disability can continue to be eligible for Medicaid even if their earnings exceed the SSI income disregard breakeven point under a special group referred to as "qualified severely impaired individuals." Special eligibility status granted by Section 1619(b)(1) and 1905(q), under which the individual is considered an SSI recipient for purposes of Medicaid eligibility (although he or she is not actually receiving a SSI cash benefit) applies as long as the individual: (1) continues to be blind or have a disabling impairment; (2) continues to meet all the other requirements, except for earnings, for SSI eligibility; (3) would be seriously inhibited from continuing to work by the termination of eligibility for Medicaid services; and (4) has earnings that are not sufficient to provide a reasonable equivalent to the benefits that would have been available if he or she did not have SSI, state supplementary payments, Medicaid and publicly funded personal care.

Other provisions give states even more flexibility to cover working persons with disabilities. The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) allows states to provide Medicaid coverage to working individuals with disabilities whose family's net income does not exceed 250% of the FPL. Two other provisions were added under the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA, P.L. 106-170). The first allows states to further expand Medicaid coverage to working individuals with disabilities, between the ages of 16 and 64, with incomes and resources as defined by the state and allows states to impose premiums and other cost-sharing on individuals who qualify. The second allows states, under certain circumstances, to provide coverage to persons whose medical conditions have improved and who have therefore become ineligible for SSI on the basis of disability.

Qualified Medicare Beneficiaries and Related Groups. Certain low-income individuals who are aged or have disabilities as defined under SSI and who are eligible for Medicare are also eligible to have some of their Medicare cost-sharing expenses paid for by Medicaid. There are four categories of such persons[8]:

- *Qualified Medicare Beneficiaries (QMB).* Qualified Medicare beneficiaries are aged or disabled Medicare beneficiaries with incomes no greater than 100% of the federal poverty level and assets no greater than $4,000 for an individual and $6,000 for a couple. States are required to cover, under their Medicaid programs, the costs of Medicare premiums, deductibles, and coinsurance for Medicare covered benefits for such persons. Other Medicaid covered services, such as nursing facility care, prescription drugs and primary and acute care services, are not covered for these individuals unless they qualify for Medicaid through other eligibility pathways (e.g., via SSI, medically needy or the special income rule).
- *Specified Low-Income Medicare Beneficiaries (SLMB).* Specified low-income Medicare beneficiaries meet QMB criteria, except that their income is greater than 100% of FPL but does not exceed 120% FPL. Under this Medicaid pathway, states are required to cover only the monthly Medicare Part B premium. Other Medicaid covered

[8] The program known as Qualifying Individuals-2 (QI-2) terminated on Sept. 30, 2002.

services are not covered for these individuals unless they qualify for Medicaid through other eligibility pathways.

- *Qualifying Individuals (QI-1).* The QI-1 eligibility pathway applies to aged and disabled Medicare beneficiaries whose income is between 120 and 135% FPL. For these individuals, states are required to pay the monthly Medicare Part B premium, only until the federal allotment for this purpose is depleted.[9] These individuals are not otherwise eligible for Medicaid.
- *Qualified Disabled and Working Individuals (QDWIs).* States are required to pay the Medicare Part A premiums for persons who were previously entitled to Medicare on the basis of a disability, who lost their entitlement based on earnings from work, but who continue to have a disabling condition. Such persons may only qualify if their incomes are below 200% of FPL, their resources are below 200% of the SSI limit ($4,000), and they are not otherwise eligible for Medicaid.

In December 2003, the President signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA 2003, P.L. 108-173). This act provides that, beginning in 2006, Medicaid eligibles who are also eligible for Medicare will receive outpatient prescription drug coverage through the new Medicare prescription drug benefit instead of through Medicaid. While this act does not change Medicaid eligibility rules, it does affect the benefits that the Medicaid program will be allowed to cover.[10] Under MMA 2003, state Medicaid programs will no longer be able to cover any drugs that are to be provided through the Medicare benefit, or pay the cost sharing amounts for those drugs.

Medically Needy

States may extend Medicaid coverage to persons who are members of one of the broad categories of Medicaid covered groups (i.e., are aged, have a disability or are in families with children), but do not meet the applicable income requirements and, in some instances, resources requirements for other eligibility pathways. Under this option, states may set their medically needy monthly income limits for a family of a given size at any level up to 133 1/3% of the maximum payment for a similar family under the state's AFDC program in place on July 16, 1996. For families of one, the

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[9] In general, Medicaid payments are shared between the federal government and the states according to a matching formula (see the section on financing). However, expenditures under the QI-1 program are paid 100% by the federal government (from the Part B trust fund) up to the state's allocation level. A state is only required to cover the number of persons which would bring its spending on these population groups in a year up to its allocation level. This temporary program, originally slated to end Sept. 30, 2002, has been extended through Sept. 30, 2004, by P.L. 108-173.

[10] Medicaid eligibility for individuals who now qualify as medically needy by "spending down" their income on medical expenses (see next section), may be affected. Those individuals may experience delayed Medicaid eligibility or no longer qualify at all because Medicare Part D will pay some portion of the drug expenses that were formally counted toward their spend down amounts.

statute gives certain states some flexibility to set these limits to amounts that are reasonably related to the AFDC payment amounts for two or more persons. While 133⅓% of the former AFDC program standard is generally higher than the nominal income standard for other Medicaid pathways for families, it is generally lower than the income standard for elderly or disabled SSI recipients.

For all groups, states are required to allow individuals to spend down to the medically needy income standard by incurring medical expenses, in the same way that SSI recipients in Section 209(b) states may spend down to Medicaid eligibility. For elderly and disabled recipients living in the community who must spend down to qualify for Medicaid, the medically needy income standard leaves individuals with less money for their living expenses than simply qualifying for Medicaid through SSI.

Under the statute, states may limit the categories of individuals who can qualify as medically needy. If a state provides any medically needy program, however, it must include all children under 18 who would qualify under one of the welfare-related groups, and all pregnant women who would qualify under either a mandatory or optional group, if their income or resources were lower. In 2002, 35 states[11] and the District of Columbia covered the medically needy.

Others

In recent years, new groups have been added to Medicaid that move the program further away from its traditional links to cash assistance programs. Demonstration waivers have given states the flexibility to target enrollment and benefits to various groups, and two new pathways were added to Medicaid for individuals with specific medical diagnoses. With specific restrictions, Medicaid is also available to certain immigrants.

Individuals Qualifying under Demonstration Waivers. Demonstration waivers available under the authority of Section 1115 (of the Social Security Act) enable states to experiment with new approaches for providing health care coverage that promote the objectives of the Medicaid program. Section 1115 allows the Secretary of HHS to waive a number of Medicaid rules — including many of the federal rules relating to Medicaid eligibility.[12] The Health Insurance Flexibility and Accountability (HIFA) Initiative is an explicit effort of HHS to encourage states to seek Section 1115 waivers to extend Medicaid and SCHIP to the uninsured, with a particular emphasis on statewide approaches that maximize private health insurance coverage options and target populations with incomes below 200% FPL. A number of states have used such waivers to enact broad-based and sometimes statewide

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[11] These include Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin. All states except Texas cover aged and disabled medically needy groups.

[12] See also the discussion of Section 1115 waivers below.

health reforms although demonstrations under Section 1115 need not be statewide. A number of the demonstrations extend comprehensive health insurance coverage to low-income children and families who would not otherwise be eligible for Medicaid.

Women with Breast and Cervical Cancer. Woman who are eligible for Medicaid under this optional coverage group are those who have been screened for and found to have breast or cervical cancer (including precancerous conditions) through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Women who qualify must be under age 65, uninsured, and otherwise not eligible for Medicaid. Benefits are limited to the period in which the beneficiary requires breast or cervical cancer treatment. In 2002, 42 states[13] chose to cover women who meet these requirements.

Persons with Tuberculosis. States may choose to offer Medicaid to people with tuberculosis (TB) who are uninsured. Individuals qualifying under this pathway are entitled only to those services related to the treatment of tuberculosis. In 2002, 8 states[14] and the District of Columbia covered such persons with TB.

Immigrants. Legal immigrants arriving in the United States after August 22, 1996 are ineligible for Medicaid benefits for their first five years here. Coverage of such persons after the five-year ban is a state option.[15] States may provide Medicaid coverage to legal immigrants who resided in the country and were receiving benefits on August 22, 1996, and for those residing in the country as of that date who become disabled in the future. States are also required to provide coverage to:

- refugees for the first seven years after entry into the United States;
- asylees for the first seven years after asylum is granted;
- certain individuals whose deportation is being withheld by the Immigration and Naturalization Service for seven years after the deportation is first withheld;
- lawful permanent aliens after they have been credited with 40 quarters of coverage under Social Security;
- and immigrants who are honorably discharged U.S. military veterans, active duty military personnel, and their spouses and unmarried dependent children who otherwise meet the state's financial eligibility criteria.

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[13] These include Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

[14] These include California, Florida, Louisiana, Minnesota, New York, Oklahoma, Utah, and Wyoming.

[15] All states except for Colorado and Utah have opted to cover such persons. Colorado's coverage for this group was repealed in May of 2003, and the repeal was later upheld after a legal challenge was mounted by the American Civil Liberties Union of Colorado.

In addition, states are required to provide emergency Medicaid services to all legal and undocumented non-citizens who meet the financial and categorical eligibility requirements for Medicaid, without regard to time in this country.

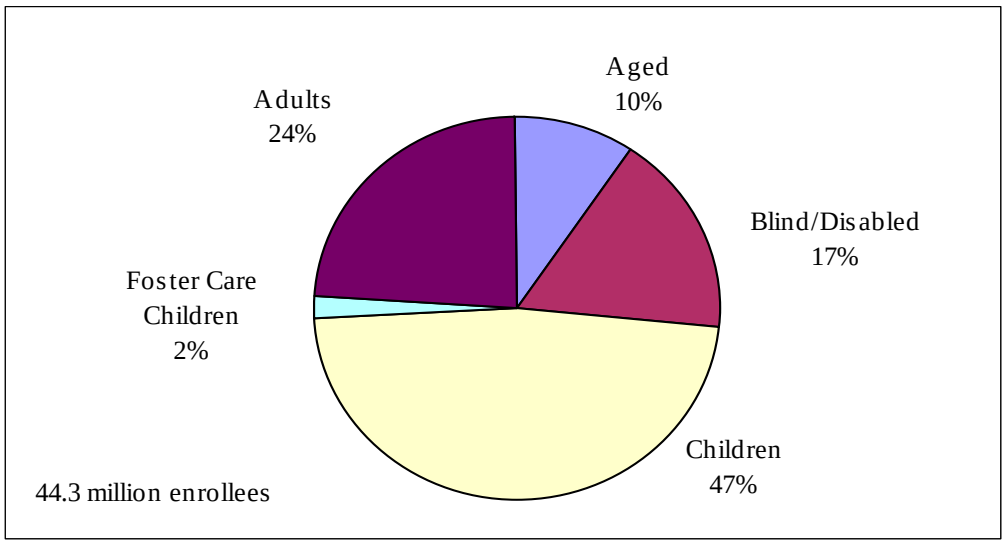
Enrollment

In 2000, there were 44.3 million people enrolled in Medicaid. Over one-half (51%) of those enrolled were under age 19,[16] about 37% were ages 19 through 64, and almost 10% were 65 or over. **Figures 1** and **2** show 2000 Medicaid enrollment by basis of eligibility (BOE) and by major enrollment group, respectively. State reported data are not available in a format that allows for examining enrollment by the pathways as described above.

Figure 1 shows that Medicaid enrollment is predominantly non-disabled adults (e.g., parents) under age 65 and children (about 73%). **Figure 2** shows that almost half of Medicaid enrollment in 2000 is through traditional pathways: 39% of enrollees are SSI recipients, SSI-related enrollees, and members of families that would have been eligible for former AFDC programs and now qualify through section 1931, and an additional 8% are the medically needy. Over one-third of 2000 enrollment is through relatively new pathways: 28% of individuals on the program are enrolled through the poverty-level pathways added to Medicaid since the mid-1980's and 8% through demonstration waivers. Finally, about 17% of Medicaid enrollees are in the "other" group; including foster care children, certain elderly individuals in institutions, families receiving transitional medical assistance, and persons receiving state supplementary SSI payments. This "other" grouping includes over 60 specific eligibility pathways.

[16] **Figure 1** shows 49% of Medicaid enrollment in 2000 was children (47% children plus 2% foster care children). There were additional children on the program in 2000 who qualified on the basis of blindness or disability. Those children are included in the blind/disabled category.

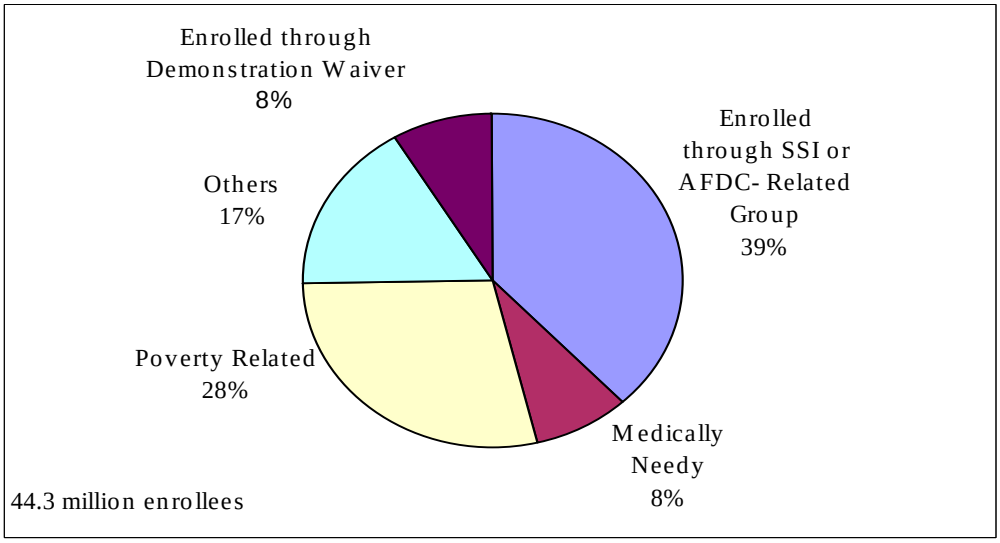
Figure 1. Medicaid Enrollees by Basis of Eligibility, FY2000



Source: Congressional Research Service (CRS) tabulation of data from the Medicaid Statistical Information System (MSIS) for FY2000 for all states except Hawaii. Hawaii did not report MSIS data for FY2000. CRS approximated FY2000 data for Hawaii using data reported for FY1999.

