

Medicaid Handbook: Interface with Behavioral Health Services

Module 2

Medicaid Overview

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Module 2: Medicaid Overview

What is Medicaid?

President Franklin Delano Roosevelt signed into law the Social Security Act of 1935 on the heels of the Great Depression. The early part of the decade was characterized by economic hardship that instigated the movement toward development of safety-net services for Americans. Initially, the Act provided financial support for retired workers aged 65 years or older (Social Security).¹ The Act has been amended many times in the intervening 77 years—for purposes of this handbook, most notably in 1965 when the Medicare and Medicaid programs were signed into law by President Lyndon Baines Johnson. In 1996, welfare reform embodied in the Personal Responsibility and Work Opportunity Act effected another monumental change. The federal government created the state-administered Temporary Assistance to Needy Families program, thereby severing the link between welfare or cash assistance and the health coverage provided by Medicaid. Thus Medicaid stands alone as a health care program, having been separated from welfare or cash assistance. Title XIX of the Social Security Act governs the Medicaid program.

Medicaid is a health insurance program jointly administered by the federal government and each state government. Medicaid is a program that entitles eligible individuals to access certain health care services. Contrast this with a federal block grant (such as the State Mental Health or Substance Abuse Block Grant), whereby eligible recipients may receive services funded by the grant only to the extent that funding is available.

Although the federal government created the authority for the Medicaid program in 1965, not all states immediately implemented one. Arizona was the last state to establish a Medicaid program in 1982. At the time of printing, all states and the District of Columbia participate in Medicaid.

Although a state's participation in Medicaid is optional, the federal government has set forth certain requirements with which states must comply if they choose to participate in the program. For example, the federal government has established certain mandatory requirements and state options concerning reimbursement, eligibility standards, and quality and scope of medical services.² A state's Medicaid State Plan is an agreement with the federal government that the state will conform to the requirements of the Social Security Act and the official issuances of the U.S. Department of Health and Human Services (HHS). The *State Plan* is the officially recognized document describing the nature and scope of the state's Medicaid program. In particular instances, a state may request—and the federal government may grant—a waiver of certain specified mandates included in the Social Security Act.

In 1997, Congress added Title XXI to the Social Security Act. Title XXI created the Children's Health Insurance Program (CHIP), which is explained more fully later in this module.

Who Administers Medicaid?

The Centers for Medicare & Medicaid Services (CMS) administer Medicaid, CHIP, and Medicare. CMS is one of several operational agencies of HHS.

Within CMS, the Center for Medicaid and CHIP Services is the entity charged with formulating, implementing, and evaluating all program policies and operations relating to Medicaid and CHIP. The Center also works in partnership with states to evaluate the success of state Medicaid agencies in carrying out their responsibilities for effective program administration and beneficiary protection. If necessary, the Center assists states in ameliorating problems and improving the quality of their operations. The Center is responsible for reviewing and approving state-proposed Medicaid policy changes in the form of waivers and State Plan Amendments (SPAs).³

What are the Roles of Central and Regional Offices?

The CMS Baltimore office is the Central Office (CO). It is responsible for developing Medicaid policies and for the final approval of state requests to change their Medicaid programs.

CMS maintains Regional Offices (ROs) in 10 different cities. The ROs were reorganized in 2007 in a structure based on the Agency's key lines of business: Medicare Health Plans Operations; Financial Management and Fee-for-Service Operations; Medicaid and Children's Health Operations; and Quality Improvement and Survey and Certification Operations. The consortia are meant to standardize issue management and communication, improve performance, and focus leadership on achieving the Agency's strategic plan.⁴

Each consortium is led by a Consortium Administrator (CA), who serves as the Agency's leader in his or her area of business expertise. The CA is responsible for standardized implementation of CMS programs, policy, and guidance across all 10 regions for issues pertaining to the business line he or she oversees. In addition to responsibility for a business line, each CA also serves as the Agency's senior management official for two or three ROs, representing the CMS Administrator in external affairs and overseeing administrative operations. The four CAs are each located in a RO (New York, Kansas City, Chicago, and Dallas). The six ROs without a CA (Boston, Philadelphia, Atlanta, Denver, San Francisco, and Seattle) each report to one of the four CAs. The Regional Administrators (RAs) that are located in the ROs without a CA are responsible for planning and implementing all external affairs initiatives within the geographic area with which they are affiliated. Each RA reports to one of the four CAs.⁴

What is the CMS Relationship With the States?

CMS has a two-way relationship with the states. It is charged with developing Medicaid policy at the CO level and with disseminating guidance for implementing these policies to the states via the ROs. The ROs are responsible for assisting with the interpretation of CMS policy and developing relationships with state and local governments, consumers, providers, and professional associations. The ROs also gather insight and information through their communications with stakeholders; this information is funneled back to the CO. In these ways, the ROs "not only represent the Agency on a grassroots level, they also represent the grassroots to the Agency."⁴ Information and data gathered in the regions impacts policy made at the CO level.

Additionally, ROs engage in ongoing monitoring of state Medicaid agency financial claims, state agencies that inspect health care facilities on behalf of CMS, managed care plans, Medicare

claims processing, and organizations that provide quality assurance services living in the states. Specifically, the agency is responsible for ensuring that beneficiaries' health care is safe, effective, efficient, patient-centered, timely, and equitable.

One of the most important functions of CMS is approving proposed changes to state Medicaid programs. Thus, CMS must review and approve policy changes envisioned at the state level and communicate to states the changes made to the Medicaid program at the federal level. When a state seeks to change any portion of its Medicaid program—such as by adding, deleting, or changing eligibility categories, altering the benefit package it covers, implementing or changing copays it charges consumers, or changing the way providers are reimbursed—it must submit either an SPA or a waiver amendment (depending on the policy to be changed). These processes are discussed further in Module 9.

What is the Role of the Sub-State Entity or Local Behavioral Health Authorities?

In this module and throughout this document, the term *behavioral health* encompasses both mental and substance use disorders. When a mental or substance use disorder is addressed singularly, the reference will be only to that disorder.

Some states use public or quasi-public sub-state entities that have statutory authority to administer services to individuals with mental and substance use disorders. This is often the case for individuals with serious and persistent mental illness (SPMI) or for seriously emotionally disturbed children and youth. In most cases, the Medicaid behavioral health services are administered through this structure while, in other states, Medicaid and behavioral health programs are administered separately.

For example, where Medicaid and other publicly funded behavioral health services are administered in an integrated fashion, the state may operate a county-administered Medicaid program in which a county is responsible for serving as the front door to the Medicaid program. In this case, the county makes determinations about priority needs for services and oversees service delivery and a variety of other administrative responsibilities. The strength of this integrated approach is the ability to manage both Medicaid and non-Medicaid services. This is important for individuals who are eligible for Medicaid and also may need behavioral health services that are not funded by Medicaid—such as housing and supported employment—and for individuals who cycle on and off of Medicaid.

