



MEDICAID 101: AN OVERVIEW OF THE PROGRAM

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Medicaid is the largest health insurance program in the United States, covering nearly 81 million people.¹ Medicaid was authorized by Title XIX of the Social Security Act, which was signed into law on July 30, 1965.² Medicaid programs were gradually established in all 50 states and the District of Columbia along with Medicare.³ Today, Medicaid beneficiaries include low-income families, pregnant women, children, individuals with disabilities, seniors, individuals in need of long-term care, and in some states low-income adults ages 18-65, without dependent children, commonly referred to as childless adults.⁴



History of the Medicaid Program

The Medicaid program was designed to provide health coverage to low-income individuals. The Centers for Medicare and Medicaid Services (CMS), a federal agency within the United States Department of Health and Human Services (HHS), establishes guidelines for the Medicaid program. Under these federal guidelines, individual states establish their own Medicaid program. As a result, there are 50 different Medicaid programs for each state and the District of Columbia. When the Medicaid program was established in 1965, the first state to adopt the program was Hawaii, in January 1966, and the last state was Arizona, in October 1983.⁵

The Medicaid program is jointly financed by federal and state governments. Federal contributions are governed by the Federal Medical Assistance Percentage (FMAP), which provides matching rates of 50-82 percent of the state's Medicaid expenditures.⁶ The formula provides higher rates to states with lower per capita income and lower rates to states with higher per capita income. Per capita income is the average income earned per person in a given state in a specified year, lower than the national average.⁷

The original Medicaid program gave medical coverage to individuals receiving cash assistance. Over the years, eligibility has expanded to cover more populations.⁸

The mission of the Institute for Medicaid Innovation is to improve the lives of Medicaid enrollees through the development, implementation, and diffusion of innovative and evidence-based models of care that promote quality, value, equity and the engagement of patients, families, and communities.

- In 1967, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program was created to provide health care services for all children who qualify for Medicaid.⁹
- In 1986, Medicaid coverage for pregnant women and infants up to 100 percent of the Federal Poverty Level (FPL) was established as a state option and later became mandated in 1988. The FPL is a measure of income issued every year by HHS.⁹
- In 1989, Medicaid coverage was expanded to include pregnant women and children under age six and coverage up to 133 percent of the FPL.⁹
- In 1990, Medicaid coverage of children ages 6 through 18 under 100 percent of the FPL was established.⁹
- In 1997, the Children's Health Insurance Program (CHIP) was established.⁹ The program provides health care coverage for children in families with high incomes who do not qualify for Medicaid. The program ensures federal matching funds to states for individuals in CHIP, which lead all states to expand children's coverage significantly through their CHIP programs, some covering children up to 200 percent of the FPL.¹⁰

Federal Medicaid laws set broad standards for coverage of populations and offered benefits while keeping much of the program's components optional. The policy and program decisions of each Medicaid program are determined by each state along with eligibility, services, and delivery systems. The states' plans and plan amendments for their Medicaid programs must be approved by CMS for the states to receive federal funds.⁸

Impact of the Affordable Care Act on the Medicaid Program

In 2010, the Patient Protection and Affordable Care Act, commonly referred to as the ACA or Obamacare, was signed into law. The law contained many provisions, including prohibiting health insurance companies from charging more or denying health insurance coverage for individuals with preexisting conditions.⁴ Beginning in 2014, the ACA also allowed states the option of expanding Medicaid eligibility to childless adults under age 65 with incomes at or below 138 percent of the FPL.⁴ The law provided for 100 percent of federal funding for the newly eligible adults in expansion states through 2016. The funding will decrease gradually to 90 percent federal support by 2020.⁴ Other mandatory sections of the ACA included requirements for all states to simplify and modernize their health plan enrollment processes. Furthermore, the ACA provided new incentives for states to reform their delivery systems to include more community-based services.

Eligibility Criteria: Categorical and Financial

Before the ACA, two factors were taken into consideration when determining if someone was eligible for Medicaid: categorical and financial. The categorical requirement refers to certain disadvantaged groups (i.e., children, parents of dependents, disabled, elderly, and pregnant women) that the federal government required states to cover in their Medicaid programs. This categorical requirement was coupled with the financial requirement, which capped eligibility at a certain income determined by a percentage of the FPL. As an example under current law, for a child to qualify for Medicaid benefits, his or her family must be at 138 percent or below the federal poverty level.¹¹ For states that have expanded Medicaid eligibility as part of the ACA to able-bodied childless adults, there

is no longer a categorical requirement. Without the ACA and Medicaid expansion, adults without children or a disability were not eligible for benefits, which left millions of Americans uninsured.¹² The ACA was intended to narrow the coverage gap and give low-income childless adults the opportunity to receive health coverage.