Note: Medicaid enrollees include all persons enrolled in Medicaid during the year whether or not any payments for services have been made on their behalf. Total enrollees in this figure include those in 50 states and the District of Columbia.

Figure 2. Medicaid Enrollees by Major Enrollment Group, FY2000



Source: Congressional Research Service (CRS) tabulation of data from the Medicaid Statistical Information System (MSIS) for FY2000 for all states except Hawaii. Hawaii did not report MSIS data for FY2000. CRS approximated FY2000 data for Hawaii using data reported for FY1999.

Note: Medicaid enrollees include all persons enrolled in Medicaid during the year whether or not any payments for services have been made on their behalf. Total enrollees in this figure include those in 50 states and the District of Columbia.

Table 2 presents Medicaid recipients by basis of eligibility for selected years from 1975 through 2000. Since the mid-1970s, the number of individuals receiving at least one Medicaid service during the year has more than doubled, and during the 1990s, Medicaid enrollment growth quickened. Rates of growth varied by basis of eligibility. Enrollment among the aged was fairly stable over this period, while the number of adults and children more than doubled. The biggest increase in enrollment occurred among the blind/disabled, whose numbers tripled between 1975 and 2000.

Table 2. Unduplicated Number of Medicaid Recipients by Eligibility Category for Selected Years

(in thousands)

Year	Total recipients	Aged	Blind/ disabled	Children	Adults	Foster care children	Average annual growth
1975	20,320	3,577	2,442	9,121	4,271	n/a	
1980	20,660	3,439	2,874	8,921	4,585	n/a	0.0%
1985	20,973	3,060	2,947	9,214	5,034	n/a	0.0%
1990	23,964	3,201	3,661	10,783	5,618	n/a	3.7%
1995	35,210	3,938	5,768	16,572	7,376	n/a	9.4%
2000	42,763	3,731	6,889	18,962	8,750	761	4.3%

Source: CRS tabulations of HCFA 2082 data (for 1975 — 1995) and MSIS person-level summary records (for 1999 and 2000). Hawaii did not report MSIS data for 2000. CRS estimated Hawaii's enrollment for FY2000 using data from 1999.

Notes: For 1975-1995, recipients are those individuals for whom a fee-for-service claim was paid during the year. For 2000, recipients include both those individuals for whom a fee-for-service claim was paid during the year AND those for whom a capitation payment was made during the year. Capitation payments are fixed payment amounts made to managed care organizations, usually monthly, for each person enrolled. The amounts are prepaid and do not vary by the frequency or type of services provided during the period over which the payments apply. Capitated service delivery systems became more prominent under Medicaid starting in 1995, primarily enrolling non-disabled adults and children. Due to data limitations, about 5.3 million people enrolled in such capitated arrangements during 1995 (and fewer in earlier years) are not included in this table. See subsection on managed care for more detailed information on capitated beneficiaries and expenditures.

Totals do not sum because this table does not include recipients of services for whom basis of eligibility is unknown.

Total recipients in this table include recipients in 50 states and the District of Columbia.

Table 3 shows all Medicaid enrollees in fiscal year 2000 by state. Individuals counted in this table include all recipients plus all other individuals enrolled in the program in any month whether or not services were paid on their behalf. States are ranked by the total number of enrollees. California, the state with the highest Medicaid enrollment, had 8.1 million individuals in the program in 2000. The second highest enrollment was in New York with 3.4 million enrollees. The top 10 states, in terms of enrollment, accounted for over one-half of the program's total enrollment.

Table 3. Medicaid Eligibles by Basis of Eligibility by State, FY2000

(in thousands of people)

State	Total eligibles	Rank	Aged	Blind/ disabled	Children	Foster care children	Adults	Others
Alabama	665.8	23	86.2	177.1	346.6	5.4	50.4	0.0
Alaska	109.5	47	6.2	10.7	65.5	1.6	25.5	0.0
Arizona	683.2	21	33.1	94.8	391.0	—	164.3	0.0
Arkansas	504.3	29	54.0	100.9	233.8	5.6	109.9	13.0
California	8,063.6	1	592.1	925.3	3,042.2	145.1	3,358.9	5.0
Colorado	377.7	32	45.9	65.5	181.0	17.1	68.2	80.0
Connecticut	417.7	30	55.5	56.9	225.2	9.3	70.8	0.0
Delaware	124.3	45	9.1	15.9	56.1	2.0	41.2	0.0
District of Columbia	150.8	43	10.0	30.5	71.4	4.3	34.6	35.0
Florida	2,237.6	4	226.1	460.2	1,071.8	39.1	440.4	0.0
Georgia	1,238.8	10	110.4	224.3	679.6	18.7	205.8	0.0
Hawaii	202.9	39	18.8	21.6	85.1	4.1	73.3	0.0
Idaho	150.8	42	11.6	23.9	90.4	2.0	23.0	0.0
Illinois	1,736.2	6	118.1	290.2	880.8	83.7	363.3	0.0
Indiana	756.2	18	76.5	106.6	439.3	11.2	122.6	0.0
Iowa	316.4	34	41.0	55.5	147.7	9.3	63.0	0.0
Kansas	267.8	35	32.8	51.1	135.9	11.0	37.0	0.0
Kentucky	724.5	19	71.4	199.5	347.3	8.4	97.9	0.0
Louisiana	827.4	16	99.1	173.0	444.6	9.9	100.8	0.0
Maine	214.1	37	24.5	48.8	93.5	3.3	44.0	0.0
Maryland	721.8	20	54.9	114.8	382.7	16.0	153.3	0.0
Massachusetts	1,103.7	12	111.4	226.6	452.2	0.7	312.8	0.0
Michigan	1,360.7	9	100.0	282.1	697.2	41.1	240.2	113.0
Minnesota	596.7	25	64.0	83.5	298.4	9.4	141.4	0.0
Mississippi	595.8	26	69.6	152.1	306.8	3.4	63.9	1.0
Missouri	991.4	13	100.6	136.5	519.2	21.6	213.5	0.0
Montana	97.1	49	9.9	17.3	46.5	4.0	19.3	2.0
Nebraska	238.1	36	23.1	29.0	131.1	9.5	44.7	721.0
Nevada	158.5	41	17.1	28.6	77.2	5.2	30.4	0.0
New Hampshire	110.2	46	13.0	13.8	64.6	2.6	16.1	0.0
New Jersey	855.7	15	107.3	163.6	430.7	18.7	135.4	0.0
New Mexico	398.5	31	22.1	49.0	252.4	3.4	71.5	0.0
New York	3,401.4	2	386.9	674.0	1,416.4	84.2	840.0	0.0
North Carolina	1,228.1	11	176.5	219.1	609.0	15.0	208.6	0.0
North Dakota	62.2	50	9.7	9.3	29.4	1.7	12.1	0.0
Ohio	1,420.4	8	146.4	262.4	730.6	39.1	241.6	156.0
Oklahoma	584.6	27	63.1	73.8	354.6	7.6	85.5	0.0
Oregon	560.7	28	41.7	61.6	224.2	14.0	219.2	35.0

State	Total eligibles	Rank	Aged	Blind/ disabled	Children	Foster care children	Adults	Others
Pennsylvania	1,767.8	5	204.9	391.4	739.9	45.6	386.1	0.0
Rhode Island	182.1	40	18.7	34.0	78.8	5.3	45.4	0.0
South Carolina	775.4	17	78.0	117.3	391.6	7.1	181.3	32.0
South Dakota	98.7	48	10.0	15.8	55.8	1.7	15.4	0.0
Tennessee	1,535.1	7	89.1	318.9	653.5	12.7	461.0	0.0
Texas	2,707.0	3	361.0	346.5	1,520.1	28.6	450.8	0.0
Utah	203.8	38	11.7	25.3	113.6	6.5	46.7	0.0
Vermont	147.8	44	18.6	18.2	63.5	2.3	45.2	49.0
Virginia	681.3	22	95.4	131.5	348.7	13.7	92.0	1.0
Washington	916.8	14	69.1	121.7	520.3	13.9	191.9	1.0
West Virginia	354.3	33	31.9	84.5	171.1	6.2	60.6	0.0
Wisconsin	619.1	24	61.8	132.0	267.6	18.8	138.8	1.0
Wyoming	52.5	51	4.9	8.2	27.8	1.5	10.0	0.0
U.S. Total	44,297.3		4,295.0	7,474.8	21,004.3	852.1	10,669.8	1,245.0

Source: Congressional Research Service (CRS) tabulation of data from the Medicaid Statistical Information System (MSIS) for FY2000 for all states except Hawaii. Hawaii did not report MSIS data for FY2000. CRS approximated FY2000 data for Hawaii using data reported for FY1999.

Note: Medicaid eligibles include all persons enrolled in Medicaid during the year whether or not any payments for services were made on their behalf. Totals do not sum because this table excludes individuals whose basis of eligibility was unknown.

Medicaid and the Poor

In calendar year 2002, Medicaid covered 11.6% of the total U.S. population (excluding institutionalized persons) and 40.5% of those with incomes below the federal poverty level (FPL), according to data from the March 2003 Current Population Survey (CPS) conducted by the U.S. Census Bureau. Because categorical eligibility requirements for children are less restrictive than those for adults, poor children are much more likely to receive coverage. **Table 4** shows Medicaid coverage by age and income status in calendar year 2002. The estimates of those with Medicaid coverage include those covered by the State Children's Health Insurance Program (SCHIP). Note that persons shown as receiving Medicaid may have had other health coverage as well. Nearly all the elderly, for example, had Medicare. Of persons with family incomes below poverty, more than two-thirds of children under age six are covered by Medicaid, compared to less than a third of those 19 and older.

Many individuals, even below the poverty level, are not eligible for Medicaid due to categorical restrictions. Nondisabled, childless, nonaged adults are never eligible for Medicaid, regardless of their income, unless their state obtains a special waiver to cover such individuals. In addition, even those who are eligible may not enroll. For example, all children under six years old in families with income below 133% of FPL are a mandatory coverage group. However, more than two million of these children are not enrolled in Medicaid. This may be for several reasons, including that these children have another source of health insurance, their families are unaware that Medicaid is available, or they do not perceive that coverage is needed.

Table 4. Medicaid Coverage by Age and Family Income, Calendar Year 2002
(in thousands)

Age	Covered by Medicaid	Persons in age group	Percent with Medicaid
In poverty:			
0-5	3,040	4,395	69.2
6-10	2,173	3,512	61.9
11-18	2,599	4,798	54.2
19-44	3,452	12,727	27.1
45-64	1,720	5,565	30.9
65 and older	1,028	3,586	28.7
Total	14,013	34,582	40.5
Family income between 100 and 132% of poverty:			
0-5	980	1,866	52.5
6-10	654	1,469	44.5
11-18	1,005	2,318	43.4
19-44	1,018	5,849	17.4
45-64	547	2,675	20.5
65 and older	553	3,047	18.1
Total	4,757	17,224	27.6
Family income between 133 and 184% of poverty:			
0-5	1,089	2,716	40.1
6-10	790	2,272	34.8
11-18	1,051	3,413	30.8
19-44	1,067	9,809	10.9
45-64	523	4,166	12.6
65 and older	508	5,245	9.7
Total	5,028	27,621	18.2
Family income of 185% of poverty and greater:			
0-5	1,670	14,452	11.6
6-10	1,108	12,596	8.8
11-18	1,711	22,855	7.5
19-44	2,295	78,406	2.9
45-64	1,209	55,227	2.2
65 and older	1,194	22,355	5.3
Total	9,187	205,891	4.5
All persons:			
0-5	6,779	23,429	28.9
6-10	4,726	19,848	23.8
11-18	6,366	33,384	19.1
19-44	7,832	106,790	7.3
45-64	3,999	67,633	5.9
65 and older	3,283	34,234	9.6
Total	**32,985**	**285,317**	**11.6**

Source: Congressional Research Service tabulations from the March 2003 Current Population Survey (CPS).

Note: Number of Medicaid enrollees on the CPS is lower than the number on administrative records. CPS counts exclude approximately 600,000 children who did not live with a family member (generally children in foster care), for whom income data are not available. In 2002, the poverty threshold for a family with two adults and two children was $18,244.

Estimates of the number of people with Medicaid based on the CPS and other national surveys tend to differ from official numbers published by the Centers for Medicare and Medicaid Services (CMS), based on data provided by states. The most recent administrative data for Medicaid are from FY2000, which reports more than 44 million Americans as enrolled in Medicaid, including those in institutions. The CPS estimates that in calendar year 2000, enrollment in Medicaid was approximately 30 million. The CPS is a survey of only the noninstitutionalized population, while the Medicaid administrative data include approximately two million institutionalized persons. Even so, the difference between the CPS estimates and the CMS administrative data is substantial. While not all of the reasons for this difference are understood, the following may be plausible explanations for at least part of the disparity:

- double counting and classification errors in the administrative data;
- imprecise imputation of Medicaid status on the CPS based on receipt of cash assistance; and
- inaccurate survey response by those respondents who did not want to report being covered by a public assistance program or who reported their current insurance coverage rather than their coverage for the entire previous year, as is requested for the CPS.

It is also questionable whether the CPS as a survey of the nation as a whole can accurately count Medicaid recipients given the great variability in eligibility rules across states. In states where the CPS sample size is small, the estimates of Medicaid participation are particularly subject to error.

Benefits

Medicaid's basic benefits rules require all states to provide certain "mandatory" services as listed in Medicaid statute. The statute lists additional services that are considered optional — that is, federal matching payments are available for optional services if states choose to include them in their Medicaid plans. States define the specific features of each mandatory and optional service to be provided under that plan within broad federal guidelines. Those four basic guidelines include:

- *Amount, duration, and scope.* Each covered service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The state may not arbitrarily deny or reduce the amount, duration, or scope of services solely because of the type of illness or condition. The state may place appropriate limits on a service based on such criteria as medical necessity.
- *Comparability.* With certain exceptions defined in regulations, services available to any categorically needy[17] beneficiary in a state

[17] To be eligible for federal matching funds, states must provide Medicaid coverage for most individuals who receive federally assisted income maintenance payments, as well as related groups not receiving cash payments. These groups are generally referred to as the (continued...)

must be equal in amount, duration, and scope to those available to any other categorically needy beneficiary in the state. Similarly, services available to any medically needy beneficiary in a state must be equal in amount, duration, and scope to those available to any other medically needy beneficiary in the state.

- *Statewideness.* Generally, a state plan must be in effect throughout an entire state; that is, the amount, duration, and scope of coverage must be the same statewide.
- *Freedom-of-Choice.* With certain exceptions, a state's Medicaid plan must allow recipients freedom of choice among health care providers or managed care entities participating in Medicaid.