Although federal law mandates that states designate a single state Medicaid agency to supervise the administration of the Medicaid program, states are allowed to delegate certain non-policymaking functions to other state agencies, localities, or private entities.⁵ The state Medicaid agency is responsible for establishing Medicaid policy, rules, and regulations. It is also responsible for providing training and technical assistance on policy implementation to county workers.⁶

Additionally, in some states, the sub-state or local public entity may share the responsibility for funding the non-federal portion of Medicaid expenditures, within certain parameters. Roughly a dozen states provide local funding for services. For example, in Ohio the local entity—the

Alcohol, Drug Addiction and Mental Health Board—has the authority to place a property tax levy on the ballot to collect tax funds for local behavioral health services. Module 5 provides background on intergovernmental transfers (IGTs) and certified public expenditures (CPEs), which are often the vehicles used to finance Medicaid’s non-federal portion.

The challenge with local public entities funding and administering certain activities often rests with some of the key principles of §1902 of the Social Security Act, which are discussed below. Of particular note are non-delegation of the single state agency responsibilities and maintaining a consistent statewide program.

What Federal Laws and Regulations Define Medicaid?

Title XIX of the Social Security Act, titled *Grants to States for Medical Assistance Programs*, provides the foundational authority for the Medicaid program. States are not required to participate in the Medicaid program; however, if they do participate, they must comply with laws that provide the framework and underpinnings of the program. Some of the most important sections of Title XIX are listed below. This list is by no means exhaustive, but is instructive in understanding the framework of Medicaid policy.

Social Security Act Title XIX: Grants to States for Medical Assistance

Social Security Act §1902—Fundamental Medicaid Principles

Section 1902 of the Social Security Act provides the basic tenets of the Medicaid program—those principles that are at the program’s core and apply to all services unless waived through a waiver approved by CMS. The following fundamental Medicaid principles share the common theme of instructing states on how to operate their Medicaid programs and maintain the Medicaid consumer’s best interests. Some of the provisions described below—such as statewideness, freedom of choice of provider, and comparability of services—can be waived under a waiver approved by CMS. Waivers are discussed in greater detail in Module 9. Although the terms used below may seem awkward, they are commonly accepted as part of the Medicaid nomenclature.

Single State Medicaid Agency

- A State Plan must specify a single state agency established or designated to administer or supervise the administration of the Medicaid program.
- Other state agencies and local entities such as counties may perform services for the state Medicaid agency; however, they cannot have the authority to change or disapprove any administrative decision of the Medicaid agency or substitute their judgment for that of the Medicaid agency with respect to the applications of Medicaid policies, rules, and regulations.⁷
- The responsibility for making policy for the state’s Medicaid program must remain with the single state agency.
- Therefore, although state governments are all organized differently and administer their Medicaid programs differently, there must be a single state entity that is ultimately responsible and maintains the relationship with CMS.

Statenideness

- A State Plan for medical assistance must “be in effect in all subdivisions of the state and, if administered by [political subdivisions, such as counties], be mandatory upon them.”⁸
- The purpose of this requirement is to ensure that services—whether mandatory or optional—do not vary from locality to locality, depending on (for example) the amount a locality is willing to contribute toward the state’s share of program costs or on the partisan political orientation of the locality or its elected officials.⁹
- Although Medicaid programs will vary considerably from state to state, *within* a state its Medicaid program must be consistent and uniform.

Reasonable Promptness

- The state Medicaid agency must determine eligibility for individuals who apply for Medicaid within specified time periods.¹⁰
- In *Doe v. Chiles*, the Eleventh Circuit Court of Appeals furthered the reach of the reasonable promptness mandate by holding that Medicaid consumers have a right to reasonably prompt *provision of medical assistance* under §1902(a)(8) of the Social Security Act.¹¹
- When thinking about what constitutes reasonable promptness in terms of the right to *receive services* promptly, it is helpful to consider the experience of an individual with commercial insurance coverage for the same type of service provided by the same type of health care professional in a similar location. For example, within a given geographic area, it may be “normal” to drive 90 minutes to a pediatrician or the nearest hospital. If a significant disparity were to exist for those covered by Medicaid compared to those covered by commercial insurance, there could be a concern about reasonable promptness—that the only pediatrician available to a Medicaid consumer is three or four times the drive time of a pediatrician available to commercially insured consumers.

Freedom of Choice of Provider

- Any individual who is eligible for Medicaid may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified and willing to furnish the services.¹²
- States have significant latitude in defining requirements for providers to become *qualified* Medicaid providers, assuming that the requirements are reasonably related to the demands or responsibilities associated with the service. However, once the requirements have been defined, a Medicaid consumer may select any eligible provider who is willing to provide the service according to the prescribed payment rates or methodology.
- This requirement can be waived under certain waiver authorities or precluded by certain managed care authorities. Medicaid managed care plans are not prohibited from limiting their networks of providers under various managed care authorities, as long as consumers have reasonable access to services. This is discussed more fully below and in Module 5.

Individual/Consumer Right to a Fair Hearing

- A State Plan must provide an opportunity for a fair hearing before the state agency “to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.”¹³
- The state agency must grant an opportunity for a hearing if any of the following events occur:
 - Denial of eligibility
 - The claim is not acted upon with reasonable promptness
 - Termination of eligibility or covered services
 - Suspension of eligibility or covered services
 - Reduction of eligibility or covered services.¹⁴

Comparability of Services

- A State Plan must specify the amount, duration, and scope of each service that it provides for eligible consumers.
- Each service must be sufficient in amount, duration, and scope to “reasonably achieve its purpose.” For example, if limiting the physical therapy benefit to *one* visit is not reasonable to achieve the purpose of improving or rehabilitating a consumer’s condition, then the service may not be so limited.
- The Medicaid agency or any agency administering a component of the Medicaid program may not arbitrarily deny or reduce the amount, duration, or scope of a required service to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.
- The Medicaid agency may place appropriate limits on a service based on such criteria as medical necessity or utilization control procedures. Utilization control procedures may not fundamentally impact access to services.
- Regardless of an individual’s category of Medicaid eligibility, the benefit package must be equal in amount, duration, and scope.¹⁵

Efficiency, Economy, and Quality of Care While Assuring Access

- State policies related to the utilization of and payment for services must protect against unnecessary utilization of services and ensure that payments are “consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in a geographic area.”¹⁶
- This requirement allows states to seek the best value through their rate-setting policies and tailor their access strategies to take into account local conditions including geographic disparities in the availability of providers and demand for particular services.
- Regardless of whether payment rate changes are made, this section ensures that consideration is given to the potential impact on access to care for Medicaid consumers and decisions are made with effective processes for ensuring that the impact on access will be monitored and do not lead to access problems.
- Payment rate changes are not in compliance with the Medicaid access requirements if they result in a denial of sufficient access to covered care and services.¹⁷

Additionally, several other parts of the Social Security Act address payment standards.