Additional groups (bolded below), such as dual eligibles and foster children, have different pathways to becoming eligible for the Medicaid program.

- More than nine million **dual eligibles** reside in the U.S. These are people who qualify for both Medicare and Medicaid. Many dual eligibles are either low-income seniors or people under age 65 who have a disability.¹³
- Typically, a Medicaid beneficiary must be a U.S. citizen or a qualified non-citizen who has been in the U.S. for at least five years. However, **unqualified non-citizens** may receive limited emergency services that are covered by Medicaid.¹⁴
- If someone is serving time for a crime in a jail, they are unable to have their health services paid for by Medicaid, although they might be eligible and registered.¹⁵ The only exception is if an **incarcerated individual** spends more than 24 hours in a hospital or nursing home, in which case they can have those services covered by Medicaid.¹⁶
- **Foster children** are automatically eligible for Medicaid, regardless of income. Under the ACA, foster children who have “aged out” of the foster care system at age 18 remain eligible for Medicaid until age 26.^{17, 18}

Although the federal government requires states to provide coverage to individuals with a certain income threshold or based on categorical eligibility, states are also allowed to cover beyond the federally mandated minimums. The autonomy of states to expand their Medicaid programs is demonstrated by the variations in eligibility for each state (Table 1).



Table 1. Eligibility by Percentage of Federal Poverty Level, Federal and State Comparisons

| Eligibility Group | Federal Minimal Requirement as Percentage of Federal Poverty Level ¹⁹ | Range of state eligibility by Percentage of Federal Poverty Level |
|--------------------|--|---|
| Children ages 0-1 | 138% | 144-324% ²⁰ |
| Children ages 2-5 | 138% | 138%-324% ²⁰ |
| Children ages 6-18 | 100% | 133%-324% ²⁰ |
| Pregnant women | 138% | 138%-380% ²⁰ |
| Parents | 11% | 18%-221% ²¹ |
| Disabled | 75% | 75%-100% ²² |
| Elderly (65+) | 75% | 75%-100% ²² |
| Childless adults | For expanded states: 138% Non-expanded states: none | Expanded states: 138%-215% Non-expanded states: no coverage, except for Wisconsin, which covers 100% FPL ²¹ |

Medicaid eligibility is determined using a household's Modified Adjusted Gross Income (MAGI). MAGI was implemented as part of the ACA in January 2014.²³ In its conversion, MAGI takes into consideration a person's household size and income to determine potential eligibility. A household size of three people and income of \$27,800 would calculate to be 138 percent of the Federal Poverty Level, making the family members eligible for Medicaid in expansion states.²⁴ The purpose of MAGI was to create a more-universal and streamlined system to determine eligibility, eliminating the process of calculating income disregards under the former Adjusted Gross Income (AGI) system.^{25, 1} To remain compatible, states converted their Medicaid eligibility levels using the MAGI conversion.²⁶

Medicaid Benefits

As part of traditional Medicaid programs, each state is required to cover a set of mandatory benefits that include various medically necessary procedures and services. In addition, states may request federal funding to expand the set of covered benefits to include optional benefits, such as physical therapy, case management, and prescription drugs. Although optional, every state has opted to cover prescription drugs in their Medicaid programs.

Newly eligible adults receive additional benefits through Alternative Benefit Plans (ABPs). ABPs are required to cover services that minimally follow the 10 essential health benefits (EHBs), listed in Figure 1. States are also required to provide coverage for non-emergency medical transportation (NEMT), family planning services, and Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services, which are not included in the EHBs.

¹ Income disregards are costs that can be deducted when calculating one's income. For example, if someone is the parent or caretaker of a dependent age 21 or younger, they can deduct \$50/month from their income. This made it possible for some people to qualify for Medicaid, even if their gross income was above the eligibility limit.