The Secretary may waive applicability of these requirements under certain circumstances (see the following discussion of waivers).

The following services are mandatory for most groups of Medicaid recipients:

- inpatient hospital services (excluding inpatient hospital services for mental disease);
- outpatient hospital care, Federally Qualified Health Center (FQHC) services and, if permitted under state law, rural health clinic (RHC) services;
- laboratory and x-ray services;
- certified pediatric and family nurse practitioners;
- nursing facility services for those age 21 and over;
- early and periodic screening, diagnosis, and treatment for children under the age 21 (EPSDT, defined further below);
- physicians' services;
- family planning services and supplies;
- medical supplies and surgical services of a dentist;
- home health services for those entitled to nursing facility care;
- nurse-midwife services;
- pregnancy-related services (including treatment for conditions that may complicate pregnancy); and
- 60 days of postpartum-related services.

The statute lists a wide variety of optional benefits that can be covered. Some of the optional benefits are specific items, such as eyeglasses and prosthetic devices, that states may include as a Medicaid benefit. Others are types of medical providers, such as chiropractors and podiatrists, whose services can be considered Medicaid covered benefits. States have a great deal of flexibility in choosing among the listed items, in defining the scope of selected optional benefits, and in developing programs that meet the needs of their Medicaid populations. Other optional services include such items as prescription drugs, and inpatient psychiatric care for individuals under age 21 or over 65, dental care, physical therapy, case management, and many other

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[17] (...continued)
categorically needy. States also have the option to provide Medicaid coverage to other categorically needy groups for whom the eligibility criteria are somewhat more liberal.

services. **Table 5** identifies the major optional benefits provided under state Medicaid plans in 2002.

Table 5. Optional Medicaid Services and Number of States Offering Each Service, November 2002

	Number of states[a] offering services to:			
	Categorically needy only	**Medically needy only**	**Both categorically and medically needy**	**Populations added through 1115 waivers**
Chiropractors	2	—	30	—
Dental	4	—	45	—
Dentures	4	—	34	—
Diagnostic services	4	—	31	—
Emergency hospital services in non-Medicare participating hospital	3	—	34	—
Eyeglasses	4	—	44	—
Home health therapies:				
- Physical	6	—	44	—
- Speech and language	6	—	43	—
- Occupational	5	—	44	—
- Audiology services	5	—	40	—
Hospice	7	—	35	1
Inpatient hospital & nursing facility services for 65 and older in IMD[b]	10	—	33	—
Intermediate care services for the mentally disabled	10	—	41	1
Inpatient psychiatric under age 21	10	—	34	1
Mental health rehabilitation and stabilization	4	—	40	—
Nurse anesthetists	2	—	26	—
Occupational therapy	2	—	37	1
Optometrists	5	—	48	—
Other rehabilitative services	2	—	20	—
Personal care	8	—	28	—
Physical therapy	3	—	42	1
Physician directed clinic services	5	—	45	—
Podiatrists	5	—	43	—
Prescribed drugs	6	—	47	—
Preventive services	3	1	31	—
Private duty nursing	3	1	25	1
Prosthetic devices	6	—	45	1
Psychologists	2	—	30	—
Religious (non-medical) health care institution	2	—	11	—
Respiratory care services for ventilator dependent	3	—	13	—

	Number of states[a] offering services to:			
	Categorically needy only	**Medically needy only**	**Both categorically and medically needy**	**Populations added through 1115 waivers**
Screening services	3	—	29	—
Skilled nursing facility for under age 21	9	—	41	—
Targeted case management	10	—	40	—
Therapies for speech, hearing and language disorders	4	—	40	1
Transportation	4	—	46	—

Source: Medicaid At-a-Glance 2002, Publication No. CMS-11024-02. Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services.

Notes: Row totals do not sum because a state may appear more than once.

a. Includes all states, the District of Columbia, Puerto Rico and Virgin Islands.
b. In Delaware, Indiana, New York, North Dakota, and Wyoming, only inpatient hospital services are provided to inpatients in institutions for mental disease (IMDs). In South Dakota and Idaho, only skilled nursing facility services are provided to inpatients in IMDs.

In addition to the above general rules regarding mandatory and optional benefits, Medicaid statute specifies special benefits or special rules regarding certain benefits for targeted groups of individuals. These special categories of benefits include:

- *EPSDT.* Children under the age of 21 are entitled to the program of preventive child care referred to as EPSDT. EPSDT is comprised of screening services including a comprehensive health and developmental history, comprehensive physical exams, appropriate immunizations according to the schedule established by the Advisory Committee on Immunization Practices, laboratory tests and lead toxicity screening, health education, vision services including eyeglasses, dental services, hearing services, and other necessary health care to correct or ameliorate defects, physical and mental illnesses, and conditions identified through the screening services. Under EPSDT, if an optional service is determined to be a necessary treatment to correct or ameliorate a condition identified through screening, states are required to provide that service, even if they have not chosen to cover that optional service under the general benefits rules described above.
- *Pregnancy-related services.* While all women who qualify for Medicaid are eligible for pregnancy-related services, women who qualify under one of the *pregnancy-related eligibility groups* are eligible for *only* pregnancy-related services (including treatment of conditions that may complicate pregnancy). Eligibility for these individuals extends through the pregnancy and for a period of 60 days postpartum.
- *Benefits for the medically needy.* Special benefits rules apply if states choose to cover medically needy populations. States may offer a more restricted benefit package for those enrollees but are required, at a minimum, to offer the following: prenatal and delivery

services for pregnant women; ambulatory services for individuals under 18 and those entitled to institutional services; and home health services for individuals entitled to nursing facility services. Broader requirements apply if a state has chosen to provide coverage for medically needy persons in institutions for mental disease and intermediate care facilities for the mentally retarded. If so, the state is required to cover either all of the mandatory services, or alternatively, the optional services listed in any seven of the categories of care and services in Medicaid law defining covered benefits.

- *Tuberculosis (TB)-related services.* States are given the option of providing TB-related services to individuals infected with tuberculosis who meet certain income and resource requirements but are not otherwise eligible for Medicaid. TB-related services include prescription drugs, physicians' services, outpatient hospital services, clinic services, FQHC services, RHC services, laboratory and x-ray services, case management, and services designed to encourage completion of regimens of prescribed drugs.
- *Prescription Drug Coverage for Medicare/Medicaid Enrollees*. MMA of 2003 provides that, beginning in 2006, Medicaid eligibles who are also eligible for Medicare will receive outpatient prescription drug coverage through the new Medicare prescription drug benefit instead of through Medicaid. State Medicaid programs will be prohibited from covering any drugs that are to be provided through the Medicare benefit, and from paying the cost sharing amounts for those drugs. The precise impact of this bill on the Medicaid drug coverage for dual eligibles is difficult to predict at this time because the scope of the new Medicare benefit is not defined in statute. (The statute includes general guidelines that private insurers and plan sponsors, who will offer and administer the Medicare benefit, must follow. Under these general guidelines, specific plan benefits may vary.) Nonetheless, prescription drug coverage offered by state Medicaid plans to dually eligible beneficiaries will be considerably reduced.[18]

In addition, states are able to waive many of the basic benefits rules to provide special home- and community-based services for persons who are in need of long-term care and to conduct demonstration projects that test alternative methods of meeting the overall purpose of the Medicaid statute. These waivers include:

- *Home and Community-Based Services (HCBS).* Under the HCBS waiver authority, states can provide special benefits tailored to meet the long-term care needs of targeted populations. Among the benefits offered under these programs are case management; homemaker; home health aide; personal care; adult day health;

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[18] For a more thorough description of the provisions in MMA of 2003, see CRS Report RL32005, *Medicare Fee-for-Service Modifications and Medicaid Provisions of H.R. 1 as Enacted*, and CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*.

habilitation; respite care; day treatment or other partial hospitalization services; and psychosocial rehabilitation and clinic services for individuals with chronic mental illness. States can also cover a wide range of other medical, non-medical, social and supportive services that allow persons who need long-term care to remain in the community. (For more information on HCBS waivers, see the "Medicaid Waiver Programs" subsection below).

- *Section 1115 Research and Demonstration Waivers.* States have a great deal of flexibility to define benefits under Section 1115 waivers. Many of the rules outlined above regarding benefits may be waived. Under comprehensive 1115 demonstrations, states generally provide a broad range of services statewide. The Bush Administration has encouraged states to pursue targeted policies under three waiver initiatives, all using Section 1115 authority. Under *Pharmacy Plus* waivers, states are encouraged to provide only pharmacy benefits to low-income seniors and individuals with disabilities. Under *Family Planning* waivers, states are encouraged to provide only family planning services to certain individuals of childbearing age. Under *Specialty Services and Populations Demonstrations*, states provide pharmacy benefits to those with HIV/AIDS and conduct cash & counseling projects that provide cash to enrollees who may then arrange and purchase certain services on their own. (For more information on research and demonstration waivers, see the "Medicaid Waiver Programs" subsection below.)

Tables 6 and **7** show recipients and expenditures[19] by type of service for fiscal year 2000. The single benefit used by the largest number of Medicaid recipients was prescription drugs, for 20.5 million recipients, followed by physician services, used by 19.1 million recipients.[20] Nursing facility services accounted for the largest share of Medicaid spending (23.9%), followed closely by inpatient hospital services (16.9%). Prescription drugs and physician services, while accounting for the largest number of users, accounted for 13.9% and 4.7% of all spending on services, respectively.

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[19] Expenditures shown in **Table 7** are those reported by states through the Medicaid Statistical Information System (MSIS) for FY 2000. These data do not match FY 2000 expenditures reported above in **Table 1** (based on CMS-64 reports). Data reported on form CMS-64 have always varied from the MSIS reported totals. Because the CMS-64 reports are filed for financial accounting purposes, they are generally considered to be a more accurate accounting of total outlays, and are preferred when examining state and/or federal totals. Those data, however, do not allow for analysis of spending patterns and use of services for individuals or among groups of individuals (for example, by basis of eligibility). For such analyses, data from the MSIS are used. **Figure 3** also uses MSIS data for this reason.

[20] Capitated payment systems accounted for a larger number of recipients than prescription drugs (almost 21.3 million recipients). Capitated payment services, however, despite being included alongside such services as prescription drugs and inpatient hospital services, are not considered a single benefit. The term refers to a managed care delivery system that provides a specified set of Medicaid benefits to a specified group of enrollees. (For more information on Medicaid managed care, see "Delivery Systems" subsection.)

Table 6. Medicaid Recipients by Service Category, Fiscal Year 2000

(in thousands of people, in order of descending number of recipients)

Service category	Number of recipients
Acute care	
Capitated payment services	21,261
Prescribed drugs	20,517
Physician services	19,104
Outpatient hospital services	13,226
Lab & x-ray services	11,396
Other care and services	9,037
Clinic services	7,667
Dental services	5,892
PCCM services*	556
Inpatient hospital services	4,933
Other practitioner services	4,735
Sterilization services	137
Mental health facility services	102
Long-term care	
Personal support services	4,549
Nursing facility services	1,703
Home health services	995
Unknown	176
Unduplicated total	42,763

Source: Congressional Research Service (CRS) tabulation of data from the Medicaid Statistical information System (MSIS) for FY2000 for all states except Hawaii. Hawaii did not report MSIS data for FY2000. CRS approximated FY2000 data for Hawaii using data reported for FY1999.

Note: Recipients in this table include all individuals for whom a fee-for-service claim was paid during the year AND those for whom a capitation payment was made during the year.

* PCCM denotes primary care case management, under which primary care providers are provided with a small fee, usually paid on a monthly basis, for each enrollee for whom they coordinate primary care services.

Table 7. Total State and Federal Medicaid Payments by Basis of Eligibility, Type of Service, and as a Percentage of Total Payments, FY2000

(in order of descending total payments)

Service type	Total service payments	Aged	Blind/ disabled	Children	Adults	Foster care	Unknown
			in millions of dollars				
Acute care							
Capitated payment services	$24,413	$1,721	$6,878	$9,459	$5,777	$323	$255
Inpatient hospital services	24,266	1,630	10,409	4,537	4,767	360	2,562
Prescribed drugs	20,014	5,355	11,591	1,338	1,444	224	62
Other care and services	14,680	2,448	9,874	848	593	554	363
Outpatient hospital services	7,053	667	3,174	1,310	1,443	123	336
Physician services	6,806	633	2,316	1,765	1,697	166	229
Clinic services	6,174	267	2,638	1,063	823	272	1,112
Mental health facility services	1,768	312	515	402	24	339	175
Dental services	1,404	80	286	764	208	40	28
Lab & x-ray services	1,288	90	538	180	423	17	39
Other practitioner services	658	79	257	192	75	49	6
PCCM services	165	3	32	108	18	2	2
Sterilization services	128	0	9	2	109	0	9
Subtotal	**108,817**	**13,285**	**48,517**	**21,968**	**17,401**	**2,469**	**5,178**
Long term care							
Nursing facility services	34,432	27,058	6,967	34	33	22	318
Personal support services	11,567	2,688	6,415	1,340	232	740	152