Social Security Act §1903—Payment to States

Section 1903 of the Social Security Act specifies the amounts states are to be paid by the federal government. It also contains provisions defining and discussing *Medicaid managed care organizations*.

Social Security Act §1905—Mandatory and Optional Services Provided Under Medicaid

Section 1905 of the Social Security Act is titled *Definitions*, and some of its most important content—found in §1905(a)—includes a list of all services that states are *required* to provide (*mandatory services*) or may *choose* to provide (*optional services*) under their Medicaid programs. Medicaid funds *services* and several services may be organized together to create a clinical program. Taken together, the package of Medicaid services comprises a state’s Medicaid program. The mandatory and optional Medicaid services are discussed in greater detail later in this module and in other modules.

The list of services included in §1905(a) serves as the structural framework for the benefits section of each state’s Medicaid State Plan. The Medicaid State Plan is discussed in greater detail in Module 9.

Social Security Act §1915—How a State Can Structure Its Medicaid Program, Including Waivers

Section 1915 of the Social Security Act provides various authorities by which states can structure their Medicaid programs and/or waive certain federal requirements of the Medicaid program.

Section 1915(a)—Voluntary Managed Care

- Section 1915(a) of the Social Security Act is the authority by which a state may implement a voluntary Medicaid managed care program. If the state chooses to implement such a voluntary program, the program does not require a waiver or inclusion in the State Plan.¹⁸
- This section permits states to enter into a voluntary contract with an entity to provide State Plan services (i.e., those services defined in the Medicaid State Plan).
- In a voluntary managed care program, the consumer has the choice to participate in the managed care program or to receive services through the state’s fee-for-service (FFS) program. Managed care and FFS systems are discussed in greater detail in Module 5.

Section 1915(b)—Mandatory Managed Care Waiver

- Several authorities can be used to implement mandatory managed care. Section 1915(b) is the *waiver* authority by which states may implement mandatory managed care.¹⁹ In a mandatory managed care program, all Medicaid consumers who meet the state’s eligibility criteria for enrollment in managed care are enrolled in the program and do not have the choice to opt out.
- Within federal parameters, and with certain exceptions, states have the ability to choose which eligibility groups it requires to participate in managed care and which may participate at their option.

- States can waive statewideness, freedom of choice of provider, and/or comparability of services.
- States wishing to waive additional requirements or include certain eligibility groups beyond those allowed with a §1915(b) waiver must use a different managed care authority to do so.

Section 1915(c)—Home and Community-Based Services Waiver

- This section is the waiver authority by which states can provide community support services in home and community settings rather than institutional settings.²⁰
- This section requires an individual to meet an institutional level of care: hospital, nursing facility, or intermediate care facility for the developmentally disabled. The reason for requiring an institutional level of care is that the home or community setting in which a waiver-eligible individual receives services effectively replaces the institution where services would otherwise be delivered. The institution provides a basis for comparing the cost of the alternative home and community-based services (HCBS).
- States can waive statewideness and/or comparability of services.
- Section 1915(c) requires budget neutrality—the state must show that proposed changes will not increase overall Medicaid costs.

Section 1915(b) and (c) waivers may be combined to allow states to provide HCBS in a managed care structure. Additional information on waivers is located in Module 9.

Section 1915(g)—Targeted Case Management

- This section authorizes states to provide targeted case management services.²¹
- Targeted case management is only one form of case management or care coordination. Case management is discussed more fully in Module 3.

Section 1915(i)—State Plan Home and Community-Based Services

- This section authorizes states to include in their State Plans HCBS before an individual needs institutional care. It also provides a mechanism to provide State Plan HCBS to individuals with mental and substance use disorders.
- Although this State Plan service package includes many similarities to options and services available through §1915(c) HCBS waivers, a significant difference is that §1915(i) does not require individuals to meet an institutional level of care in order to qualify for HCBS.
- In order to promote state utilization of §1915(i), the Affordable Care Act included changes that enable states to target HCBS to particular groups of people, make HCBS accessible to more individuals, and ensure the quality of the HCBS.²² These changes are discussed more fully in Module 7.

Section 1915(j)—State Plan Self-Directed Personal Assistance Services

- This section allows states to elect to provide self-directed personal assistance services in their Medicaid State Plans so that waivers are not necessary.²³

Section 1915(k)—State Plan Community First Choice Option

- This section gives states enhanced federal Medicaid matching funds for providing community-based attendant services and supports to consumers who meet an institutional level of care.²⁴

Social Security Act §1932—Voluntary or Mandatory Managed Care

Section 1932 of the Social Security Act provides states the option—within federal parameters—of including in their Medicaid State Plans a framework for voluntary or mandatory Medicaid managed care or primary care case management (PCCM) programs. States can implement managed care under §1932 of the Act and can choose to disregard any or all of three requirements: statewideness, freedom of choice of providers, and comparability of services.

Social Security Act Title XI: General Provisions, Peer Review, and Administrative Simplification

§1115—Research and Demonstration Waiver

Section 1115 of the Social Security Act gives states the flexibility to design and improve their Medicaid programs by letting them test innovative ways to deliver and pay for coverage. Under this authority, and subject to the discretion of the Secretary of the U.S. Department of Health and Human Services, states have broad waiver authority to implement projects that test policy innovations that are likely to further the objectives of the Medicaid program. Section 1115 waivers are also known as research and demonstration waivers. The authority provided by this section can be used to waive statewideness, freedom of choice of provider, and/or comparability of services.

Certain policy changes prior to implementation of the Affordable Care Act, such as expanding eligibility to childless adults, cannot be accomplished without the use of an 1115 waiver. In those instances, 1115 waivers are helpful instruments. However, it should be noted that 1115 waivers have more burdensome requirements than other types of waivers. Specifically, 1115 waivers—

- Cannot reduce access or quality of care
- Must be budget neutral—they cannot cost the federal government more than the state Medicaid plans would cost without the waiver
- Must include a research component and test an innovative idea
- Must maintain quality assurance processes

Social Security Act Title XXI: Children’s Health Insurance Program

Title XXI of the Social Security Act describes the CHIP. Like Medicaid, CHIP is administered by the states and jointly funded by the federal and state governments. Unlike Medicaid, however, CHIP is not an entitlement program—it is a block grant; Congress must periodically reauthorize the program and reappropriate funding for it.

States are able to administer their CHIPs in one of three ways:

1. **As an expansion of their Medicaid programs.** As of March 2012, seven states and the District of Columbia operate their CHIPs this way.²⁵ *Example:* Ohio uses the CHIP allocated funding to expand Medicaid eligibility above the minimum level

established in federal law. A child enrolled in Medicaid/CHIP does not necessarily know in which program he or she is enrolled, and delivery of health care services is the same regardless of whether he or she is enrolled in Medicaid or CHIP. To the state, however, there is a significant difference—the portion of the bill paid by the federal government. This is explained in greater detail later in this module.

