WISCONSIN LEGISLATIVE COUNCIL

IssueBrief

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Medicaid Program Overview

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Medical Assistance (MA), also known as "Medicaid," is a public health care program administered by Centers for Medicare and Medicaid Services (CMS) in partnership with the states. MA is authorized under the federal Social Security Act (SSA). Its costs are paid from a combination of state and federal funds. Each state administers its own unique version of the program, providing health care and long-term care services to eligible individuals within parameters established by CMS. The program accounts for about 15 percent of all health spending in the United States, in a given year.

BENEFITS

Federal law requires states to offer coverage for certain **mandatory** benefits and allows them to choose to offer coverage for **optional** benefits if desired. States have general authority to determine the scope of services covered in connection with both mandatory and optional benefits, including the amount and duration of the services. Federally mandated benefits include physician services, hospital services, nursing facility services, home health services, and others. Some of the benefits that are not required under federal law, but are commonly offered by states, include case management services, prescription drug coverage, physical therapy, and occupational therapy.

ELIGIBILITY

Individuals may receive Medicaid services by meeting eligibility criteria set by the states, subject to the minimum standards under federal law. Individuals must meet both a categorical requirement and a financial requirement in order to become eligible for a state's program. Categorical eligibility requirements are satisfied by individuals who are elderly, blind, disabled, pregnant, a parent of dependent children, or qualifying childless adults. Financial eligibility requirements are satisfied by individuals who meet certain income limits and, in certain cases, asset limits. Individuals must also meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship to qualify for the program.

Some individuals belong to **mandatory** coverage groups, meaning that all states with a Medicaid program must provide them with Medicaid coverage. Mandatory coverage groups include the following:

- Pregnant women with income up to 138 percent of the federal poverty level (FPL).
- Children under 19 years of age with family income up to 138 percent FPL.
- Children in an adoption assistance or foster care program identified under federal law, and certain youth who have aged out of foster care.
- Parents/caretakers of dependent children with family income up to the state's eligibility limit in 1996 for Aid to Families with Dependent Children (AFDC) cash assistance.
- Elderly, blind, and disabled individuals receiving cash benefits under the federal Supplemental Security Income (SSI) program.

States may also establish criteria offering Medicaid eligibility to individuals in groups for which coverage is **optional** under the federal law. Optional coverage groups include the following:

- Pregnant women, children, and parents/caretakers of dependent children with income above the federal minimum level.
- Medically needy individuals who are categorically eligible, but have income that exceed the applicable requirements.

- Childless adults, not otherwise eligible, with income up to 138 percent FPL.

Wisconsin's Medicaid program extends eligibility beyond the federally mandated coverage requirements in various categories of eligibility. For example, children and pregnant women are eligible at income levels up to 305 percent FPL. The adult group (which includes parents/caretakers and childless adults) are eligible up to 100 percent FPL. Wisconsin also provides coverage for elderly, blind, and disabled individuals who qualify under certain criteria not specified in federal law, in addition to those who qualify through SSI determinations as provided above.

Dual Eligible Population

Under federal law, individuals may qualify for Medicare either because they are age 65 or older or because they are under the age of 65, have a disability, and are receiving SSDI. Many of those Medicare-eligible individuals may also meet categorical and eligibility requirements under the Medicaid program, as described above. This population of dual-eligible beneficiaries tend to be sicker and poorer than the Medicaid population as a whole; however, not all dual-eligible beneficiaries are in poor health. The Affordable Care Act established the Medicare-Medicaid Coordination Office (MMCO) within CMS to improve care coordination for dual-eligible beneficiaries. CMS is funding demonstration projects to develop approaches to coordinate care for dual-eligible individuals and to integrate Medicare and Medicaid financing for these individuals.

Provider Certification and Reimbursement

The Department of Health Services (DHS) must certify health care providers for participation in the MA program. Providers may include individual health care practitioners, hospitals, nursing homes, managed care organizations, local governmental entities, and school districts. The certification of a provider allows Medicaid recipients to receive covered, medically necessary health care and long-term care services furnished by the provider. Certification also authorizes the provider to submit claims to DHS for reimbursement for the services.

Service Delivery Models

In general, benefits are available to Medicaid recipients through one of two service delivery systems. Under the traditional delivery system, the state Medicaid program pays health care providers on a fee-for-service (FFS) basis. Under FFS, providers receive a separate payment for each service they deliver to a Medicaid recipient. Under the "managed care" alternative, benefits are delivered through contracted arrangements with managed care organizations (MCOs) in exchange for payment to the MCO of an actuarially based per-member, per-month fee.

In addition to the two main service delivery models, states including Wisconsin have fashioned alternative payment and service delivery models to promote policy objectives, in certain cases, involving complex physical and mental health. Some of the alternative models have arisen through a state plan option to enroll a group of qualifying recipients in a "health home" for delivery of Medicaid services. States may use health homes to create payment structures to incentivize case management, care coordination, and access to community supports, according to the needs of individual recipients.[1]

[1] ACA s. 2703.