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Medicaid Primer

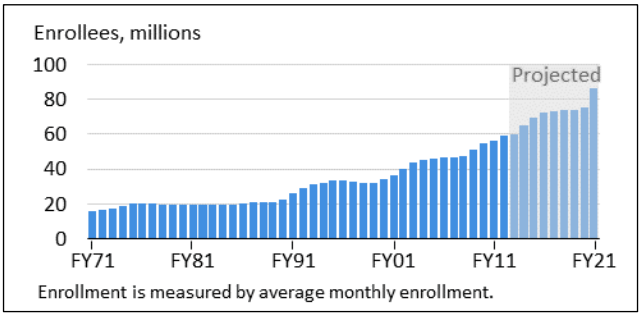
Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports (LTSS), to a diverse low-income population, including children, pregnant women, adults, individuals with disabilities, and people aged 65 and older. In FY2021, Medicaid covered health care services for an estimated 85 million individuals at an estimated cost of $748 billion.

Participation in Medicaid is voluntary for states, though all states, the District of Columbia, and the territories choose to participate. The federal government requires states to cover certain mandatory populations and benefits but allows states to cover other optional populations and benefits. Due to this flexibility, there is substantial state variation in factors such as Medicaid eligibility, covered benefits, and provider payment rates. In addition, several waiver and demonstration authorities in statute allow states to operate their Medicaid programs outside of certain federal rules.

Eligibility

Historically, Medicaid eligibility generally has been limited to low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities. However, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) included the ACA Medicaid expansion, which expands Medicaid eligibility to non-elderly adults with income up to 133% of the federal poverty level (FPL) at state option. **Figure 1** shows Medicaid enrollment for FY1970 through FY2021.

Figure 1. Medicaid Enrollment



Source: Medicaid and CHIP Payment and Access Commission (MACPAC), MACStats: Medicaid and CHIP Data Book, Exhibit 10, December 15, 2022.

Note: Comparable actual Medicaid enrollment data is not available for FY2013-FY2021. The FY2021 increased enrollment is mainly due to the continuous coverage requirement for the Family First Coronavirus Response Act (P.L. 116-127) federal medical assistance percentage (FMAP) increase.

To be eligible for Medicaid, individuals must meet both categorical (e.g., elderly, children, or pregnant women) and financial (i.e., income and sometimes assets limits) criteria. Some eligibility groups are mandatory for states to cover under their Medicaid programs; others are optional.

Individuals in need of Medicaid-covered LTSS must demonstrate the need for long-term care by meeting state-based eligibility criteria for services, and they also may be subject to a separate set of Medicaid financial eligibility rules in order to receive LTSS coverage.

All Medicaid applicants must meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship.

Benefits

Medicaid coverage includes a variety of primary and acute-care services as well as LTSS. Not all Medicaid enrollees have coverage of the same set of services. Different eligibility classifications determine the covered services.

For traditional Medicaid benefits, states are required to cover a wide array of mandatory services (e.g., inpatient hospital, physician, and nursing facility care). States may cover optional additional services, such as personal care services, prescription drugs, and physical therapy.

Alternative Benefit Plan (ABP) coverage is generally required for enrollees in the ACA Medicaid expansion and optional for other Medicaid enrollees. Under ABPs, states have more flexibility to define which populations are served and what specific benefit packages enrollees will receive. In general, ABPs may cover fewer benefits than traditional Medicaid, but there are some requirements that might make ABPs more generous than private insurance (e.g., nonemergency transportation).

Service-Delivery Systems

Medicaid enrollees generally receive benefits via one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, Medicaid enrollees receive services through a managed care organization under contract with the state. States traditionally used FFS for Medicaid. However, since the 1990s, the share of Medicaid enrollees covered by managed care has increased. Almost 84% of Medicaid enrollees are covered by some form of managed care as of July 1, 2020, and most of them (72% of Medicaid enrollees) are covered with comprehensive risk-based managed care.

Cost Sharing

In general, premiums and enrollment fees are prohibited in Medicaid. However, premiums may be imposed on certain enrollees, such as individuals with incomes above 150% of FPL. States can impose nominal co-payments, coinsurance, or deductibles on most Medicaid-covered benefits, but there are limits on the amounts states can impose, the eligibility groups that can be required to pay, and the services for which service-related cost sharing can be charged. The aggregate cap on most enrollee out-of-pocket cost sharing is generally 5% of monthly or quarterly household income. Certain enrollees receiving Medicaid-covered LTSS are required to share in the cost of certain LTSS, which is outside of the aggregate cap.