2. **As a separate CHIP program.** As of March 2012, 17 states operate their CHIPs in this way.²⁵ *Example:* Oregon operates a Medicaid look-alike program that is technically a separate freestanding CHIP. This allows the state to limit the number of enrollees, but the program is identical to Medicaid expansion programs in almost all other respects.²⁶ The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for children and youth—which is discussed more fully below and in subsequent modules—is an *optional* service for children covered under separately administered CHIP plans.
3. **As a combination of the first two approaches.** As of March 2012, 26 states operate their CHIPs in this way. Florida and New York have combination CHIP and Medicaid programs—allowing these states to establish an entitlement for certain age or income groups, while maintaining flexibility to implement caseload limits for other groups.²⁵

United States Code

The Social Security Act, along with all other general and permanent laws of the United States, is codified in the United States Code. It is helpful to understand this relationship, because references to Medicaid provisions are sometimes given as sections of the Social Security Act and sometimes as sections of the United States Code. They may be cross referenced as follows—

- §1902 of the Social Security Act = 42 U.S. Code 1396a
- §1905 of the Social Security Act = 42 U.S. Code 1396d
- §1915 of the Social Security Act = 42 U.S. Code 1396n
- §1932 of the Social Security Act = 42 U.S. Code 1396u-2
- §1115 of the Social Security Act = 42 U.S. Code 1301
- Title XXI of the Social Security Act = 42 U.S.C. 1397

Code of Federal Regulations

Rules and regulations are codified in the Code of Federal Regulations (CFR). Federal regulations governing the Medicaid program are located in Title 42 (Public Health), Chapter IV (CMS, HHS) of the CFR, specifically in Parts 430–505.

Who is Eligible for Medicaid?

Medicaid and CHIP provide health coverage to nearly 60 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities. To participate in Medicaid, federal law *requires* states to cover certain population groups and *allows* them to cover others.²⁷

Because the Affordable Care Act made such significant changes in Medicaid eligibility and insurance coverage policy, and because each state's Medicaid program is built—within federal parameters—on a different foundation of eligibility decisions, it is important to understand the explanation of Medicaid eligibility that follows. For example, Ohio has more than 150 eligibility categories, whereas North Carolina has 25. These states—and all the others—will be impacted differently by full implementation of the Affordable Care Act. Understanding a state's Medicaid eligibility structure is also important when designing and managing the interface with the Health Insurance Marketplace, also known as the Health Insurance Exchange. These considerations are especially true in light of the U.S. Supreme Court's decision to make optional a state's expansion of Medicaid to 133 percent of the federal poverty guideline.

All mandatory and optional populations, except for medically needy beneficiaries, are considered *categorically needy*. States may provide Medicaid to certain groups of individuals who are not otherwise eligible for Medicaid; these are *medically needy* populations.²⁸ The medically needy have too much money and/or resources (e.g., savings) to be eligible as categorically needy, but they are deemed to have excessive medical bills.²⁹ The medically needy program is used by states to expand coverage primarily to two groups: (1) persons who spend down their income by incurring medical expenses so that, after medical expenses, their income falls below a state-established medically needy income limit; and (2) low-income young adults aged 19–20 and parents in states where it is the only eligibility category for these individuals or where the medically needy program has the highest maximum allowable income for Medicaid eligibility.

The Social Security Act mandates that states cover certain population groups and gives them the flexibility to cover others. In general, Medicaid covers low-income mothers and children, elderly people, and people with disabilities, although specific income and other requirements vary by state. Mothers and children are commonly known as the *Covered Families and Children* (CFC) population; elderly and disabled individuals are known as the *Aged, Blind, and Disabled* (ABD) population. Disability status is often linked to disability as determined by the Social Security Administration for Supplemental Security Income (SSI). The CFC group comprises about 75 percent of the total Medicaid population; the ABD group comprises the remainder.³⁰ The inverse is generally true of cost—care for the ABD population is significantly more costly than for the CFC population.

States set individual eligibility criteria within federal minimum standards; they are also able to request from CMS a waiver of federal law to expand health coverage beyond these groups. Many states have expanded coverage above the federal minimums, particularly for children.²⁷

Currently, adults who are childless, nonelderly, or do not have a disability cannot qualify for Medicaid, regardless of their income level. An exception exists if the state in which they live has a waiver that allows coverage, such as the one in Arizona. However, this will change in 2014 with the addition of a new eligibility option for states. In 2014, states will have the option to expand Medicaid eligibility to uninsured earning up to 133 percent of the federal poverty guideline.³¹

For many eligibility groups, income is calculated as a percentage of the federal poverty guideline.^A As a reference, in 2013, 100 percent of the federal poverty guideline for a family of four is \$23,550. For other groups, income standards are based on income or other nonfinancial criteria standards for other programs, such as the SSI program. Beginning in 2014, eligibility for Medicaid and CHIP for most individuals will be determined using methodologies that are based on modified adjusted gross income (MAGI), as defined in the Internal Revenue Code of 1986. For these individuals, eligibility determinations will be based strictly on the individual's MAGI and will no longer take into consideration resource limits, spend-down, and other eligibility determination factors that complicate the process.³²

Mandatory Eligibility Groups

Children

Children are in a mandatory Medicaid eligibility group if they are:

- **Infants born to women who are eligible for Medicaid**—eligibility for these infants must continue through the first year of life.³³
- **Children younger than 6 years old whose families earn up to 133 percent of the federal poverty guideline**
- **Children aged 6–18 years whose families earn up to 100 percent of the federal poverty guideline**
- **Certain children who receive adoption assistance or are in foster care.**³⁴

In an effort to protect this vulnerable population, every state has chosen to expand coverage to children beyond the minimum thresholds established in federal law. Most states have elected to provide Medicaid coverage to children with family incomes above the minimum, and all states have expanded coverage to children with higher incomes through CHIP. In general, children in families earning up to 200 percent of the federal poverty guideline (\$46,100/year for a family of four in 2012 or \$22,340 for an individual) are likely to be eligible for Medicaid or CHIP coverage. In fact, the average CHIP income eligibility level for children is 241 percent of the federal poverty guideline.³⁴

As of 2010, 46 states and the District of Columbia covered children with incomes up to 200 percent of the federal poverty guideline under Medicaid and CHIP.³⁵ In many States, families with higher incomes can still qualify for coverage for their children. Indeed, 18 states and the District of Columbia have CHIP upper income limits of 300 percent of the federal poverty guideline or more.³⁵ This includes children in mandatory Medicaid eligibility groups and children in optional eligibility groups that a state may choose to cover. *Together, as of May 2012, Medicaid and CHIP provide health care to more than 43 million children, including half of all low-income children in the United States.*³⁴