Figure 1. Mandatory and Optional Medicaid Benefits

| Mandatory Medicaid Benefits | |
|--|--|
| Traditional Medicaid | Newly Eligible |
| <ul style="list-style-type: none"> • Inpatient hospital services • Outpatient hospital services • EPSDT • Nursing facility services • Home health services • Physician services • Rural health clinic services • Federally Qualified health Center (FQHC) services • Laboratory and X-ray services • Family planning services • Nurse Midwife services • Certified Pediatric and Family Nurse Practitioner services • Freestanding Birth Center services • Transportation to medical care • Tobacco cessation counseling for pregnant women | <ul style="list-style-type: none"> • Non-emergency medical transportation • Family planning services and supplies • FQHC and RHC services • Parity between physical and mental health benefits • 10 Essential Health Benefits: <ul style="list-style-type: none"> - Ambulatory patient services - Emergency services - Hospitalization - Maternity and newborn care - Mental health services and addiction treatment - Prescription drugs - Rehabilitative services and devices - Laboratory services - Preventive services, wellness services, and chronic disease treatment - Pediatric services |
| Optional Medicaid Benefits | |
| <ul style="list-style-type: none"> • Eyeglasses • Other practitioner services • Chiropractic services • Prosthetics • Dentures • Dental services • Optometry services • Other diagnostic, screening, preventive and rehabilitative services • Respiratory care services • Speech, hearing and language disorder services • Occupational therapy • Physical therapy • Clinic services • Prescription drugs | <ul style="list-style-type: none"> • Private duty nursing services • Personal care • Hospice • Case management • Services for individuals age 65+ in IMDs • ICF-ID services • TB related services • Inpatient psychiatric services for individuals under 21 • Health homes for enrollees with chronic conditions • Home and community based services • Self-Directed personal Assistance Services • Other approved services |

Medicaid Waiver vs. State Plan Amendments

As noted, states have some flexibility in the design of their own Medicaid programs, including covered benefits, through waivers and State Plan Amendments (SPA). Before changes can be made to the traditional Medicaid program, states must submit a request and obtain approval from CMS. With an SPA, states can propose a change to any component of their Medicaid program in regard to eligibility, benefits, services, provider payments, etc. Waivers, on the other hand, are requests to waive federal requirements in their individual Medicaid programs. There are many types of waivers, including ones for research and experimentation, managed care, and home and community-based services.

The intent of the waiver program is to provide states with the opportunity to improve and develop Medicaid program objectives that are not permitted under federal law. States can use waivers to conduct demonstration projects, offer alternative benefits, provide plans for a subset of beneficiaries, or expand coverage to groups not covered in Medicaid law.²⁷ The waiver process for a majority of Medicaid waivers begins with the state submitting a CMS preprinted form and receiving approval. Most waivers, unlike SPAs, are not subject to a 90-day deadline for CMS approval, which allows the negotiation process between the state and CMS to take several months or years.²⁸ The lengthy process can be attributed to Medicaid waivers' nature to be comprehensive, as opposed to an SPA, which can be narrow in focus. In addition to the lengthy approval process, a major criticism of Medicaid waivers is the budget-neutrality requirement, which means that federal Medicaid costs of a state cannot exceed what they would have been without the waiver.²⁹ The legal authority for Medicaid waivers can be found within specific sections of the Social Security Act and Affordable Care Act. Table 2 offers an overview of the types of Medicaid waivers by section.



Table 2. Overview of Medicaid Waivers in the Social Security Act

| Waivers by Authority | Description |
|--|---|
| <p>Social Security Act Section 1115 (a)</p> | <p>This waiver allows states to obtain approval to cover services and populations that are not in the traditional Medicaid state plan. In addition, states can request federal financial support for costs that weren't originally matched by federal funding.³⁰ The waiver provides that states have broad authority to implement projects that work to improve current objectives of the Medicaid and CHIP programs. Waivers are granted for up to five years with an option to continue upon renewal.²⁷</p> |
| <p>Affordable Care Act Section 1332</p> | <p>Innovation waivers allow states to request approval to experiment with and improve the Affordable Care Act if they meet certain requirements. The proposed waiver must include the following elements:²⁷</p> <ul style="list-style-type: none"> • Provide essential coverage to a comparable number of residents as would receive coverage without the waiver.³¹ • Coverage must be as affordable for all residents by protecting against excessive out-of-pocket spending, as would be the case without the waiver.³¹ • Provide coverage that is as comprehensive as it would be without the waiver.³¹ • Not increase the federal deficit and maintain deficit neutrality over the period of the waiver and the ten-year budget window.³¹ <p>The first three requirements will be assessed based on their impact on the most vulnerable residents of the state, including low-income individuals, those with serious health conditions, and the elderly.³¹ Furthermore, states using the federal enrollment platform, HealthCare.gov, cannot modify the enrollment periods and financial assistance levels because the system cannot accommodate different rules for each state.³²</p> |
| <p>Social Security Act Section 1902 (a)</p> | <p>This waiver allows states to obtain approval to establish non-emergency medical transportation (NEMT) in Medicaid state plans.³⁰ With approval, states can waive the following Medicaid requirements:</p> <ul style="list-style-type: none"> • Comparability: requires benefits to be provided in the same scope to all enrollees.²⁸ • Freedom of Choice: beneficiaries are allowed to choose from any participating health care provider.²⁸ |
| <p>Social Security Act Section 1915 (a)</p> | <p>This waiver allows states to obtain approval to implement voluntary managed care programs once managed care contracts are approved by CMS.³³</p> |