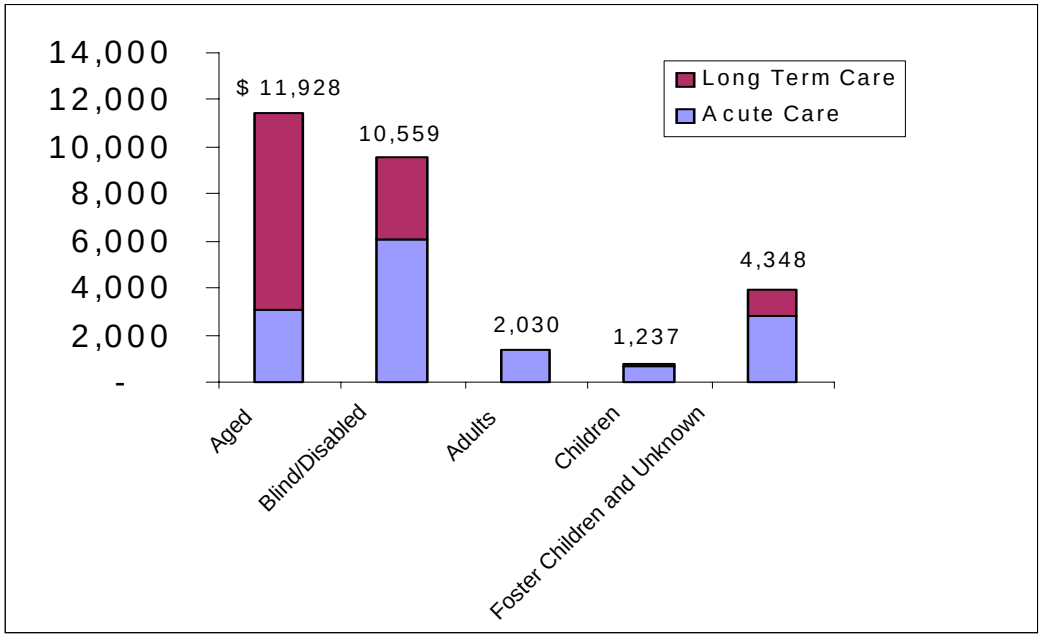
Service type	Total service payments	Aged	Blind/ disabled	Children	Adults	Foster care	Unknown
ICF/MR services	9,375	708	8,611	15	5	18	17
Home health services	3,119	718	2,175	90	65	60	12
Subtotal	**58,493**	**31,172**	**24,168**	**1,479**	**335**	**840**	**499**
Unknown	997	45	57	18	27	1	850
Total	**168,307**	**44,503**	**72,742**	**23,466**	**17,763**	**3,309**	**6,525**
			percentage of total payments by BOE				
Acute care							
Capitated payment services	14.5%	3.9%	9.5%	40.3%	32.5%	9.8%	3.9%
Inpatient hospital services	14.4%	3.7%	14.3%	19.3%	26.8%	10.9%	39.3%
Prescribed drugs	11.9%	12.0%	15.9%	5.7%	8.1%	6.8%	1.0%
Other care and services	8.7%	5.5%	13.6%	3.6%	3.3%	16.7%	5.6%
Outpatient hospital services	4.2%	1.5%	4.4%	5.6%	8.1%	3.7%	5.1%
Physician services	4.0%	1.4%	3.2%	7.5%	9.6%	5.0%	3.5%
Clinic services	3.7%	0.6%	3.6%	4.5%	4.6%	8.2%	17.0%
Mental health facility services	1.1%	0.7%	0.7%	1.7%	0.1%	10.2%	2.7%
Dental services	0.8%	0.2%	0.4%	3.3%	1.2%	1.2%	0.4%
Lab & x-ray services	0.8%	0.2%	0.7%	0.8%	2.4%	0.5%	0.6%
Other practitioner services	0.4%	0.2%	0.4%	0.8%	0.4%	1.5%	0.1%
PCCM services	0.1%	0.0%	0.0%	0.5%	0.1%	0.1%	0.0%
Sterilization services	0.1%	0.0%	0.0%	0.0%	0.6%	0.0%	0.1%
Subtotal	**64.7%**	**29.9%**	**66.7%**	**93.6%**	**98.0%**	**74.6%**	**79.4%**

Service type	Total service payments	Aged	Blind/ disabled	Children	Adults	Foster care	Unknown
Long Term Care							
Nursing Facility Services	20.5%	60.8%	9.6%	0.1%	0.2%	0.7%	4.9%
Personal Support Services	6.9%	6.0%	8.8%	5.7%	1.3%	22.4%	2.3%
ICF/MR Services	5.6%	1.6%	11.8%	0.1%	0.0%	0.5%	0.3%
Home Health Services	1.9%	1.6%	3.0%	0.4%	0.4%	1.8%	0.2%
Subtotal	**34.8%**	**70.0%**	**33.2%**	**6.3%**	**1.9%**	**25.4%**	**7.6%**
Unknown	0.6%	0.1%	0.1%	0.1%	0.2%	0.0%	13.0%

Source: Congressional Research Service (CRS) tabulation of data from the Medicaid Statistical Information System (MSIS) for FY2000 for all states except Hawaii. Hawaii did not report MSIS data for FY2000. CRS approximated FY2000 data for Hawaii using data reported for FY1999.

Figure 3 shows average per recipient Medicaid spending by basis of eligibility for fiscal year 2000. The figure points out the relatively low cost of non-disabled children and adults to the Medicaid program. While these groups comprise the majority of Medicaid enrollment, their costs are relatively small ($2,030 per adult and $1,237 per child) when compared with the per recipient cost of the elderly ($11,928), and blind and disabled ($10,559) recipients. This figure, on the other hand, underestimates the average cost of long-term care services for the comparatively few users of those services (see **Table 6**). Because these averages were calculated for all program recipients (of any service), they are below the average cost of services for only those individuals actually using the specific service. This difference is especially pronounced for long-term care services because relatively few users of those services account for a small number of very expensive claims.

Figure 3. Medicaid Expenditures per Recipient by Acute and Long-Term Care and Basis of Eligibility, FY2000



Source: Congressional Research Service (CRS) tabulation of data from the Medicaid Statistical Information System (MSIS) for FY2000 for all states except Hawaii. Hawaii did not report MSIS data for FY2000. CRS approximated FY2000 data for Hawaii using data reported for FY1999.

Notes: Medicaid recipients include all individuals for whom ANY claim was paid during the year AND for whom a capitation payment was made during the year.

In these calculations, total expenditures for long term care and acute care services were divided by the TOTAL number of program recipients of any service in each eligibility group, whether or not all of those individuals were users of long-term care services and acute care services. This results in averages for all recipients that can diverge from the averages among only those individuals who used that particular type of service. This is especially true for long-term care where relatively few users account for a small number of large and costly claims.

For a list of which services were classified as long term care and acute care, see **Table 6**.

Financing

The federal government helps states pay for Medicaid services by means of a variable matching formula, called the federal medical assistance percentage (FMAP), which is adjusted annually.[21] With specific exceptions (described below), the federal matching rate, which is inversely related to a state's per capita income, can range from 50 to 83%. Beginning in fiscal year 1998, the federal matching rate for the District of Columbia increased to 70% and Alaska's matching percentage is calculated using the three-year average per capita income for the state divided by 1.05. Federal matching for five territories is 50% with a maximum dollar limit placed on the amount each territory can receive.

To provide fiscal relief to states, federal matching rates for benefits were changed temporarily by the Jobs and Growth Tax Relief Reconciliation Act (JGTRRA, P.L. 108-27), which altered the rates for qualifying states[22] for the last two quarters of fiscal year 2003 and the first three quarters of fiscal year 2004. For these quarters, the federal matching percentage for each state is held harmless for declines from the prior fiscal year, and then is increased by 2.95 percentage points. The federal matching percentages for all states and jurisdictions for fiscal years 2003 and 2004 are shown in **Table 8**.

MMA 2003 includes provisions intended to continue, after 2005, some state financing of outpatient prescription drugs for individuals dually eligible for Medicare and Medicaid even though Medicare will be their primary source of drug coverage. Beginning in 2006, each state will be required to make a monthly payment to the Secretary of HHS equal to the product of the state's share of 2003 Medicaid per capita spending for drugs for all full-benefit dual eligibles[23] trended forward to the current year, multiplied by the total number of such dual eligibles for such state for the month, and multiplied again by the "factor" for the month. The "factor" is 90% in 2006, and will phase down to 75% over 10 years. The formula ensures that states continue to fund a significant share of the cost of the new Medicare drug benefit for those individuals who would have otherwise been eligible for Medicaid prescription drugs. A state's failure to make the required payments will result in interest charges and in an offset to amounts otherwise payable under Medicaid.

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[21] FMAP is a measure of the average per capita income in each state, squared, compared to that of the nation as a whole.

[22] For further information on the state eligibility criteria for the higher FMAP, see the Legislative History subsection.

[23] Including the estimated actuarial value of prescription drug benefits provided under capitated care.

Table 8. Federal Medical Assistance Percentages by State for Fiscal Years 2003 and 2004

	FY2003		FY2004			FY2003		FY2004	
State	First 2 qtrs	Last 2 qtrs	First 3 qtrs	Last qtr	State	First 2 qtrs	Last 2 qtrs	First 3 qtrs	Last qtr
Alabama	70.60	73.55	73.70	70.75	Nevada	52.39	55.34	57.88	54.93
Alaska	58.27	61.22	61.34	58.39	New Hampshire	50.00	52.95	52.95	50.00
Arizona	67.25	70.20	70.21	67.26	New Jersey	50.00	52.95	52.95	50.00
Arkansas	74.28	77.23	77.62	74.67	New Mexico	74.56	77.51	77.80	74.85
California	50.00	54.35	52.95	50.00	New York	50.00	52.95	52.95	50.00
Colorado	50.00	52.95	52.95	50.00	North Carolina	62.56	65.51	65.80	62.85
Connecticut	50.00	52.95	52.95	50.00	North Dakota	68.36	72.82	71.31	68.31
Delaware	50.00	52.95	52.95	50.00	Ohio	58.83	61.78	62.18	59.23
District of Columbia	70.00	72.95	72.95	70.00	Oklahoma	70.56	73.51	73.51	70.24
Florida	58.83	61.78	61.88	58.93	Oregon	60.16	63.11	63.76	60.81
Georgia	59.60	62.55	62.55	59.58	Pennsylvania	54.69	57.64	57.71	54.76
Hawaii	58.77	61.72	61.85	58.90	Rhode Island	55.40	58.35	58.98	56.03
Idaho	70.96	73.97	73.91	70.46	South Carolina	69.81	72.76	72.81	69.86
Illinois	50.00	52.95	52.95	50.00	South Dakota	65.29	68.88	68.62	65.67
Indiana	61.97	64.99	65.27	62.32	Tennessee	64.59	67.54	67.54	64.40
Iowa	63.50	66.45	66.88	63.93	Texas	59.99	63.12	63.17	60.22
Kansas	60.15	63.15	63.77	60.82	Utah	71.24	74.19	74.67	71.72
Kentucky	69.89	72.89	73.04	70.09	Vermont	62.41	66.01	65.36	61.34
Louisiana	71.28	74.23	74.58	71.63	Virginia	50.53	54.40	53.48	50.00
Maine	66.22	69.53	69.17	66.01	Washington	50.00	53.32	52.95	50.00
Maryland	50.00	52.95	52.95	50.00	West Virginia	75.04	78.22	78.14	75.19
Massachusetts	50.00	52.95	52.95	50.00	Wisconsin	58.43	61.52	61.38	58.41
Michigan	55.42	59.31	58.84	55.89	Wyoming	61.32	64.92	64.27	59.77
Minnesota	50.00	52.95	52.95	50.00	America Samoa	50.00	52.95	52.95	50.00
Mississippi	76.62	79.57	80.03	77.08	Guam	50.00	52.95	52.95	50.00
Missouri	61.23	64.18	64.42	61.47	N. Marina Islands	50.00	52.95	52.95	50.00
Montana	72.96	75.91	75.91	72.85	Puerto Rico	50.00	52.95	52.95	50.00
Nebraska	59.52	62.50	62.84	59.89	Virgin Islands	50.00	52.95	52.95	50.00

Sources: The FMAPs displayed for the first two quarters of fiscal year 2003 and the last quarter of fiscal year 2004 were published in the *Federal Register* (Nov. 30, 2001, vol. 66, no. 231, and Nov. 15, 2002, vol. 67, no. 221, respectively.)

The FMAPs displayed for the last two quarters of fiscal year 2003 were taken from the Centers for Medicare and Medicaid Services Memorandum of Jun. 13, 2003 (MDL #03-005) to State Medicaid Directors on the impact of P.L. 108-27. Finally, the FMAPs displayed for the first three quarters of fiscal year 2004 were estimated by the Congressional Research Service.

Reimbursement Policy

For the most part, states establish their own rates to pay Medicaid providers for services. By regulation these rates must be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries at least to the extent they are available to the general population in a geographic area. The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) required that beginning October 1, 1997, states must provide public notice of the proposed rates for hospitals, nursing facilities, and intermediate care facilities for the mentally retarded and the methods used to establish those rates.

All providers are required to accept payments under the program as payment in full for covered services except where states require nominal cost-sharing by beneficiaries. States may generally impose such charges with certain exceptions. They are precluded from imposing cost sharing on services for children under 18, services related to pregnancy, family planning or emergency services, and services provided to nursing facility residents who are required to spend all of their income for medical care except for a personal needs allowance. Effective August 5, 1997, states are permitted to pay Medicaid rates, instead of Medicare rates, to providers for services to dual eligibles (those Medicare beneficiaries who are also eligible for full Medicaid benefits) and qualified Medicare beneficiaries (QMBs; see "Eligibility" subsection). Effective in 2006, Medicaid programs are prohibited from paying the cost sharing charges for Medicare covered drugs under the MMA 2003 prescription drug benefit.

Certain types of providers are subject to special rules. Three such circumstances are discussed in detail below.

Reimbursement for Prescription Drugs

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90, P.L. 101-508) established rules for Medicaid reimbursement of prescription drugs. Medicaid payments for drugs are subject to upper payment limits. For drugs with generic versions available from three or more manufacturers, the upper payment limit is 150% of the average wholesale price. For other drugs, the upper payment limit is either the estimated price paid by the provider for the drug plus a dispensing fee or the provider's usual charge for the drug to the general public.

In addition, drug manufacturers participating in the Medicaid program must provide rebates to states. Rebates, intended to ensure that states pay the "best price" for Medicaid pharmaceuticals, vary depending upon whether the drug is available from multiple sources (a generic version of the drug is available) or available from a single source (a generic version of the drug is not available). The rebate for drugs ranges from 11% to 15.1% of the average manufacturer price.

Disproportionate Share Hospital Payments

States must provide for additional payments to hospitals serving a disproportionate share of low-income patients. Medicaid disproportionate share

hospital (DSH) payments must follow a formula that considers a hospital's charity patients as well as its Medicaid caseload. Beginning in fiscal year 1992, state DSH payments were limited as part of an effort to rein in fast growth. DSH payments were limited to 12% of total Medicaid spending. The 12% figure was phased in through the use of state-specific DSH allotments (caps on federal matching payments) for each federal fiscal year. BBA 97 lowered the DSH allotments by imposing a freeze and making graduated proportional reductions for 1998-2002. MMA 2003 included a special rule for calculating DSH allotments for certain years. Under the new law, DSH allotments to states for FY2004 and for certain subsequent fiscal years are increased by 16% over the amounts authorized under prior law. Thereafter, annual DSH allotments for a state equal the allotment for the preceding fiscal year increased by the percentage change in the medical care component of the Consumer Price Index for All Urban Consumers.

Other ceilings as well as a floor are imposed on DSH allotments. They include: a cap on DSH payments to institutions for mental disease and other mental health facilities; and a cap on DSH payments to specific hospitals equal to a percentage of each hospital's uncompensated care costs. This "hospital specific" cap for all public hospitals in the nation for a two-year period beginning in state fiscal year 2003 is equal to 175% of uncompensated care costs. For private hospitals, the ceiling is at 100% of uncompensated care costs. Finally, certain low DSH states are guaranteed a floor on their DSH allotments. Under MMA 2003, states in which total DSH payments for FY2000 are less than 3% of the state's total Medicaid spending on benefits, allotments for FY2004 through FY2008 will be equal to 16% above the prior year amounts. For FY2009 forward, as for all other states, the allotment for low DSH states for each year equals the prior year amount increased by inflation.