Section 1931 Adults

Section 1931 defines *adults* as parents/caretaker relatives of dependent children with incomes at about 41 percent of the federal poverty guideline. Welfare reform, which took place in 1996,

^A The U. S. Department of Health and Human Services uses the term *poverty guideline*, although this is commonly called the *federal poverty level* (FPL). The poverty guidelines are issued each year in the *Federal Register* by the Department.

delinked Medicaid from welfare/cash assistance—then called *Aid to Families with Dependent Children* (AFDC) and now called *Temporary Assistance to Needy Families*. Previously, this linkage guaranteed Medicaid eligibility for those receiving AFDC benefits. Under welfare reform, §1931 of the Social Security Act froze Medicaid eligibility based on AFDC criteria in effect on July 16, 1996. At the time, AFDC varied significantly among states, but the national average income was about 41 percent of the federal poverty guideline.³⁶ States have the option to cover parents with incomes above the 1996 minimum levels, and many states choose this option.³⁷

Pregnant Women

Pregnant women whose family income is up to 133 percent of the federal poverty guideline are eligible for Medicaid through 60 days following delivery.³⁸ States have the flexibility to offer Medicaid coverage to pregnant women whose family income is greater than 133 percent of the federal poverty guideline, and most have chosen to do so. *Currently, Medicaid finances about 40 percent of all births in the United States.* Pregnant women receive care related to their pregnancy, labor, and delivery and for any complications that may occur during pregnancy, as well as perinatal care for 60 days post partum. States have the option to provide pregnant women with full Medicaid coverage, or they may elect to limit coverage to certain services related to their pregnancy.³⁹ States have placed significant emphasis on getting coverage for pregnant women as early in their pregnancies as possible, striving for the best potential outcomes for the baby and mother.

Individuals Receiving Supplemental Security Income

Individuals who receive SSI are eligible for Medicaid, because SSI establishes both low-income status (adults and elderly) and disability status for adults. Most individuals who qualify for Medicaid based on disability also receive federal cash assistance under SSI.

- In 32 states and the District of Columbia, SSI eligibility automatically qualifies an individual for Medicaid coverage. These are called *1634(a) states*. Linking SSI to the disability status has limited eligibility for those with substance use disorders, as in 1996 when Congress eliminated addictions as a qualifying diagnosis under Social Security programs.
- Seven states use the same Medicaid eligibility criteria for their disabled populations as are used for the SSI program, but the state requires that these individuals apply for Medicaid separately from their application for SSI. These are known as *SSI-criteria states*. In SSI-criteria states, individuals are eligible for Medicaid if they are receiving or deemed to be receiving SSI.⁴⁰ This includes individuals receiving SSI pending a final determination of blindness or disability. This means that in SSI-criteria states, as long as the individual is receiving SSI—even if a final determination is pending—he or she is eligible for Medicaid.
- Eleven states use more restrictive eligibility criteria than those used by the SSI program. In those states—commonly referred to as *209(b) states*—receipt of SSI does not guarantee eligibility for Medicaid. Similarly, an individual may become eligible for Medicaid while still awaiting an SSI-eligibility determination. The 209(b) states use at least one eligibility criterion more restrictive than the SSI program. States that have elected this option may not use more restrictive standards than those in effect in January 1, 1972, and they must provide for deducting incurred medical expenses from

income through Medicaid spenddown so that individuals may reduce their income to the income eligibility level.⁴¹ Individuals not receiving SSI but seeking coverage based on disability must demonstrate that they have an impairment that prevents them from performing “substantial gainful activity” for at least 1 year. Once a disability determination is made, the individual must then undergo an asset test and meet specific income requirements in order to be considered for Medicaid eligibility.⁴² All states are required to establish an “annual review system” to identify individuals “who lose categorically needy eligibility for Medicaid because of a loss of SSI.”⁴³ Generally, states are required to redetermine Medicaid eligibility at least every 12 months to report circumstances that may change. However, states may consider blindness and disability as continuing until the reviewing physician determines that the recipient no longer meets the definition of blind or disabled included in the State Plan.⁴⁴

Medicare Recipients

State Medicaid programs are required to pay for Medicare coverage for elderly and disabled individuals who have limited incomes and resources. For some, Medicaid also covers additional services beyond those provided under Medicare, including nursing facility care outside of Medicare’s 100-day limit, prescription drugs, eyeglasses, and hearing aids. Services covered by both programs are first paid by Medicare, and Medicaid covers the difference up to the state’s payment limit. In total, 8.3 million people are eligible for both Medicaid and Medicare enrollment; these individuals—called *Medicare-Medicaid enrollees* or *dually eligible individuals*—comprise more than 17 percent of all Medicaid enrollees.⁴⁵

Individuals receiving both Medicaid and Medicare benefits may be described as follows:

- **Qualified Medicare Beneficiaries** are eligible for Medicaid if they earn up to 100 percent of the federal poverty guideline and have resources less than \$6,680/individual or \$10,020/couple. For these individuals, Medicaid pays for Part A premiums, Part B premiums, and deductibles/coinsurance/copayments.
- **Specified Low-Income Medicare Beneficiaries** are eligible for Medicaid if they earn up to 120 percent of the federal poverty guideline and have resources less than \$6,680/individual or \$10,020/couple. For these individuals, Medicaid pays for Part B premiums only.
- **Qualified Individuals** are eligible for Medicaid if they earn up to 135 percent of the federal poverty guideline and have resources less than \$6,680/individual or \$10,020/couple. For these individuals, Medicaid pays for Part B premiums only.
- **Qualified Disabled Working Individuals** are eligible for Medicaid if they earn up to 200 percent of the federal poverty guideline and have resources less than \$4,000/individual or \$6,000/couple. For these individuals, Medicaid pays for Part A premiums only.⁴⁵

Certain Individuals Earning Up to 133 Percent of the Federal Poverty Guideline and Former Foster Children Up to Age 26

The Affordable Care Act added two mandatory Medicaid eligibility groups. One mandatory Medicaid eligibility group that the Affordable Care Act added to the Social Security Act is

former foster care children through age 25 who were enrolled in foster care and Medicaid when they turned 18 or aged out of foster care.⁴⁶

Another mandatory Medicaid eligibility group that the Affordable Care Act added to the Social Security Act is nonelderly, non-pregnant adults with income at or below 133 percent of the federal poverty guideline (an annual income of approximately \$15,282 for an individual and \$31,322 for a family of four in 2013) who are not otherwise eligible for a mandatory Medicaid eligibility category or enrolled in or eligible for Medicare. This group is commonly known as the *Medicaid extension* or *Medicaid expansion* group.