| | |
|--|---|
| <p>Social Security Act Section 1915 (b)</p> | <p>This waiver allows states to obtain approval to implement mandatory managed care delivery systems, with CMS approval. The four waivers in this demonstration include:³³</p> <ul style="list-style-type: none"> • (b)(1) Freedom of Choice - restricts Medicaid enrollees to receive services within the managed care network. • (b)(2) Enrollment Broker - utilizes a “central broker.” • (b)(3) Non-Medicaid Services Waiver - uses cost savings to provide additional services to beneficiaries. • (b)(4) Selective Contracting Waiver - restricts the provider from whom the Medicaid-eligible may obtain services. |
| <p>Social Security Act Section 1915 (c) Home and Community-Based Services (HCBS)</p> | <p>This waiver allows states to obtain approval to provide long-term services and supports (LTSS) to limited groups through home and community-based services instead of institutional care. States must demonstrate cost-neutrality and the ability to promote people’s health through individualized care plans. States can waive the following Medicaid requirements under HCBS waivers:³⁴</p> <ul style="list-style-type: none"> • Statewideness – each state targets waivers to areas of greatest need. • Comparability – each state provides services to meet the needs of at-risk individuals, which can differ by state. • Income and resource rules – provide Medicaid to those otherwise ineligible because of their income level. |
| <p>Social Security Act Concurrent 1915 (a)/(c)</p> | <p>This waiver allows states to implement voluntary managed care programs that include HCBS for long-term services through managed care. Without a concurrent waiver, 1915(c) waiver services are paid through fee-for-service, not managed care.³⁰</p> |
| <p>Social Security Act Concurrent 1915 (b)/(c)</p> | <p>This waiver allows states to implement a voluntary or mandatory managed care program that includes HCBS in the managed care contract. The combination of the two waivers allows states to mandate enrollment in managed care programs that provide HCBS.³⁰</p> |
| <p>Social Security Act Section 1915 (I) Home and Community-Based Services (HCBS) State Plan</p> | <p>This waiver allows states to offer HCBS programs through the state plan for needs-based, eligible enrollees regardless of the individual’s institutional level of care. If the state targets a specific group, CMS approval would be for five years and continued upon renewal.³⁰</p> |

| | |
|--|--|
| Social Security Act Section 1915 (k) Community First Choice | <p>This waiver allows states to provide home and community-based attendant services and supports on a statewide basis to eligible Medicaid enrollees under state plans. States must ensure continuity of services and supports, cover assistance and maintenance with activities of daily living (ADLs)/ instructional activities of daily living (IADLs), and provide voluntary training on how to select, manage, and dismiss staff.³⁰</p> |
| Social Security Act Section 1932 (a) State Plan Basics | <p>This waiver allows states who have state plan amendments approved by CMS to use a managed care delivery system without further need of renewal. The state plan must include information such as enrolled groups and organizations that will be used for the managed care system. The state does not have the authority to require children with special health needs, American Indians, or dual eligibles to enroll in managed care.³⁰</p> |
| Social Security Act Section 1937 Alternative Benefit Plan | <p>This waiver allows states to provide alternative benefits to address the needs of targeted Medicaid population groups in certain areas of the state and provide services through different delivery systems, as opposed to traditional Medicaid.³⁰</p> |
| Social Security Act Section 1945 Health Homes | <p>This waiver allows states to establish health homes that offer the integration and coordination of primary, acute, behavioral health, and long-term services and supports for enrollees with chronic conditions.³⁰ Health homes must include the following:</p> <ul style="list-style-type: none"> • Care coordination and health promotion. • Comprehensive care management. • Individual and family support. • Comprehensive traditional care. • Community support services referrals. • Use of health information technology. |

Delivery System Models for Medicaid

The Medicaid program utilizes several models for delivering coverage for benefits. Several models will be explored in this section.