Upper Payment Limits for Certain Institutional Providers

In 1987, the Secretary of HHS issued regulations establishing separate upper payment limits for inpatient and outpatient services provided by different types of facilities. An aggregate upper payment limit was established for each type of institutional provider of Medicaid services by ownership (state versus other) that would not exceed what would have been paid for those services under Medicare payment principles. In 2000, the Secretary determined that some states made arrangements with city or county facilities to pay these facilities at inflated rates. The city or county facilities then transferred some or all of the enhanced payments back to the state. BIPA 2000 addressed these funding methods by requiring regulations to provide separate upper payment limits for private and non-state public facilities up to 100% of the Medicare rate for such services. Later, through regulation, the Clinton Administration allowed payments to city and county public hospitals up to 150% of the Medicare rate for their services. In January 2002, the Bush Administration changed the special rule for city and county hospitals to 100% of the Medicare rate.

Administration

Medicaid is a state-administered program. At the federal level, the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (DHHS) is responsible for overseeing state operations.

Federal law requires that a single state agency be charged with administration of the Medicaid program. Generally, that agency is either the state welfare agency, the state health agency, or an umbrella human resources agency. The single state agency may contract with other state entities to conduct some program functions. Further, states may process claims for reimbursement themselves or contract with fiscal agents or health insuring agencies to process these claims. The federal share of administrative costs is 50% for all states, except for certain items for which the authorized rate is higher.

Delivery Systems

There are two systems for delivering services under Medicaid: fee-for-service and managed care. These systems differ in how the state pays for the services it covers, and how the individual accesses service providers. Most states use a combination of both of these systems to deliver Medicaid services. The primary elements of these systems and initiatives to deliver long-term care services are discussed below.

Fee-for-service

The fee-for-service (FFS) system has been the primary method of paying for and delivering Medicaid services since the program's enactment in 1965. Under fee-for-service, a Medicaid beneficiary determines, in consultation with a physician, the type of services needed and can receive those services from any Medicaid participating provider. States may limit the amount of services or require prior approval of services, but the individual retains significant flexibility. The provider receives payment from the state Medicaid agency for that particular service based on rates established by the state. States have significant flexibility in developing how payment rates are calculated and there is significant variation by state and by service. For example, the rate may be related to the actual cost of the service for an individual provider or could be a fixed, pre-determined amount for a particular procedure.

Although enrollment in managed care has increased over the last decade, the fee-for-service system continues to be a widespread and important service delivery mechanism. The fee-for-service system is used for individuals whose Medicaid eligibility group or geographic location is not served through managed care, or for persons who opt out when managed care is voluntary. The fee-for-service system is also used for those Medicaid services not covered by a managed care contract.

For individuals who live in rural areas and individuals who are elderly or have a disability, fee-for-service continues to be the dominant delivery system. States have tended to exclude these groups from managed care programs. Individuals in rural areas often have limited choice of managed care plans and service providers.

Individuals who are elderly or who have a disability, often have complex medical conditions which can be costly and require specialty care, and their health status can be unpredictable. Though individuals who are elderly or who have a disability tend to be excluded, states have started to develop managed care approaches for these groups to contain cost and test alternative delivery systems as discussed below.

Under a primarily fee-for-service system, state Medicaid expenditures and the number of enrollees has increased significantly. Over the 10-year period between 1985 and 1995, state Medicaid expenditures increased from $18.2 billion to $67.3 billion, an average growth rate of 14% annually. This increase primarily reflected increases in medical costs and increases in the number of Medicaid enrollees, among other causes. Between 1985 and 1995, the number of Medicaid enrollees increased 66% from 21.8 million to 36.2 million. During that period, states also lacked a coordinated system for delivering services. No one was designated to assist the individual in sorting through his or her health care options or ensuring timely access to appropriate services. In an effort to slow the growth of expenditures and improve service delivery, many states turned to managed care for many of their enrollees.

Managed Care

The number of Medicaid beneficiaries enrolled in a managed care plan of any type increased from 9.5% of the Medicaid population in 1991 to 57.6% in 2002. As of June 30, 2002, 21.3 million individuals receiving Medicaid were enrolled in some form of managed care. Alaska, Mississippi and Wyoming were the only states that did not use managed care to deliver services to Medicaid beneficiaries.

Under managed care, the state contracts with a plan(s) to provide an agreed upon set of benefits. The contract could include a comprehensive set of services or include only one service, for example, case management. For each managed care contract, the state establishes fixed, prospective, monthly, per person payment rates referred to as a "capitation" payment for the covered services. The capitation rate is based on the average cost of services for a defined group. After determining the average cost, states may use a variety of actuarial methods to adjust the average cost for specific individuals by age, geographic location, and/or diagnosis. For example, a state may establish different rates for men and women, and different rates for specific age brackets. The plan would receive the rate associated with the individual enrolled based on that person's gender and age. The capitation payment does not vary on a monthly basis if the volume of services actually used by the individual differs from that assumed in the capitation payment. The plan also negotiates payment rates with participating providers. In contrast, under fee-for-service, the state establishes the provider payment rates as described earlier. The goal of managed care is to reduce unnecessary service use, improve access to quality health care by having a central point of contact, and increase care coordination thereby reducing expenditures.

Types of Managed Care. Managed care plans vary in the financial responsibility or "risk" the plan assumes and the services they provide. In a risk-based managed care contract, the plan is fiscally responsible for the provision of all services agreed upon in the contract regardless of actual use by beneficiaries. Under a non-risk based contract, states either implement processes to share the financial burden with the plan or the state assumes full financial responsibility for the services

provided. For example, in a non-risk based contract, at the end of the fiscal period, a state may modify the payments to a managed care plan if actual service use differs from projected use (upon which the original capitation payment was based).

There is also significant variation in the amount and types of services that each state includes in its Medicaid managed care contracts. Some states contract with a plan for a limited benefit package such as case management, dental, or mental health services. Other states have included a comprehensive[24] set of services.

The primary types of Medicaid managed care arrangements are described below:

- *Managed care organization (MCO).* Under a managed care organization (such as a health maintenance organization or HMO), the entity has a comprehensive, risk-based contract with the state. The state pays the organization a fixed, prospective, per person per month rate for providing medical care for all plan enrollees.
- *Pre-paid health plan (PHP).* Pre-paid health plans refer to risk-based contracts that include less than a comprehensive set of services (such as only behavioral health services), or non-risk based contracts for any package of services. Essentially, such plans do not have a *risk-based contract* with the state for a *comprehensive* set of services.
- *Primary care case management (PCCM).* Under a PCCM model, providers receive a per person, monthly fee for coordinating each enrollee's care. The provider is not fiscally responsible for the services used by the individual. All services are provided through the fee-for-service delivery system. The PCCM must be a physician or licensed health care professional; this provider acts as a care coordinator and/or gatekeeper to the services specified under the PCCM contract.

There are also several hybrids of the MCO, PHP and PCCM models. Most states have implemented multiple models. For example, a state may have an MCO for children and families enrolled in Medicaid and a PHP for mental health services for individuals with a relevant disability. As of June 30, 2002, 47 states and the District of Columbia were using some form of Medicaid managed care, 44 states had risk-based plans[25] and 30 states had non-risk PCCM plans.[26]

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[24] The law considers a service package to be "comprehensive" if it includes inpatient hospital services and any of the following services, or any three or more of the following services 1) outpatient hospital services, 2) rural health clinic services, 3) federally qualified health center (FQHC) services, 4) other laboratory and x-ray services, 5) nursing facility service, 6) early and periodic screening, diagnostic, and treatment (EPSDT) services, 7) family planning services, 8) physician services, or 9) home health services.

[25] Includes PHPs and hybrid managed care models.

[26] CMS, 2002 *Medicaid Managed Care Enrollment Report, Plan Type Breakout Enrollment by State,* See [http://www.cms.hhs.gov/medicaid/managedcare/mctype02.pdf].

As discussed earlier, managed care has primarily included low-income adults and children, as shown in **Table 9**. Of the 21.3 million Medicaid recipients enrolled in a managed care organization or pre-paid health plan in fiscal year 2000, 78% were low-income adults and children, 18% were individuals with disabilities and the elderly, and 5% had an unknown basis of eligibility.[27]

Table 9. Medicaid Recipients Served Through MCO And/or PHP Plans by Basis of Eligibility, Fiscal Year 2000

(in thousands of people)

State	Total[a]	Aged	Blind and disabled	Children	Adults	Foster care	Unknown
Alabama	—	—	—	—	—	—	—
Alaska	—	—	—	—	—	—	—
Arizona	650	29	90	379	137	8	6
Arkansas	—	—	—	—	—	—	—
California	5,778	501	863	2,409	1,152	125	728
Colorado	343	39	58	162	50	16	17
Connecticut	291	—	1	213	64	7	5
Delaware	100	—	10	51	36	2	—
Dist. of Columbia	101	—	3	66	30	—	1
Florida	769	19	116	480	126	9	19
Georgia	22	—	4	15	4	—	—
Hawaii	167	—	5	84	71	4	3
Idaho	—	—	—	—	—	—	—
Illinois	237	—	1	173	55	1	7
Indiana	178	—	6	131	36	1	4
Iowa	252	2	46	133	56	9	6
Kansas	57	—	—	43	11	—	2
Kentucky	700	49	184	346	97	8	16
Louisiana	—	—	—	—	—	—	—
Maine	3	—	—	2	1	—	—
Maryland	507	7	71	335	77	15	2
Massachusetts	779	2	117	385	255	1	19
Michigan	1,055	10	185	596	181	24	59
Minnesota	375	35	4	229	105	1	1
Mississippi	9	—	3	5	1	—	1
Missouri	395	—	1	277	99	13	4
Montana	3	—	—	—	2	—	—
Nebraska	172	1	13	116	35	8	—
Nevada	71	—	—	47	17	—	7
New Hampshire	7	—	—	6	1	—	—
New Jersey	560	33	19	403	95	1	8

[27] Does not total to 100% due to rounding. This does not include individuals only receiving PCCM services.

State	Total[a]	Aged	Blind and disabled	Children	Adults	Foster care	Unknown
New Mexico	297	1	28	217	44	3	4
New York	1,082	9	90	570	304	4	104
North Carolina	62	—	6	39	11	1	4
North Dakota	1	—	—	1	—	—	—
Ohio	362	—	6	273	82	—	1
Oklahoma	382	—	37	274	69	1	1
Oregon	508	35	53	207	198	12	3
Pennsylvania	1,015	66	215	510	180	26	18
Rhode Island	123	—	1	76	44	1	1
South Carolina	43	—	3	36	3	—	—
South Dakota	99	10	16	56	15	2	—
Tennessee	1,552	87	315	637	452	12	49
Texas	727	40	64	504	114	3	1
Utah	195	9	21	103	35	6	21
Vermont	66	—	1	35	29	2	—
Virginia	213	2	30	144	37	—	—
Washington	613	3	3	466	126	1	14
West Virginia	—	—	—	—	—	—	—
Wisconsin	342	1	10	221	106	3	1
Wyoming	—	—	—	—	—	—	—
U.S. Total	**21,263**	**992**	**2,700**	**11,456**	**4,647**	**330**	**1,137**
Percentage of Total		**5%**	**13%**	**54%**	**22%**	**2%**	**5%**

Source: Congressional Research Service (CRS) tabulation of data from the Medicaid Statistical Information System (MSIS) for FY2000 for all states except Hawaii. Hawaii did not report MSIS data for FY2000. CRS approximated FY2000 data for Hawaii using data reported for FY1999.

a. Does not include individuals who only received primary care case management services (PCCM).

— Denotes no managed care program, except in some cases states reported capitation payments as part of other services and did not report these payments in the MCO or PHP categories. This was most likely to occur when there was only one service provided under that managed care program (e.g., transportation). Alternate data sources from the Centers for Medicare and Medicaid Services website [cms.hhs.gov/medicaid/managedcare/mmcns600.asp] show that Alabama, Arkansas, and West Virginia had capitated MCO or PHP programs during FY2000.

Medicaid expenditures in fiscal year 2000 for services provided in managed care or a pre-paid health plan followed a similar pattern, as shown in **Table 10**.[28] Of the $24.4 billion in Medicaid expenditures for individuals in a managed care organization or pre-paid health plan, 64% were for low-income adults and children, 35% were for individuals with disabilities and the elderly, and 1% were for individuals whose basis of eligibility was unknown.

[28] Expenditures shown in **Table 10** are those reported by states through the MSIS database for FY 2000. See footnote 19 for further information.