The Medicaid expansion provision in the Affordable Care Act required states to implement the expansion or face losing all federal financing for the state's Medicaid program. On June 29, 2012, the U.S. Supreme Court ruled that the Medicaid expansion is constitutional, but the proposed penalty that would result in a state losing all federal financing for its Medicaid program was too harsh and, therefore, unconstitutional. Therefore, although Congress added this Medicaid eligibility group to the section of the Social Security Act that described mandatory Medicaid eligibility group, the Supreme Court's ruling, in effect, made implementation optional.⁴⁷ As of May 2013, 22 states and the District of Columbia had decided to implement the Medicaid expansion, 17 had decided not to implement the expansion, and 11 were undecided.⁴⁸ This eligibility group is discussed at length in Module 7.

Optional Eligibility Groups

In addition to populations that states are required to cover under Medicaid, they can choose to cover additional populations. Optional eligibility groups include:

- Children younger than 6 years who are above 133 percent of the federal poverty guideline
- Children aged 6–18 years who are above 100 percent of the federal poverty guideline
- Parents with low income that is above the 1996 AFDC level
- Women who are pregnant with income above 133 percent of the federal poverty guideline
- Individuals who are disabled, elderly, and have income below 100 percent of the federal poverty guideline
- Residents of nursing homes with income below 300 percent of SSI
- Individuals who are disabled and receiving HCBS under a waiver
- Certain individuals who are working disabled
- Individuals who are medically needy.⁴⁹

According to a 2005 report prepared by the Henry J. Kaiser Family Foundation, 29 percent of national Medicaid beneficiaries qualify for the program on the basis of optional eligibility group criteria. Moreover, although most children (80 percent) qualify on the basis of mandatory coverage, more than half (56 percent) of the elderly qualify through optional eligibility groups.

Presumptive Eligibility

States have the option to authorize “qualified entities” such as health care providers, community-based organizations, and schools to screen for Medicaid and CHIP eligibility and immediately

enroll children and pregnant women who appear to be eligible and those individuals who are *presumed eligible*. The only entities that can determine presumptive eligibility for pregnant women are Medicaid providers that deliver prenatal services. In presumptive eligibility for children, any kind of Medicaid provider can be a qualified entity, as can the organizations that determine eligibility for Head Start; the Special Nutrition Program for Women, Infants, and Children; and the Child Care and Development Block Grant.⁵⁰

Presumptive eligibility allows children to access Medicaid or CHIP services without having to wait for their application to be fully processed. Qualified entities can also help families gather the documents needed to complete the full application process, thereby reducing the administrative burden on states to obtain missing information.⁵¹ Neither families nor providers have to repay the costs of services obtained during the presumptive eligibility period even if the family never completes a Medicaid application or completes the application and is denied coverage. Likewise, states are reimbursed at the regular federal Medicaid matching rate for covering children during the presumptive eligibility period, even if the children are not ultimately found eligible. However, if a child does not establish eligibility after the presumptive Medicaid eligibility period expires, expenditures will be deducted from the state's CHIP allotment.⁵⁰

Medicaid Eligibility for Individuals With Behavioral Health Needs

Like consumers without behavioral health needs, individuals with mental and substance use disorders can qualify for the program through a variety of eligibility categories. Individuals with behavioral health needs are not a specific eligibility category. However, some data exist indicating that although about 5 percent of Medicaid beneficiaries qualify because they receive SSI because of a mental illness, about two-thirds of Medicaid enrollees who use mental health services qualify for the program in ways other than those based on a disability.⁵²

In a research study conducted by the Best Practices in Schizophrenia Treatment (BEST) Center, BEST used Ohio Medicaid claims data to identify adults with serious mental illness (SMI). These individuals were fairly evenly distributed across Medicaid eligibility categories, but most (36 percent) fell into the nonelderly, nondisabled adult category, while 31 percent fell into the category representing elderly or disabled adults, and 32 percent fell into the category of adults who are eligible for Medicaid and Medicare. However, among the group of adults with SMI, the majority of adults with schizophrenia and psychosis are dually eligible for both Medicare and Medicaid. Among adults with substance use disorders, the majority fall into the nonelderly, nondisabled adult category.⁵³

What Services Does Medicaid Cover?

Medicaid is generally considered to be a robust benefit package, especially for children who qualify for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit described below. Additionally, Medicaid is prohibited from excluding beneficiaries for pre-existing conditions, as many commercial plans historically have done.

Section 1905(a) of the Social Security Act outlines the services that state Medicaid programs *must* cover and those it *may* cover. These services are provided under the state's Medicaid State

Plan. The lists below name services and, in fact, also list some types of providers who are permitted by state professional practice acts to supply a variety of services under these categories. Other services may be covered under an approved waiver. Waivers are discussed in greater detail in Module 9.

The Medicaid behavioral health services benefit package is examined specifically in Module 3. This section discusses all services—not just behavioral health services—that a state may or must provide.

The following services *must* be covered under a state’s Medicaid State Plan—

- Inpatient hospital
- Outpatient hospital
- EPSDT
- Nursing facility
- Home health
- Physician
- Rural health clinic
- Federally qualified health center (FQHC)
- Laboratory and X-ray
- Family planning
- Nurse midwife
- Certified pediatric and family nurse practitioner
- Freestanding birth center (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation and tobacco cessation counseling for pregnant women and youth under 21 as part of EPSDT⁵⁴

A state can *choose* to cover the following optional services under its Medicaid State Plan—

- Prescription drugs
- Clinic
- Physical therapy
- Occupational therapy
- Speech, hearing, and language disorder therapy
- Respiratory care
- Other diagnostic, screening, preventive, and rehabilitative care
- Podiatry
- Optometry
- Dental
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic
- Other practitioner
- Private duty nursing
- Personal care

- Hospice
- Case management
- Services for individuals aged 65 years or older in an institution for mental diseases (IMD)
- Intermediate care facility for the developmentally disabled^B
- State Plan home and community-based care (under §1915(i))
- Self-directed personal assistance (under §1915(j))
- Community First Choice Option (under §1915(k))
- Tuberculosis-related care
- Inpatient psychiatric care for individuals younger than 21 years
- Other Secretary-approved care⁵⁴

A state has the ability to reasonably limit services in amount, scope, and/or duration, so long as it does not violate the *comparability of services* standard discussed earlier in this module. For example, many states set annual limits on the number of dental visits or physical therapy sessions to which a Medicaid beneficiary is entitled.