Fee-For-Service³⁵

Traditionally, Medicaid has used a fee-for-service (FFS) model as its delivery system to provide benefits. It is a reimbursement method that is based on the volume of services provided by providers to those enrolled in Medicaid. Through the FFS model, providers are paid each time they provide a service, regardless of medical necessity, quality of care, or patient health outcome. This method incentivizes providers to increase the volume

of appointments and tests recommended to patients. Those enrolled in Medicaid are responsible for finding providers whose services are covered by Medicaid.

Medicaid Managed Care

Patients began paying hospitals or clinicians a fixed monthly rate in exchange for medical services as early as the 1930s. By the early 1970s, some states had begun to use this system—managed care—for certain Medicaid populations.^{36,37} The federal government didn't start regulating states' managed care until the 1970s, when the Professional Standards Review Board (now known as the Quality Improvement Organization) created an infrastructure and data capacity for managed care organizations (MCOs) to use.³⁸ By 1997, many states were using managed care to deliver health services to their beneficiaries.² However, before the Balanced Budget Act of 1997, states had to request and obtain a waiver before implementing managed care.³⁹ After the Balanced Budget Act, there was no longer a requirement to obtain a waiver, making it easier for states to apply managed care models in innovative new approaches. As an example, states could more easily incorporate specialty MCOs, such as for behavioral or dental health, into their delivery system model.³⁹ The purpose of Medicaid MCOs is to increase the quality of care that Medicaid beneficiaries are receiving and to decrease the costs of health care for the state.³⁵ There are now 39 states offering Medicaid MCOs to serve the health needs of their Medicaid population, using risk-based managed care.⁴⁰ In 28 of the 39 states with MCO models, over 75 percent of their Medicaid population receives benefit management under managed care.⁴⁰ Alaska, Connecticut, and Wyoming are the only states that do not have any form of managed care in place, and their delivery systems are 100 percent FFS.⁴¹

Under this delivery system, Medicaid MCOs are paid a per-member-per-month (PMPM) rate, or capitation rate, that covers the required services for a member of a specific eligibility group. If the income from the PMPM rate is not enough to cover the services used, the Medicaid MCO is responsible for absorbing the losses—as it is fully capitated. This system appeals to states because costs are more predictable and under a state's control.⁴²

In this arrangement, Medicaid MCOs negotiate contracts with clinicians to establish their network. Once in a network, clinicians are paid a negotiated rate for services provided to beneficiaries. The value of Medicaid managed care is based on the care coordination and case management provided by the MCO. The integrated system allows plans to oversee the various services that their beneficiaries receive and the effectiveness of each one.⁴²

It is worth noting that under Medicaid MCO, states have the option to “carve-out” certain services from MCO contracts, such as oral health and behavioral health. In these circumstances, the carved-out services and benefits are then covered under FFS or another different delivery system model. States are also able to implement Medicaid MCO quality initiatives, such as pay for performance. States can assess the success of individual MCOs based on their quality metrics such as the Healthcare Effectiveness Data and Information Set (HEDIS).⁴⁰ Approximately 90

² More information about each state's Medicaid programs can be found in our State Fact Sheets.

percent of MCOs use HEDIS to assess the quality of care their Medicaid members are receiving, making it easier to compare performance across various MCOs within a state.⁴³

One form of managed care is Managed Long-Term Care Services and Supports (MLTSS). MLTSS is intended for beneficiaries who require long-term services, such as the aged, blind, and disabled populations.⁴⁴ Many states are beginning to transition to managed care to care for these beneficiaries in an effort to ensure that they receive timely and efficient care from qualified providers. States can create MLTSS programs using 1915a, 1915b, or 1115 waivers approved by CMS.⁴⁵ The number of states with an MLTSS program in place has increased from 8 in 2004 to 16 in 2012 to 19 in 2017. The 19 states include Arizona, California, Delaware, Florida, Hawaii, Indiana, Illinois, Kansas, Massachusetts, Michigan, Minnesota, North Carolina, New Jersey, New Mexico, New York, Rhode Island, Tennessee, Texas, and Wisconsin.^{45, 46}