Table 10. Total Medicaid Payments for MCO and PHP Recipients by Basis of Eligibility, Fiscal Year 2000

(in millions of dollars)

State	Total[a]	Aged	Blind and disabled	Children	Adults	Foster care	Unknown
Alabama	--	--	--	--	--	--	--
Alaska	--	--	--	--	--	--	--
Arizona	$1,709	$330	$690	$395	$257	$9	$29
Arkansas	--	--	--	--	--	--	--
California	$3,846	$347	$650	$1,828	$837	$41	$142
Colorado	$372	$49	$156	$82	$32	$52	--
Connecticut	$411	--	$1	$284	$116	$8	$1
Delaware	$169	$2	$51	$45	$70	$1	--
Dist. of Columbia	$136	--	$27	$63	$46	--	--
Florida	$743	$78	$297	$247	$104	$6	$10
Georgia	$7	--	$3	$2	$1	--	--
Hawaii	$235	--	$5	$120	$101	$7	$1
Idaho	--	--	--	--	--	--	--
Illinois	$213	$1	$1	$133	$76	--	$1
Indiana	$143	--	$5	$96	$41	$1	$1
Iowa	$139	$1	$36	$60	$40	$2	--
Kansas	$43	--	--	$23	$14	--	$5
Kentucky	$467	$21	$214	$190	$38	$4	--
Louisiana	--	--	--	--	--	--	--
Maine	$2	--	--	$1	$1	--	--
Maryland	$911	$30	$395	$301	$174	$15	($3)
Massachusetts	$525	$25	$178	$178	$142	--	$2
Michigan	$1,274	$15	$658	$347	$235	$10	$8
Minnesota	$660	$135	$8	$329	$190	$1	($2)
Mississippi	($3)	--	--	($2)	--	--	($1)
Missouri	$383	--	$1	$277	$91	$13	--
Montana	$3	--	--	--	$2	--	--
Nebraska	$110	$2	$24	$40	$15	$29	--
Nevada	$72	--	--	$33	$32	--	$7
New Hampshire	$4	--	--	$4	$1	--	--
New Jersey	$648	$8	$49	$422	$168	$1	--
New Mexico	$526	$2	$173	$243	$84	$18	$5
New York	$1,469	$142	$263	$558	$492	$3	$11
North Carolina	$55	--	$17	$23	$14	$1	--
North Dakota	$1	--	--	$1	--	--	--
Ohio	$385	--	$4	$248	$132	--	--
Oklahoma	$221	$1	$63	$130	$26	--	--
Oregon	$763	$74	$212	$164	$288	$24	$1
Pennsylvania	$2,523	$253	$1,144	$734	$349	$42	$1
Rhode Island	$140	--	$1	$64	$74	--	--
South Carolina	$28	$9	$5	$11	$2	--	--

State	Total[a]	Aged	Blind and disabled	Children	Adults	Foster care	Unknown
South Dakota	$6	$1	$1	$4	$1	--	--
Tennessee	$2,948	$105	$1,106	$733	$974	$20	$9
Texas	$634	$68	$188	$297	$81	$1	--
Utah	$131	$5	$52	$39	$16	$2	$16
Vermont	$25	--	--	$11	$13	$1	--
Virginia	$322	$5	$139	$124	$54	--	--
Washington	$658	$2	$1	$387	$261	--	$7
West Virginia	--	--	--	--	--	--	--
Wisconsin	$358	$11	$59	$190	$91	$7	--
Wyoming	--	--	--	--	--	--	--
U.S. Total	**$24,413**	**$1,721**	**$6,878**	**$9,459**	**$5,777**	**$323**	**$255**
Percentage of Total		**7%**	**28%**	**39%**	**24%**	**1%**	**1%**

Source: Congressional Research Service (CRS) tabulation of data from the Medicaid Statistical Information System (MSIS) for FY2000 for all states except Hawaii. Hawaii did not report MSIS data for FY2000. CRS approximated FY2000 data for Hawaii using data reported for FY1999.

[a] Does not include individuals receiving only primary care case management services (PCCM).

- - Denotes no managed care program, except in some cases states reported capitation payments as part of other services and did not report these payments in the MCO or PHP categories. This was most likely to occur when there was only one service provided under that managed care program (e.g., transportation). Alternate data sources from the Centers for Medicare and Medicaid Services website [cms.hhs.gov/medicaid/managedcare/mmcns600.asp] show that Alabama, Arkansas, and West Virginia had capitated MCO or PHP programs during FY2000.

Trends in Managed Care. In the early and mid-1990's, states significantly expanded enrollment in Medicaid managed care programs, but this growth is slowing. In fiscal year 2001 and fiscal year 2002, the number of individuals enrolled in a managed care plan as a percentage of all Medicaid eligible individuals increased 1.9% and 1.3% respectively. This is a significant decrease over the 61.1% and 38.4% annual growth rates of fiscal year 1994 and fiscal year 1995, respectively. The expansion of Medicaid managed care in the early and mid-1990's should be viewed in the context of a general trend toward managed care across many sectors of the U.S. health care system. Despite the significant growth of managed care both in Medicaid and the overall health care system, the extent to which it has accomplished the goal of controlling health care expenditures and increasing quality has been inconclusive.

Finally, in both Medicaid and the U.S. health care system in general, managed care continues to evolve. Some of these changes include plans entering and exiting certain geographic locations, and company consolidations and bankruptcies. There has been a significant number of risk-based managed care plans that have entered and left the Medicaid program. In a survey of all states that had risk-based programs in 1998 conducted by the National Academy for State Health Policy (May 2001), 82% of these states had turnover in plans between 1998 and 2000. While plan turnover occurred in a majority of managed care programs, plan exits affected a minority of Medicaid enrollees (8.4% of managed care enrollees in 2000 and 4.6% of all Medicaid beneficiaries). State agencies most commonly cited financial reasons (e.g.,

insufficient capitation payments, inadequate risk-sharing methodology) for managed care plans leaving the Medicaid program. Five states reported that this turnover in plans resulted in moving solely to a PCCM model of service delivery. The turnover is not necessarily negative if it strengthens the overall delivery system, but it may result in decreased continuity of services and additional administrative costs if beneficiaries must switch providers or re-enroll in a different plan.

Long-Term Care Delivery System

Long-term care refers to a wide range of supportive and health services for persons who have lost the capacity for self-care due to illness, frailty, or a disabling condition. It differs from acute care in that the goal of long-term care is not to cure an illness that is generally of short duration, but to allow an individual to attain and maintain an optimal level of functioning over the long-term.

Since the establishment of the Medicaid program in 1965, long-term care services (i.e., nursing home and home care) have been delivered largely through the fee-for-service delivery system. A 1981 amendment to the Medicaid statute established Section 1915(c) waivers, giving states the option of providing home and community-based services to individuals who would otherwise be eligible for institutional care. Many states arrange for these services to be delivered on a fee-for-service basis, often using case managers to determine service needs and authorize delivery. Concerns about uncoordinated long-term and acute care, inefficiencies in disease management for persons with multiple chronic conditions, and growing costs, however, have encouraged federal and some state governments to develop alternative systems to pay for and deliver long-term care services.

In recent years, many of the alternative delivery systems that states and the federal government have developed coordinate long-term care services for dual eligibles — persons who are eligible for both Medicaid and Medicare — through managed care programs. One example is the Program for All-Inclusive Care for the Elderly (PACE), originally modeled after the On Lok Senior Health Services pilot project in San Francisco. PACE makes available all services covered under both programs without amount, duration or scope limitations, and without application of any deductibles, copayments or other cost sharing. Under the program, certain low-income individuals age 55 and older, who would otherwise require nursing home care, receive all health, medical, and social services they need. An interdisciplinary team of physicians, nurses, physical therapists, social workers, and other professionals develop and monitor care plans for enrollees. Monthly capitated payments are made to providers from both the Medicare and Medicaid programs. As specified in Medicare and Medicaid statutes, the amount of these payments from both programs must be less than what would have otherwise been paid for a comparable frail population not enrolled in the PACE program. Payments are also adjusted to account for the comparative frailty of PACE enrollees. PACE providers assume the risk for expenditures that exceed the revenue from the capitation payments. The Balanced Budget Act of 1997 made PACE a permanent benefit category under Medicare and a state plan optional benefit under Medicaid. As of February 2003, there were 28 PACE sites across the country.

Other examples of state initiatives to provide coordinated long-term care services include the Minnesota Senior Health Options (MSHO), the Wisconsin Partnership Program, and the Continuing Care Network (CCN) demonstration of Monroe County, New York. The MSHO program combines Medicare and Medicaid financing to integrate acute and long-term care services for dually eligible seniors residing in seven counties in Minnesota. The program consolidates all Medicare and Medicaid managed care requirements into a single contract overseen by the state, allowing MSHO to reduce duplication and resolve important differences across Medicare and Medicaid delivery systems. Like PACE, the Wisconsin Partnership Program pays capitated payments to providers to coordinate acute and long-term care services for persons who would otherwise qualify for nursing home care. It also places a strong emphasis on services provided in home and community settings. This program, however, was designed specifically to serve rural areas. New York's CCN project enrolls at least 10,000 elderly beneficiaries, including 1,500 who had been certified for care in a nursing facility. To participate, enrollees must be age 65 or over, eligible for Medicare and/or Medicaid, and reside in the program's service area. Capitation payments made to CCN are intended to cover all of Medicare's acute care services for this population and most of Medicaid's long-term care services. Medicaid prescription drug coverage, for example, is paid separately on a fee-for-service basis.

States have also experimented with other initiatives that capitate payments for acute and long-term care services under the Medicaid program only. Examples of these demonstrations include the nation's only statewide mandatory Medicaid managed care program — the Arizona Long-Term Care System (ALTCS) — and small, voluntary programs such as Florida's Community-Based Diversion Pilot Project. Florida's Diversion program serves selected metropolitan areas and counties. Case managers employed through both of these programs arrange Medicaid long-term care services and coordinate with Medicare providers to deliver acute care services.

All of these programs were designed with the expectation that they would control costs and reduce administrative complexity. They also intend to delay institutionalization, and thus incur savings for Medicaid through the provision of expanded home and community-based care options and, in some cases, greater beneficiary control over services. Those programs that also capitate Medicare are intended to reduce hospitalization and skilled nursing facility expenditures as well as other acute care costs associated with institutional care. While these initiatives exist in a number of states, they account for a relatively small share of total Medicaid spending for long-term care.

Medicaid Waiver Programs

Under current law, states have the flexibility to waive certain Medicaid program requirements to provide services to individuals not traditionally eligible for Medicaid, limit benefit packages for certain groups, and provide home and community-based services to people with long-term care needs, among other purposes. States must submit proposals outlining terms and conditions for proposed

waivers to CMS for approval before implementing these programs. The two primary provisions of the Social Security Act used today that authorize states to implement waiver programs are Section 1115 and Section 1915(c).

In recent years, there has been increased interest among states in demonstration programs as a means to restructure Medicaid coverage, control costs, and increase flexibility. Whether large or small reforms, the waiver programs have resulted in significant changes for Medicaid beneficiaries nationwide.

Section 1115 Waiver Demonstration Programs

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services (HHS) with broad authority to waive certain statutory requirements in the Medicaid program allowing states to conduct research and demonstration programs to further the goals of Title XIX.[29] Under Section 1115, the Secretary may waive Medicaid requirements contained in Section 1902, known as freedom of choice of provider, comparability, and statewideness (see "Benefits" subsection for a discussion of these requirements).

States often use Section 1115 waivers to offer different service packages or a combination of services in different parts of the state, test new reimbursement methods, change eligibility criteria in order to offer coverage to new or expanded groups, cover non-Medicaid services (e.g., cash and counseling demonstrations),[30] or contract with a greater variety of managed care plans. Demonstration programs are generally approved for a five-year period, however CMS has granted program extensions for many of the comprehensive waiver programs (i.e., programs that generally offer a state-wide comprehensive service package to populations traditionally eligible for Medicaid as well as expansion populations). Some of these extensions have allowed Section 1115 waiver programs to remain in operation for 10 or more years. For example, Arizona's entire Medicaid program operates under the Section 1115 waiver authority, and this program is in its 20th year.

While Section 1115 is explicit about provisions in Medicaid law that may be waived in conducting research and demonstration projects, a number of other provisions in Medicaid law and regulations specify limitations or restrictions on how

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[29] Section 1115 also authorizes the Secretary to conduct research and demonstration projects under several other programs authorized in the Social Security Act, including TANF, SSI and SCHIP.

[30] Cash and counseling demonstrations are designed to test a consumer-directed approach to the financing and delivery of personal attendant services (e.g., assistance with activities of daily living such as eating, bathing, toileting, transport from bed to chair, etc.) for elderly and disabled individuals. These demonstrations provide cash payments to enrollees so that they may directly arrange and purchase services that best meet their needs. States must submit a Section 1115 waiver for a Cash and Counseling demonstration if: cash is provided directly to an individual; cash is used to pay a legally responsible relative (e.g., spouses or parents); the state intends to change Medicaid eligibility requirements; and/or the state intends to waive the requirement to pay only those agencies that have provider agreements with the state.

a state may operate a waiver program. For example, one provision restricts states from establishing waivers that fail to provide all mandatory services to the mandatory poverty-related groups of pregnant women and children; another provision specifies restrictions on cost-sharing imposed under demonstration waivers.

Financing. Approved Section 1115 waivers are deemed to be part of a Medicaid state plan and are financed through federal and state matching funds at the regular FMAP rate. However unlike regular Medicaid, costs associated with waiver programs must be *budget neutral* to the federal government over the life of the waiver program. To meet the budget neutrality test, estimated spending under the waiver cannot exceed the estimated cost of the state's existing Medicaid program. For example, costs associated with an expanded population (e.g., those not already covered under the state's Medicaid program), must be offset by reductions elsewhere within the Medicaid program. Several methods used by states to generate cost savings for the waiver component include: (1) moving part of the Medicaid population into managed care; (2) limiting benefit packages for certain eligibility groups; (3) providing targeted services to certain individuals so as to divert them from full Medicaid coverage; and (4) using enrollment caps and cost-sharing to reduce the amounts states must pay.

Program Types. CMS classifies Section 1115 waiver programs into five distinct categories. They are:

- *Comprehensive demonstrations.* These demonstrations provide a broad range of services that are generally offered statewide. In fiscal year 2002, there were 20 approved Medicaid comprehensive state reform waivers,[31] with two pending implementation. Fiscal year 2002 state-reported enrollment estimates for the comprehensive demonstration waivers totaled approximately 7.2 million,[32] and federal expenditures for these programs were approximately $15.8 billion.[33]
- *Family planning demonstrations.* These demonstrations provide family planning services for certain individuals of childbearing age

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[31] States with comprehensive demonstration waivers include Arizona, Arkansas, California (Los Angeles county), Delaware, District of Columbia, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New York, Oklahoma, Oregon, Rhode Island, Tennessee, Utah, Vermont, and Wisconsin.

[32] California's Section 1115 waiver program (i.e., Los Angeles county) uses demonstration authority to provide financial support to continue county delivery system restructuring efforts. Because of the nature of the demonstration project, California does not submit enrollment estimates to CMS. Several states cover SCHIP targeted low-income children in their Medicaid Section 1115 waiver programs. Because expenditures associated with these children are not captured in the Medicaid Section 1115 expenditure reports, when possible, counts of targeted low-income children (as identified on CMS' SYMS data system) have been removed from the Medicaid Section 1115 state-reported enrollment totals.