Early Periodic Screening, Diagnosis, and Treatment

The EPSDT benefit for children and youth was established as a mandatory component of Medicaid in 1967—just 2 years after the Medicaid program’s inception—to “ascertain their physical or mental defects and such health care, treatment and other measures to correct or ameliorate defects and chronic conditions.”⁵⁵ It provides an overarching mandate specific to children and youth, including a comprehensive package of services for individuals younger than 21 years. Under EPSDT, “States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines.”⁵⁶ Expanded in 1981 and 1989, *Section 1905(r) of the Social Security Act specifically requires that any medically necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available to adults under the state’s Medicaid plan.*⁵⁷ The principles of EPSDT can be summarized as follows:

- **Early**—assess and identify problems early in the child’s life;
- **Periodic**—check the child’s health at periodic, age-appropriate intervals;
- **Screening**—provide physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems;
- **Diagnosis**—perform diagnostic tests to follow up when a risk is identified; and
- **Treatment**—control, correct, or reduce health problems found.⁵⁶

EPSDT is comprised of the following screening, diagnosis, and treatment services—

Screening Services

- Comprehensive health and developmental history, including assessment of both physical and mental health

^B Social Security Act §1905(a) refers to these facilities as “intermediate care facilities for the mentally retarded,” but we choose to refer to them throughout this document as intermediate care facilities for the developmentally disabled.”

- Comprehensive unclothed physical exam
- Appropriate immunizations (according to the Centers for Disease Control’s Advisory Committee on Immunization Practices, a group of medical and public health experts that develops recommendations on how to use vaccines to control diseases in the United States)
- Laboratory tests, including lead toxicity screening
- Health education; anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention

Vision Services

- At a minimum, diagnosis and treatment for defects in vision, including eyeglasses. Vision services must be provided according to a distinct periodicity schedule developed by the state and at other intervals as medically necessary.

Dental Services

- At a minimum, dental services include relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services may not be limited to emergency services.

Hearing Services

- At a minimum, hearing services include diagnosis and treatment for defects in hearing, including hearing aids.

Other Necessary Health Care Services

- States are required to provide any additional health care services that are coverable under the federal Medicaid program and found to be medically necessary to treat, correct, or reduce illnesses, as well as conditions that are discovered. Any needed Medicaid service must be provided, regardless of whether the service is covered in a state’s Medicaid plan. It is the responsibility of states to determine medical necessity on a case-by-case basis.

Diagnostic Services

- When a screening examination indicates the need for further evaluation of an individual’s health, diagnostic services must be provided. Necessary referrals should be made without delay and there should be follow-up to ensure that the enrollee receives a complete diagnostic evaluation. States should develop quality assurance procedures to ensure that comprehensive care is provided.

Treatment

- Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.⁵⁶

Periodicity schedules for periodic screening, vision, and hearing services must be provided at intervals that meet reasonable standards of medical practice, and states must consult with recognized medical organizations involved in child health care when developing the schedules. Alternatively, states may elect to use a nationally recognized pediatric periodicity schedule (e.g.,

Bright Futures/American Academy of Pediatrics). Each state is also required to develop a dental periodicity schedule.⁵⁶

For example, the Bright Futures/American Academy of Pediatrics' periodicity schedule indicates that the following measurements, screenings, assessments, or procedures should be performed at each visit at the following recommended ages—

- Body Mass Index (BMI) Measurement: Ages 24 months through 21 years
- Alcohol and Drug Use Risk Assessment: Ages 11 years through 21 years
- Immunizations: Ages newborn through 21 years

This list describes just three of many recommendations for preventive pediatric health care.⁵⁸

Medical necessity for EPSDT services is an area where the involvement of the courts has had a significant impact on Medicaid policy. Federal Medicaid law does not define medical necessity directly; instead, it gives states the ability and flexibility to do so. However, federal law reflects the delicate balance between providing clinically appropriate services that are cost effective. Federal law also requires that states do “not arbitrarily deny or reduce the amount, duration, or scope of a required service...solely because of the diagnosis, type of illness, or condition.”⁵⁹ Yet, the state “may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.”⁶⁰

State treatment of medical necessity falls along a continuum. Some states use a definition of medical necessity that is very deferential to the discretion of the medical professional. These states base their policy decision in large part on the outcome of the *Rosie D. v. Romney* court case. Practically speaking, if a state Medicaid program in these states sets a limit on a service specifying that a maximum number of visits to a certain type of professional are adequate to achieve the purpose of the care, a physician's decision that provision of more services is medically necessary can override the state Medicaid program's limitation. Other states employ greater controls in their definition of medical necessity including, for example, language that requires services to be performed in the least costly setting.

EPSDT Toolkit of State Resources

The Bright Futures website (<http://www.brightfutures.org/wellchildcare/toolkit/states.html#>) provides information about each state's EPSDT program, including manuals, forms, rules and regulations, and other detailed policy and operational guidance. It also includes contact information for state Medicaid and health department officials.

Who Provides Medicaid Services?

Medicaid services are provided by a range of public and private health care professionals and organizations, the list of which varies from state to state. By and large, states have latitude in defining the types and qualifications of providers that may receive Medicaid reimbursement for delivering services. The federal government is deferential to state professional practice acts, which are state statutes and regulations that contain specific licensing requirements, professional standards, scope of practice and prohibited acts, etc. for health care providers. These practice acts

often specify the types of providers to whom responsibility for providing services and/or oversight of service delivery may be delegated.

A more extensive discussion of providers of behavioral health services is located in Module 4.

How is Medicaid Financed?

How the Cost is Shared

Fundamentally, Medicaid is a partnership between the federal and state governments, which includes sharing the cost of the program. The percentage of the cost attributable to the parties varies by state and, in certain instances, varies with the activity for which payment is sought.

The Medicaid share paid by the federal government is called *federal financial participation* (FFP) or the *federal medical assistance percentage* (FMAP). Section 1905(b) of the Social Security Act sets forth the formula for calculating FMAPs. The FMAP varies by state based on criteria such as per capita income. The regular average state FMAP is 57 percent, but FMAPs range from 50 percent to 75 percent.⁶¹ The FMAP for family planning services is 90 percent in all states.

FMAPs for Medicaid and CHIP are different, even for states that operate their children's health insurance programs as Medicaid expansions. As an incentive for states to expand Medicaid coverage to children, when Congress created CHIP it allocated federal matching rates that are generally about 15 percentage points higher than the Medicaid rate.⁶²

Further, the federal government assumes a different FMAP for program administration costs than it does for costs associated with the provision of medical services. Medicaid administrative claiming is the payment of FFP at different matching rates—generally about 50 percent—for amounts “found necessary by the Secretary for the proper and efficient administration of the state plan.” Administrative claims must be directly related to Medicaid program administration, and payment may only be made for the percentage of time actually spent on Medicaid-eligible individuals.⁶³

CMS has indicated its approval for the following types of costs that are necessary for proper administration of the Medicaid State Plan:

- Medicaid eligibility determinations
- Medicaid outreach
- Prior authorization for Medicaid services
- Medicaid Management Information System (MMIS) development and operation
- EPSDT administration
- Third Party Liability activities
- Utilization review.⁶³