Accountable Care Organizations

An alternative payment model used in some state Medicaid programs is the Accountable Care Organization (ACO). According to CMS, “Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients.”⁴⁷ ACOs operate through a cost-sharing model that is dependent on meeting quality metrics and reducing medical costs. ACOs pay their individual providers on a fee-for-service (FFS) basis but have a benchmark budget parameter within which they need to maintain costs. Therefore, ACOs have a financial incentive to lower costs of care while maintaining high-quality care, as they can retain some of the savings. ACOs have shared accountability for patient care and health outcomes. States can integrate ACOs into their Medicaid programs through waivers or state plan amendments.⁴⁸ Ten states currently have ACOs (Oregon, Utah, Colorado, Minnesota, New York, Maine, Vermont, Massachusetts, Rhode Island, and New Jersey), and thirteen states are pursuing ACOs (Washington, Pennsylvania, Iowa, Missouri, New Mexico, Alabama, Louisiana, North Carolina, Virginia, Connecticut, Delaware, Maryland, and the District of Columbia).⁴⁹

Alternative Payment Models and Value-based Care

The Institute for Health Care Improvement (IHI) developed the “Triple Aim,” which focuses on improving three aspects of the health system: improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care.⁵⁰ The ACA included provisions that focused on the triple aim as a method to improve existing health care systems and to create new health delivery system models.⁵¹ This led to the creation of new delivery systems and payment models in Medicaid through Alternative Payment Models (APMs).⁵¹ APMs are used in Medicaid to promote high-quality care and to lower health care costs. The models are built on states’ existing payment networks and can apply to a specific clinical condition, a care episode, or a population.⁵² APM goals include creating incentives for improving health care cost efficiency, promoting care coordination, and improving quality in the delivery of services to Medicaid beneficiaries.

Alternative payment models shift the focus from FFS, which essentially rewards volume of services, to incorporate value-based care, which focuses on quality of care. Value-based programs work to address health care costs, clinical inefficiency, and care through selective metrics such as patient outcomes and Medicaid spending. These programs are designed around patients and include care coordination and the use of advanced technology to connect patients with providers. There are several delivery systems that promote value-based care, such as Patient-Centered Medical Homes (PCMH), Health Homes (HH), Episode of Care (ECO) payments, and Pay for Performance (P4P).

- **Patient-Centered Medical Homes (PCMH)** – PCMH is a team-based model of care led by a primary care provider that integrates care coordination and is responsible for the ongoing care of a person’s health. The practice uses quality and cost of patient care metrics to improve care delivery.³⁵
- **Health Homes (HH)** – HH is designed to be a person-centered system of care that targets individuals with multiple chronic conditions. These programs facilitate access to and coordination with primary and acute physical health services, behavioral health services, and long-term services and supports.³⁵
- **Episode-of-Care (EOC) payments** – EOC payments are single payments made to providers for all services involved in treating a patient’s health event, such as a hip replacement or a health condition such as attention deficit hyperactivity disorder (ADHD). The system promotes cost efficiency and limits overtreatment of patients.³⁵
- **Pay-for-Performance (P4P)** – P4P initiatives are aimed at improving the quality, efficiency, and overall value of health care. P4P financially rewards providers for improving or maintaining quality goals while keeping overall payment rate increases low. The quality and efficiency measures are agreed upon by providers, hospitals, and health plans.³⁵

Dual Demonstrations

Dual demonstrations are intended to coordinate care for beneficiaries who qualify for both Medicaid and Medicare. Currently, 13 states (California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas, Virginia, Colorado, Washington, and Minnesota) have a dual-eligible demonstration to cut costs and better manage benefits.⁵³ States must receive approval from CMS in order to implement a dual-eligible demonstration in their state. The delivery system and payment models may vary from state to state, but 10 of the 13 states (California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas, and Virginia) that have implemented a dual-eligible demonstration have a capitated model. Of the other three, two (Colorado and Washington) have a managed FFS model, while Minnesota made changes to an existing program.⁵⁴ Enrollment of dually eligible beneficiaries in demonstrations is optional, and enrollment was lower than expected (about 50 percent of those eligible).⁵⁵ One reason why dual eligibles may not be enrolling in dual demonstrations could be that if they suddenly become ineligible for one of the two programs, they could lose all of their benefits. For example, if someone’s income is just barely eligible for Medicaid, and one month they make above the eligibility requirements (or there’s a mistake that says that they did), then they will lose all of their benefits covered under the dual demonstration. This also results in the risk of having to repeatedly re-enroll in

the program, each time one's eligibility is dropped.^{55, 56} CMS has offered to continue Dual Eligible Demonstrations in Massachusetts, Minnesota, and Washington, in order to have more time to evaluate the programs.⁵⁷