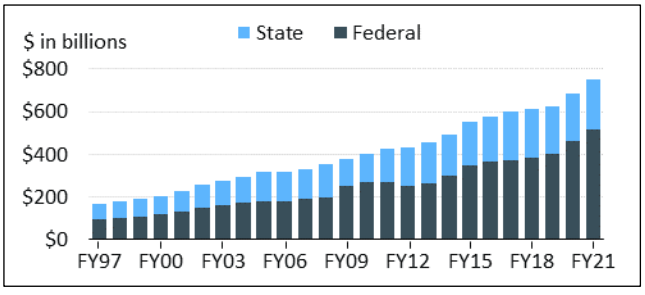
Provider Payments

For the most part, states establish their own payment rates for Medicaid providers. Federal statute requires that these rates be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that Medicaid enrollees have access to covered services at least to the same extent that the general population in the same geographic area has access to these services. However, low Medicaid payment rates and their impact on provider participation have been perennial policy concerns. In some cases, states make supplemental payments to Medicaid providers that are separate from, and in addition to, the payment rates for services rendered to Medicaid enrollees.

Financing

The federal government and the states share the cost of Medicaid. The federal government reimburses states for a portion of each state's Medicaid program costs. Federal Medicaid funding is an open-ended entitlement to states, which means there is no upper limit or cap on the amount of federal Medicaid funds a state may receive.

Figure 2. Federal and State Medicaid Expenditures



Source: Centers for Medicare & Medicaid, Form CMS-64 data as reported by states to the Medicaid Budget and Expenditure System.

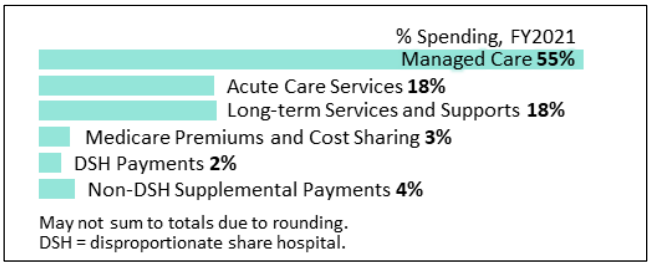
Figure 2 shows Medicaid expenditures for FY1997 through FY2021. In FY2021, Medicaid spending on services and administrative activities in the 50 states, the District of Columbia, and the territories totaled $748 billion with the federal government paying $518 billion of that amount.

The federal government's share for most Medicaid expenditures is called the federal medical assistance percentage (FMAP). The FMAP formula is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes). In FY2023, FMAP rates range from 50% (12 states) to 77.86% (Mississippi). Other federal Medicaid matching rates are provided for certain states, situations, populations, providers, and services.

Medicaid Benefit Spending

Figure 3 shows the distribution of Medicaid expenditures on benefits by type of service for FY2021. Capitated payments (i.e., predetermined fixed amounts) under managed-care arrangements accounted for 55% of benefit spending. The remaining 45% of benefit spending was FFS, and FFS spending on acute care services and LTSS each accounted for 18% of Medicaid benefit spending.

Figure 3. Medicaid Benefit Spending, by Service

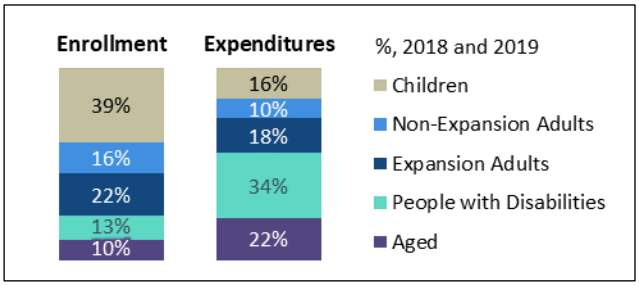


Source: CRS analysis of Form CMS-64 data as reported by states to the Medicaid Budget and Expenditure System, as of July 19, 2022.

Enrollment Versus Expenditures

Different Medicaid enrollment groups have different service-utilization patterns. For calendar years 2018 and 2019, **Figure 4** shows together Medicaid enrollment for children, nonexpansion adults, and expansion adults comprised 77% of Medicaid enrollment but accounted for only 44% of Medicaid's total benefit spending. In contrast, together individuals with disabilities and the aged populations represented less than a quarter (23%) of Medicaid enrollment but accounted for more than a half of Medicaid benefit spending (56%). These patterns generally hold true across years.

Figure 4. Estimated Medicaid Enrollment and Expenditures for Benefits, by Enrollment Group



Source: CMS, 2022 *Medicaid and CHIP Beneficiary Profile: Enrollment, Expenditures, Characteristics, Health Status, and Experience*, July 2022.

For more information about the Medicaid program, see CRS Report R43357, *Medicaid: An Overview* and CRS Report R42640, *Medicaid Financing and Expenditures*.

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