When an entity other than the single state agency charged with overseeing the state's Medicaid program is involved in the administration of the program, the state can claim—to some degree—administrative costs for the purpose of drawing down federal funding. For example, another state agency or local entity such as a county or parish may be charged with conducting eligibility

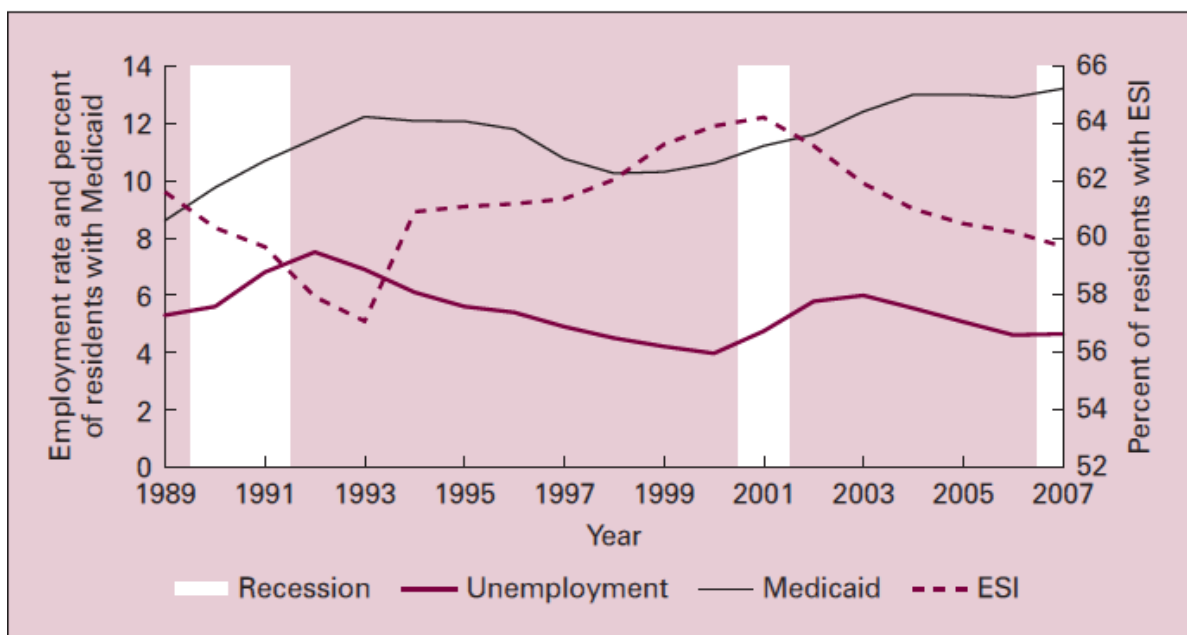
determinations or some aspects of care planning or service coordination. Through Medicaid administrative claiming, the state can develop—subject to CMS approval—a mechanism for identifying allowable time and recouping these costs.

The MMIS is the claims processing and information retrieval system that states are required to have. Although development and operation of the MMIS is a Medicaid administrative function, FFP for this activity is 90 percent for design, development, and installation of the system and 75 percent for operation of state claims processing and information retrieval systems approved by the Secretary.⁶⁴ States request enhanced FMAP for systems design changes by submitting to CMS an advanced planning document.

FMAPs are adjusted regularly to account for fluctuations in the economy. Medicaid is *countercyclical*, meaning that enrollment in the program increases when the economy worsens. Figure 2-1 from the Urban Institute illustrates several important features of Medicaid’s relationship with the economy:

- A change in unemployment is mirrored by a change in Medicaid rates, in the same direction, and at the same time.
- The unemployment rate and Medicaid enrollment peak during times of recession.
- The leveling off or reduction in Medicaid enrollment lags economic recovery following a recession; it takes longer for these individuals to experience the recovery.
- The rate of employer-sponsored insurance enrollment moves opposite the rate of Medicaid enrollment and unemployment.
- Throughout the 18 years illustrated here, at least 4 percent of all Americans have relied on Medicaid.

Figure 2-1 *Unemployment Rate, Share of U.S. Residents with Medicaid, and Share of U.S. Residents with Employer-Sponsored Insurance (ESI), 1988–2007*



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The recent nationwide economic downturn resulted in booming Medicaid enrollment across the country. To soften the significant impact of increased Medicaid rolls on state budgets, the federal government included in the American Recovery and Reinvestment Act a provision increasing FMAPs by 6.2 percent. This was called *enhanced* FMAP (EFMAP). The EFMAP was reduced from 6.2 percent to 3.2 percent in January of 2011, and further reduced to 1.2 percent in the second calendar quarter of 2011.⁶⁶ This is not the first time that Congress has used a change in the FMAP as a vehicle to provide states with additional time-limited funds.

How States Finance The State Portion

States must ensure that they can properly fund the services that they cover in their Medicaid State Plans for all beneficiaries determined eligible. Over the last few years, because of the nationwide economic crisis, states have routinely been tasked with resolving ever-widening budget deficits. For state fiscal years 2012 through 2013, states faced budget shortfalls of at least \$149 billion, on top of the \$430 billion in shortfalls they already closed in state fiscal years 2009, 2010, and 2011.⁶⁷ Because Medicaid is often the largest single expense (except for education) in state budgets, it is often a significant target for state legislators—despite the fact that reducing state spending on Medicaid results in a greater loss of federal reimbursement.

Because Medicaid is an entitlement, a shortage of state matching funds cannot be used by a state to stop providing Medicaid services. State Medicaid directors have essentially three key tools at their disposal to control Medicaid spending (although each comes with limitations): reduce provider payments, eliminate or manage utilization of services, or restrict eligibility. They may reduce reimbursement to providers, although payment cuts may not have a deleterious effect on ensuring adequate access to providers. They also may stop providing optional services or reduce amounts of services provided to adults, although they may not violate the requirement that a service be sufficient in amount, duration, and scope to reasonably achieve its purpose. States also may seek cost savings by restricting eligibility criteria, implementing Medicaid managed care programs, or redesigning service delivery throughout the Medicaid program. The ability to predict costs and control growth is one important reason that state Medicaid programs utilize managed care. Managed care is discussed more thoroughly in Module 5.

Most states use general revenue fund appropriations that are approved by their legislatures to fund the state match, but some also use local government resources to fund a portion. Other financing mechanisms include inter-governmental transfers, CPEs, and permissible taxes and provider donations. However, a provision in §1902(a)(2) of the Act mandates that state governments pay for at least 40 percent of the *non-federal share* of Medicaid.⁶⁸

In fiscal year 2012, states experienced large increases in their spending for Medicaid because the enhanced FMAP ended on June 30, 2011. This forced them to replace lost federal funding with increased state spending. On average, in fiscal year 2012, state funding appropriated for Medicaid increased by about 29 percent compared to the prior year. This is much larger than the two percent growth in total Medicaid spending.⁶⁷

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