Looking Forward: Medicaid Payment Reform

With the escalating costs of the Medicaid program in proportion to the increase in eligible beneficiaries and health care costs, there are discussions about potential opportunities to reform the program. Proposals to reform Medicaid often consist of common themes, such as resetting eligibility limits, changing the required benefits, redesigning delivery systems, incentivizing providers to improve quality of care with value-based initiatives, and shifting the balance of federal and state financing and responsibilities.⁵⁸ In the early 2000s, the focus was on increasing state flexibility by allowing the implementation of Section 1115 waivers, but this failed to increase the State Children's Health Insurance Program (SCHIP) eligibility aimed at limiting overall Medicaid expenditures.⁵⁹ Later in 2010, with passage of the ACA, Medicaid eligibility expanded within existing populations and to newly eligible adults, increased the federal share of funding to cover the new enrollees, and ensured access to preventive services.⁶⁰ The financing of Medicaid is always a key focus of reform because of the ever-increasing costs of running the program at both the federal and state levels. Two approaches for Medicaid reform that are commonly discussed are per capita caps and block grants.

Per Capita Caps

The per capita cap is a set amount of federal funding per beneficiary. It can be determined by eligibility group or set for all recipients, and is designed to increase by a specified amount each year, such as with inflation. The set per capita cap would be multiplied by the number of beneficiaries in each eligibility group and again by the pre-set growth rate. An aggregate sum of the amounts from each group would then be totaled and given to the states as a budgetary limit. Per capita caps, however, do not take in account changes in health care costs.⁶¹ Therefore, states would be forced to continuously limit increases in expenditures to below the aggregate sum, which would grow at a slower rate than health care costs.⁶¹ To cope with this reduced funding, states would be forced to either limit eligibility, decrease covered benefits, use funds from other areas such as education to finance their Medicaid programs, or a combination of the three options.⁶¹ Some states would be disproportionately affected by the implementation of per capita caps, including those with low incomes, rapidly increasing costs per beneficiary, stricter eligibility and benefit policies, or low provider payments or that are at risk of natural disasters.⁶² Projections of recent reform proposals have shown that in the next 3-4 years, states would have to increase the state share of Medicaid funding by at least a third beyond the already anticipated increased growth in expenditures to maintain current programs.⁶³

Block Grants

A block grant is a pre-set funding allowance given to states for their Medicaid costs.⁶¹ Block grants are designed to increase every year by a specified amount, such as with inflation.⁶¹ These increases, however, do not reflect

changes in health care costs or account for increases in Medicaid enrollment.⁶¹ Therefore, states' capability to deal with increased health care costs, public health emergencies, or increased enrollment could be reduced.⁶¹ Again, states would be forced to either limit eligibility, decrease covered benefits, use funds from other areas such as education to finance their Medicaid programs, or a combination of the three options.⁶¹

With both potential approaches for Medicaid reform, states would be forced to make significant changes to their existing Medicaid programs. Enhanced federal funding for the ACA Medicaid expansion population is particularly at risk, and it is estimated that almost 11 million Medicaid enrollees in the new expansion population could lose their coverage if states were unable to maintain current eligibility limits as a result.⁶¹ To maintain current eligibility groups and benefits, states would either have to fund expenditures without federal support or cut provider payments.⁶¹ The former could result in cuts to other state-funded programs, and the latter could decrease access to care for enrollees, result in the failure of Medicaid managed care systems, and increase uncompensated care costs. Over time, however, most states would have to limit eligibility and/or optional benefits, increase taxes, or increase cost-sharing for beneficiaries.⁶⁴ Limiting eligibility could drastically decrease Medicaid enrollment and create increases in cost-sharing that would make health care more costly and, therefore, less accessible for existing Medicaid beneficiaries.⁶⁴ Because the elderly, disabled, and low-income children disproportionately depend on the program, they would be most affected by these changes.⁶⁵

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