[33] The fiscal year 2002 state-reported expenditure estimate for Utah is not available. New York's fiscal year 2002 state-reported estimate was based on historical spending.

in 16 states.[34] For the family planning demonstrations, fiscal year 2002 enrollment counts totaled 1.8 million, and federal expenditures were approximately $327 million.[35]

- *Specialty services and population demonstrations*. These demonstrations generally include programs that provide cash to enrollees so that they may directly arrange and purchase services that best meet their needs. In addition, they also include waivers to provide pharmacy benefits to persons with specific conditions, such as HIV/AIDS. In fiscal year 2002, there were 10 such programs in eight states.[36] These demonstrations covered just under 7,000 individuals at a federal cost of approximately $41.6 million.[37]
- *The Health Insurance Flexibility and Accountability Initiative (HIFA)*. These demonstrations are designed to encourage states to extend Medicaid and SCHIP to the uninsured, with a particular emphasis on statewide approaches that maximize private health insurance coverage options and target populations with incomes below 200% FPL. As of January 2003, there were six Medicaid Section 1115 waivers approved under the HIFA initiative in five states.[38] Four of the six HIFA programs (Illinois, New Jersey, New Mexico, and Oregon) are Medicaid/SCHIP combined waivers. A combined HIFA waiver generally means that the state will finance changes to its Medicaid program using unspent SCHIP funds. No enrollment or expenditure data were available for fiscal year 2002 as these programs were new at that time.
- *Pharmacy plus demonstrations*. These demonstrations provide comprehensive pharmacy benefits for low-income seniors and individuals with disabilities with income at or below 200% FPL. The demonstrations may provide pharmaceutical products, assist individuals who have private pharmacy coverage with high premiums and cost sharing, or provide wraparound pharmaceutical coverage to bring private sources of pharmacy coverage up to the level of desired demonstration benefit coverage. Enrollees will not be eligible for the comprehensive Medicaid benefits available under

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[34] States with family planning demonstration waivers include Alabama, Arizona, Arkansas, California, Delaware, Florida, Maryland, Missouri, New Mexico, New York, Oregon, Rhode Island, South Carolina, and Washington.

[35] Arizona, Delaware, Missouri, New York, and Rhode Island report their family planning demonstration expenditures as a part of their comprehensive demonstration waivers. Fiscal year 2002 state-reported expenditures for Maryland were not available.

[36] States with specialty service and population demonstration waivers include Arkansas (2 waivers), Colorado (2 waivers), District of Columbia, Florida, Maine, New Jersey, New Hampshire, and Oregon.

[37] Fiscal year 2002 state-reported enrollment and expenditure data were not available for Arkansas and New Hampshire.

[38] States with approved Medicaid or Medicaid/SCHIP combined waivers include Illinois, Maine, New Jersey, New Mexico (2 waivers), and Oregon. HIFA waivers authorized solely under the SCHIP program are not included.

the state's Medicaid plan. In fiscal year 2002, there were four approved Pharmacy Plus waivers in four states.[39] Two states reported waiver data in fiscal year 2002. In these states, enrollment counts totaled 193,574 at a federal cost of approximately $169 million.

Section 1915(c) Home and Community-based Waiver Programs

In 1981, Congress added Section 1915(c) to the Medicaid statute. Section 1915(c) authorizes the Secretary of HHS to waive certain requirements[40] of Medicaid law to allow states to cover a range of home and community-based services for persons who would otherwise be eligible for Medicaid-funded institutional care. The 1915(c) waivers, often referred to as home and community-based services (HCBS) waivers, were designed to reduce the institutional bias in the Medicaid program that made it easier for persons to qualify for Medicaid coverage of institutional care than for care in the home or in the community.

The waivers allow states to cover a broad range of medical and non-medical social services to enable people with chronic long-term care needs to remain in the community. Unlike the budget neutrality test required for Section 1115 waivers (where estimated spending under the waiver cannot exceed the estimated costs of the state's existing Medicaid program), the cost-effectiveness test under 1915(c) prohibits expenditures from exceeding the cost of institutional care that would have been provided to waiver recipients absent the waiver.[41] To assist states in containing costs, Section 1915(c) allows states to place caps on the total number of individuals that may be covered under each waiver and/or set expenditure restrictions on a per capita basis (e.g., not to exceed $20,000 per year per waiver recipient) or on an aggregate basis (e.g., a cost cap applied to all persons under a waiver in the state).

Medicaid regulations require that waiver participants fall into one of the following target groups: the aged, persons with physical disabilities, persons with mental retardation or developmental disabilities (MR/DD), and persons with mental illness. Generally, states must apply for separate waivers to serve these different groups. Section 1915(c) also gives states the flexibility to define the categories of individuals within these broader target groups who may be eligible for certain waivers and the services they will receive. For example, states may cover only the elderly for case management services, or only individuals with physical disabilities for personal attendant care. States may also limit eligibility for services to individuals who have certain conditions, such as HIV/AIDS.

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[39] States with approved Pharmacy Plus waivers include Florida, Illinois, Wisconsin, and South Carolina.

[40] States can waive statewideness and comparability, and may apply certain institutional eligibility rules to persons in home and community-based waivers.

[41] Section 1915(c) waivers are prohibited from covering expenses for room and board, while such costs would be covered by Medicaid in an institutional setting.

Further, eligibility is limited to individuals who would otherwise be eligible for institutional care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF/MR). There are no federal requirements that describe the level and or severity of functional limitations that individuals must have to be admitted to an institutional setting and thus be eligible for a 1915(c) waiver, although states generally determine eligibility for long-term care services based on a test of applicants' functional limitations for most waiver programs. The design of these tests varies across states, but often includes tests to determine an applicant's limitations in ability to carry out activities of daily living (ADLs) and instrumental activities of daily living (IADLs).[42]

Although these programs are optional, all states provide some HCBS waiver services to certain Medicaid enrollees with long-term care needs. As of June 2003, CMS reported that 246 programs were in operation across the country. In 1999, the most recent year for which data are available, 1915(c) waivers served 707,132 individuals. CMS estimates that about 875,000 people were served in 2000.[43] The most recent expenditure data from fiscal year 2002 showed that total Medicaid spending on 1915(c) waivers reached $16.3 billion versus $11.2 billion in 1999.

The cost of providing waiver services to recipients varies across target populations (see **Figure 4**). Spending on waivers for persons with MR/DD, for example, totaled $12 billion in fiscal year 2002, accounting for 73.6% of total HCBS waiver spending. Waiver spending on elderly individuals and persons with physical disabilities totaled $4 billion in fiscal year 2002, accounting for 24.5% of total spending on HCBS waivers. Waivers for AIDS or AIDS-related conditions (ARC) totaled $66.2 million (0.4%), for technology dependent individuals totaled $88.8 million (0.5%), and for persons with brain injuries totaled $104.7 million (0.6%). In addition, three small waiver programs serving individuals with a primary diagnosis of mental illness totaled $32.4 million and accounted for about 0.2% of all HCBS waiver expenditures.

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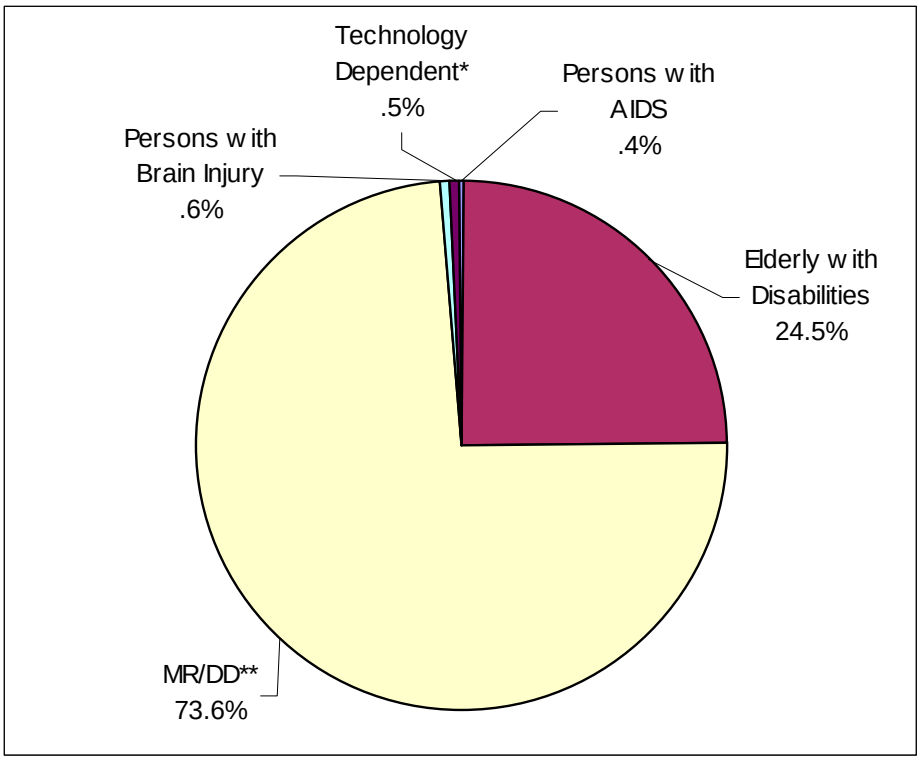
[42] ADLs refer to activities necessary to carry out basic human functions, and include the following: bathing, dressing, eating, mobility inside the home, toileting, and transferring from a bed to a chair. IADLs refer to tasks necessary for independent community living, and include the following: shopping, light housework, telephoning, money management, and meal preparation.

[43] States are required to report enrollment data for 1915(c) waivers to CMS through the submission of Forms 372. The most recent year for which all states have submitted these forms is 1999.

Figure 4. Medicaid HCBS Waiver Expenditures by Target Population, 2002



Source: Eiken, S. and Burwell, B. Medicaid HCBS Waiver Expenditures, FY1997 through FY2002, The MEDSTAT Group, May 15, 2003.

* Persons who are technology dependent or medically fragile.

** MR/DD = Persons with mental retardation and/or developmental disabilities.

Data are provided to CMS through Form 64 reports by States. Eiken and Burwell report that FY2002 waiver expenditures may be understated by about $400 million (2-3%) since they do not include all prior period adjustments or corrections submitted by States to CMS. CMS Form 64 data are by date of payment, not by date of service. CMS 64 data on HCBS waiver spending represent only Medicaid fee-for-service spending, not spending through capitated managed care programs. Arizona, Florida, Wisconsin, Texas, and Minnesota are examples of states that pay for at least some HCBS waiver services through capitated long-term care programs. Totals may not sum to 100% due to rounding.

Legislative History

Below is a summary of major Medicaid changes enacted in public laws passed during 1996 forward. (For legislative history prior to 1996, see the 1996 edition and earlier editions of the *Green Book: Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means.*)

Contract with America Advancement Act of 1996, P.L. 104-121:

- *Alcoholics and drug addicts.* SSI benefits are terminated for individuals receiving disability cash assistance based on a finding of alcoholism and drug addiction. Persons who lose SSI eligibility may still be eligible for Medicaid if they meet other Medicaid eligibility criteria. States are required to perform a redetermination of Medicaid eligibility in any case in which an individual loses SSI.

Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L. 104-193:

- *Eligibility*. A new cash welfare block grant to states, Temporary Assistance for Needy Families (TANF), is established. The automatic link between AFDC and Medicaid is severed. Families who meet AFDC eligibility criteria as of July 16, 1996 are eligible for Medicaid, even if they do not qualify for TANF. States must use the same income and resource standards and other rules previously used to determine eligibility, including the prereform AFDC family composition requirement. A state may lower its income standard, but not below the standard it applied on May 1, 1988. A state may increase its income and resource standards up to the percentage increase in the Consumer Price Index (CPI) subsequent to July 16, 1996. States may use less restrictive methods for counting income and resources than were required by law as in effect on July 16, 1996. States are permitted to deny Medicaid benefits to adults and heads of households who lose TANF benefits because of refusal to work; states may not apply this requirement to poverty-related pregnant women and children.
- *Disabled children*. The definition of disability used to establish the eligibility of children for SSI is narrowed. Children who lose SSI eligibility may still be eligible for Medicaid if they meet other Medicaid eligibility criteria. States are required to perform a redetermination of Medicaid eligibility in any case in which an individual loses SSI and that determination affects his or her Medicaid eligibility.
- *Aliens*. Legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996 are barred from Medicaid for five years. Significant exceptions are made for such aliens with a substantial U.S. work history or a military connection. Except for emergency services, Medicaid coverage for such aliens

entering before August 22, 1996 and coverage after the five-year ban are state options.

- *Administration*. A state may use the same application form for Medicaid as they use for TANF. A state may choose to administer the Medicaid program through the same agency that administers TANF or through a separate Medicaid agency. A special fund of $500 million is provided for enhanced federal matching for states' expenditures attributable to the administrative costs of Medicaid eligibility determinations due to the law.

Balanced Budget Act of 1997, P.L. 105-33:

- *Eligibility*. The Balanced Budget Act restores Medicaid eligibility and SSI coverage for legal immigrants who entered the country prior to August 22, 1996 and later become disabled; guarantees continued Medicaid eligibility for children with disabilities who are expected to lose their SSI eligibility as the result of restrictions enacted in 1996; and extends the period that states must provide coverage to refugees, asylees, and individuals whose deportation has been withheld from five to seven years. States are permitted to provide continuous Medicaid coverage for 12 months to all children, regardless of whether they continue to meet income eligibility tests. States are permitted to create a new Medicaid eligibility category for working persons with disabilities with income up to 250% of poverty and who would, but for income, be eligible for SSI. Such individuals can "buy into" Medicaid by paying a sliding scale premium based on the individuals' income as determined by the state.
- *Payment methodology*. The law repeals the Boren amendment, which directed that payment rates to institutional providers be "reasonable and adequate" to cover the cost of "efficiently and economically operated" facilities, and repeals the law requiring states to assure adequate payment levels for services provided by obstetricians and pediatricians. The requirement to pay federally qualified health centers and rural health clinics 100% of reasonable costs is phased out over six fiscal years, with special payment rules in place during fiscal years 1998 — 2002 to ease the transition.
- *Payments for disproportionate share hospitals*. This law includes several provisions affecting disproportionate share hospital (DSH) payments provided to hospitals that treat a disproportionate share of the uninsured and Medicaid beneficiaries. It reduces state DSH allotments by imposing freezes and making graduated proportionate reductions. Limitations are placed on payments to institutions for mental disease. The Act establishes additional caps on the state DSH allotments for fiscal years beginning in 1998 and specifies those caps for 1998 — 2002. States are required to report annually on the method used to target DSH funds and to describe the payments made to each hospital.
- *Managed care*. The law eliminates the need for 1915(b) waivers to enroll most Medicaid populations in managed care. States can

require the majority of Medicaid recipients to enroll in managed care simply by amending their state plan. Waivers are still required to mandate that children with special health care needs and certain dually eligible Medicaid-Medicare beneficiaries enroll with managed care entities. The law establishes a statutory definition of primary care case management (PCCM), adds it as a covered service, and sets contractual requirements for both PCCM and Medicaid managed care organizations. The Act also includes managed care provisions that establish standards for quality and solvency, and provide protections for beneficiaries. The law repeals the provision that requires managed care organizations to have no more than 75% of their enrollment be Medicaid and Medicare beneficiaries, and the prohibition on cost sharing for services furnished by health maintenance organizations.

Nursing Home Resident Protection Amendments of 1999, P.L. 106-004:

- *Transfer or discharge of nursing facility residents.* This law prohibits the transfer or discharge of nursing facility residents, both those covered and not covered by Medicaid, as a sole result of a nursing home's voluntary withdrawal from participation in the Medicaid program, except under certain circumstances.
- *Information for new residents.* For new residents, meaning those entering a facility subsequent to the effective date of the facility's withdrawal from Medicaid, the following information must be provided orally and in writing: (a) notice that the facility does not participate in Medicaid, and (b) the facility may transfer or discharge such a new resident when that resident is no longer able to pay for his/her care, even if such a new resident is covered by Medicaid.
- *Facility requirements.* Facilities that voluntarily withdraw from Medicaid are still subject to all applicable requirements of Title XIX, including the nursing facility survey, certification and enforcement authority, as long as patients covered under Medicaid prior to the facility's withdrawal continue to reside in the facility.

1999 Emergency Supplemental Appropriations Act, P.L. 106-31:

- *Tobacco settlement payments to states.* Amounts recovered or paid to states by manufacturers of tobacco products as part of the comprehensive tobacco settlement of November 1998 or to any individual state based on a separate settlement or litigation shall be retained in full by such states. That is, such states do not have to pay the federal government a portion of these amounts equal to the applicable (state-specific) federal medical assistance percentage.
- *Restriction on use of tobacco settlement funds.* States receiving these sums are not permitted to use these funds to pay for administrative expenses incurred in pursuing such tobacco litigation.

Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999, incorporated by reference in the Consolidated Appropriations Act for Fiscal Year 2000, P.L. 106-113:

- *Increase in DSH allotments for selected States.* The law increases the federal share of DSH payments to Minnesota, New Mexico, Wyoming, and the District of Columbia for each of fiscal years 2000 — 2002.
- *Administration.* The law extends beyond fiscal year 2000 the availability of a $500 million fund created to assist with the transitional costs of new Medicaid eligibility activities resulting from welfare reform, and allows these funds to be used for costs incurred beyond the first three years following welfare reform.
- *Federally qualified health center (FQHC) services and rural health clinics (RHCs).* The law slows the phase-out of the cost-based system of reimbursement for services provided by FQHCs and RHCs, and authorizes a study of the impact of reducing or modifying payments to such providers.
- *Payments for monitoring services and external review requirements.* The law provides that states will receive enhanced matching payments for medical and utilization reviews for Medicaid fee-for-service, and quality reviews for Medicaid managed care, when conducted by certain entities similar to peer review organizations. It also eliminates duplicative requirements for external review, and requires the DHHS Secretary to certify to Congress that the external review requirements for Medicaid managed care are fully implemented.
- *Federal matching for disproportionate share hospital payments.* The law clarifies that Medicaid disproportionate share hospital payments are matched at the Medicaid federal medical assistance percentage and not at the enhanced Federal medical assistance percentage authorized under title XXI (SCHIP).
- *Outpatient drugs.* The law allows rebate agreements entered into after the date of enactment of this Act to become effective on the date on which the agreement is entered into, or at state option, any date before or after the date on which the agreement is entered into.
- *Disproportionate share hospital transition rule.* The law extends a provision included in the Balanced Budget Act of 1997 related to allocation of DSH funds among California's hospitals.

Foster Care Independence Act of 1999, P.L. 106-169:

- *Former foster care children.* States are given the option to extend Medicaid coverage to former foster care recipients ages 18, 19, and 20, and states may limit coverage to those who were eligible for assistance under Title IV — E before turning 18 years of age. The law also includes a "sense of Congress" statement indicating that states should provide health insurance coverage to all former foster care recipients ages 18, 19, and 20.

Ticket to Work and Work Incentives Improvement Act of 1999, P.L. 106-170:

- *Employed, disabled individuals.* States can opt to cover working persons with disabilities at higher income and resource levels than otherwise permitted (i.e., income over 250% of the federal poverty level and resources over $2,000 for an individual or $3,000 for a couple). States may also cover financially eligible working individuals whose medical condition has improved such that they no longer meet the Social Security definition of disability. States can require these individuals to "buy in" to Medicaid coverage. These individuals pay premiums or other cost-sharing charges on a sliding fee scale based on income, as established by the state.

Agriculture Risk Protection Act of 2000, P.L. 106-224:

- *Information sharing*. This law allows schools operating federally subsidized school meal programs to take a more active role in identifying children eligible for, and enrolling such children in, the Medicaid and SCHIP programs. It permits schools to share income and other relevant information collected when determining eligibility for free and reduced-price school meals with state Medicaid and SCHIP agencies, as long as there is a written agreement that limits use of the information and parents are notified and given a chance to "opt out."
- *Demonstration project.* The law also establishes a demonstration project in one state in which administrative funds under the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) may be used to help identify children eligible for, and enroll such children in, the Medicaid and SCHIP programs.

Children's Health Act of 2000, P.L. 106-310:

- *Rights of institutionalized children.* The law requires that general hospitals, nursing facilities, intermediate care facilities and other health care facilities receiving federal funds, including Medicaid, protect the rights of each resident, including the right to be free from physical or mental abuse, corporal punishment, and any restraints or involuntary seclusions imposed for the purposes of discipline or convenience. Restraints and seclusion may be imposed in such facilities only to ensure the physical safety of the resident, a staff member or others. Additional requirements govern reporting of resident deaths, promulgation of regulations regarding staff training, and enforcement. (Other Medicaid requirements regarding restraints and seclusion for inpatient psychiatric services for persons under age 21 are specified in federal regulations.)
- *Children's rights in community-based settings.* The law also includes requirements for protecting the rights of residents of certain non-medical, community-based facilities for children and adolescents, when that facility receives funding under this Act or under Medicaid. For such individuals and facilities, restraints and

seclusion may only be imposed in emergency circumstances and only to ensure the physical safety of the resident, a staff member or others, and less restrictive interventions have been determined to be ineffective. Use of a drug or medication that is not a standard treatment for a resident's medical or psychiatric condition is prohibited. Likewise, use of mechanical restraints is prohibited. Seclusion may only be used when a staff member is providing continuous face-to-face monitoring and when strong licensing/accreditation and internal controls are in place. (Time out is not considered to be seclusion.) Additional requirements govern reporting of resident deaths, promulgation of regulations regarding staff training, and enforcement.

Breast and Cervical Cancer Prevention and Treatment (BCCPT) Act of 2000, P.L. 106-354:

- *Eligibility.* The law establishes a new optional coverage group under Medicaid for uninsured women who are under age 65, have been screened under the Centers for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program and need treatment for breast or cervical cancer, and who are not otherwise eligible for Medicaid under a mandatory coverage group. States have the option of extending presumptive eligibility to these women; presumptive eligibility allows individuals whose family income appears to meet applicable financial standards to enroll temporarily in Medicaid, until a final formal determination of eligibility is made. Medicaid providers are the only entities qualified to determine presumptive eligibility for these women.
- *Benefits.* Medicaid coverage is limited to medical assistance provided during the period in which the individual requires breast or cervical cancer treatment.
- *Financing.* The federal share of Medicaid payments for this group uses the enhanced matching rate structure under the State Children's Health Insurance Program, which ranges from 65 to 85%.

Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, incorporated by reference in P.L. 106-554:

- *Disproportionate share hospitals.* State DSH allotments for 2001 and 2002 are increased. It also extends a special DSH payment rule for hospitals in California to qualifying facilities in all states, and provides additional funds to certain public hospitals not receiving DSH payments.
- *Federally qualified health centers (FQHCs) and rural health clinics (RHCs).* The law replaces cost-based reimbursement with a prospective payment system for FQHCs and RHCs.
- *Upper payment limit rules.* It also modifies proposed rules governing upper payment limits on inpatient and outpatient services provided by certain types of facilities, and requires that the final regulations be issued by the end of 2000.

- *Other provisions.* Additional changes affect extensions of Section 1115 Medicaid waivers, Medicaid county-organized health systems, the federal medical assistance percentage for Alaska, transitional medical assistance for welfare-to-work families, determination of presumptive eligibility for children, outreach to and enrollment of certain Medicare beneficiaries eligible for Medicaid cost-sharing assistance, PACE waivers, and posting of information on nursing facility services.

Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001, P.L. 107-121:

- *Eligibility.* This law allows states to include in the optional Medicaid eligibility category created by the Breast and Cervical Cancer Prevention and Treatment (BCCPT) Act of 2000, American Indian and Alaskan Native women with breast or cervical cancer who are eligible for health services provided under a medical program of the Indian Health Service or a tribal organization. All provisions under the BCCPT Act of 2000 apply to such women.

Public Health Security and Bioterrorism Preparedness and Response Act of 2002, P.L. 107-188:

- *Waiver of provider requirements and Medicare+Choice payment limits.* The law authorizes the Secretary to temporarily waive conditions of participation and other certification requirements for any entity that furnishes health care items or services to Medicare, Medicaid, or SCHIP beneficiaries in an emergency area during a declared disaster or public health emergency. During such an emergency, the Secretary may waive: (a) participation, State licensing (as long as an equivalent license from another state is held and there is no exclusion from practicing in that state or any state in the emergency area), and pre-approval requirements for physicians and other practitioners; (b) sanctions for failing to meet requirements for emergency transfers between hospitals; (c) sanctions for physician self-referral; and (d) limitations on payments for health care and services furnished to individuals enrolled in Medicare+Choice (M+C) plans when services are provided outside the plan. To the extent possible, the Secretary must ensure that M+C enrollees do not pay more than would have been required had they received care within their plan network.
- *Notification to Congress.* The law also requires the Secretary to provide Congress with certification and written notice at least two days prior to exercising this waiver authority. It also provides for this waiver authority to continue for 60 days, and permits the Secretary to extend the waiver period.
- *Evaluation.* The Secretary is further required, within one year after the end of the emergency, to provide Congress with an evaluation of this approach and recommendations for improvements under this waiver authority.

Health Care Safety Net Amendments of 2002, P.L. 107-251:

- *Study of migrant farm workers.* This law requires the Secretary to conduct a study of the problems experienced by farm workers and their families under Medicaid and SCHIP, specifically, barriers to enrollment, and lack of portability of Medicaid and SCHIP coverage for farm workers eligible in one state who move to other states on a periodic basis. The Secretary must also identify possible strategies to increase enrollment and access to benefits for these families. Strategies to be examined must include: (a) use of interstate compacts to establish portability and reciprocity, (b) multi-state demonstration projects, (c) use of current law flexibility for coverage of residents and out-of-state coverage, (d) development of programs of national migrant family coverage, (e) use of incentives to private coverage alternatives, and (f) other solutions as deemed appropriate. In conducting the study, the Secretary must consult with several groups. The Secretary must submit a report on this study to the President and Congress in October, 2003. This report shall address findings and conclusions and provide recommendations for appropriate legislative and administrative action.

Jobs and Growth Tax Relief Reconciliation Act of 2003, P.L. 108-27:

- *Temporary increase in the federal medical assistance percentage (FMAP).* With respect to expenditures for Medicaid benefits, this law increases FMAP for all 50 states, the District of Columbia and 5 commonwealths and territories for a period of five calendar quarters, including the last two quarters of fiscal year 2003 and the first three quarters of fiscal year 2004. There is a two-step process for determining the increase. First, each state's fiscal year 2003 FMAP, as would otherwise be calculated, must be at least equal to the state's fiscal year 2002 FMAP, and second, the FMAP determined under this step is increased by 2.95 percentage points. For the fiscal year 2004 FMAP change, the same calculations (substituting fiscal year 2003 for fiscal year 2002) are applied to determine the temporary increase. The law also increases the limitation on payments for the commonwealths and territories.
- *State eligibility for increased FMAP*. To qualify for the increased FMAP payments, a state cannot have a Medicaid plan with more restrictive eligibility rules than the plan in effect on September 2, 2003. If a state restores the program eligibility to the levels in effect on September 2, 2003, then the state would qualify for increased matching payments for the entire quarter in which eligibility is reinstated. If a state expands eligibility rules after the beginning of the higher payments (April 1, 2003) and before September 2, 2003, the state is not eligible for the higher payments for the period beginning on April 1, 2003 to the date that eligibility was expanded.

SCHIP Financing Act of 2003, P.L. 108-74:

- *State eligibility for increased FMAP*. This law modifies the requirements regarding state eligibility for the temporary increase in FMAP payments authorized under P.L. 108-27 (see above). Specifically, P.L. 108-74 provides that if a state reduces eligibility after September 2, 2003, and later restores eligibility to the September 2, 2003 levels, the state would qualify for the higher payments from the date of the eligibility restoration rather than for the entire calendar quarter. In addition, if a state expands eligibility rules after the beginning of the higher payments (April 1, 2003) and before September 2, 2003, the state is eligible for the higher payments for the period beginning on April 1, 2003 to the date that eligibility was expanded.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173:

- *Disproportionate share hospital payments*. This law establishes a temporary 16% increase in DSH allotments to states for FY2004 and for certain subsequent fiscal years. Allotments for subsequent years will be equal to FY2004 amounts unless the Secretary of HHS determines that the allotments as would have been calculated under prior law equal or exceed the FY2004 amounts. For such fiscal years, allotments will be equal to allotments for the prior fiscal year increased by the percentage change in the CPI-U for the previous fiscal year. The law also changes the definition of a low DSH state to those states in which total DSH payments for FY2000 are less than 3% (rather than 1% as under prior law) of the state's total Medicaid spending on benefits. In addition, P.L. 108-173 increases the floor allotment amount for low DSH states for FY2004 through FY2008 by 16% each year (over the prior year amount). For FY2009 forward, as for all other states, the allotment for low DSH states for each year equals the prior year amount increased by inflation. Finally, as a condition of receiving federal Medicaid payments for FY2004 and beyond, states are required to submit a detailed annual report and an independent certified audit on their DSH payments to hospitals.
- *Clarification regarding non-regulation of transfers*. In accordance with certain specified criteria, and on a temporary basis (through December 31, 2005), the law clarifies that the non-federal share of Medicaid funds transferred to the state from a specific public, regional medical center may be used by the state as the non-federal share of Medicaid expenditures. This provision targets, but is not limited to, a medical center located in Memphis, Tennessee.
- *Exempt prices of drugs provided to certain safety net hospitals from the Medicaid best price drug program*. The law modifies the definition of "best price" for the purpose of calculating Medicaid drug rebates to also exclude the discounted inpatient drug prices charged to certain public safety net hospitals. Such hospitals must

also comply with the auditing and record keeping requirements applicable to other providers with similar exemptions from Medicaid's "best price" determinations.

- *Extend special treatment for a specific Medicaid provider*. The moratorium on the determination of Saginaw Community Hospital in Michigan as an institution for mental disease (IMD) is permanently extended. That is, this facility is not to be designated as an IMD for Medicaid purposes.