

Federal Requirements and State Options:

How states exercise flexibility under a Medicaid state plan

Medicaid, enacted as part of the Social Security Amendments of 1965 (P.L. 89-97), is a joint federal-state program. Federal Medicaid law sets broad requirements for the program and mandates coverage of some populations and benefits, while leaving others optional. States make the many policy and operational decisions that determine who is eligible for enrollment, which services are covered, and how payments to providers are established. In some areas of the program, the federal requirements may be more or less prescriptive. For example, states have a great deal of flexibility in establishing fee-for-service provider payments, as long as they are sufficient to provide access to care that is equivalent to the general population. By contrast, there is more uniformity in the enrollment and renewal procedures states must use.

Each state specifies how it will structure its Medicaid program through the state plan. This comprehensive document must be approved by the Centers for Medicare & Medicaid Services (CMS). The state plan can be amended as needed to reflect changes in state policy as well as federal law and regulation.

This publication examines state plan requirements and options across the following dimensions of the Medicaid program:

- eligibility standards,
- enrollment and renewal procedures,
- benefits,
- cost sharing requirements,
- delivery systems,
- premium assistance,
- provider payment policies, and
- appeals.

Additional details on the federal requirements and state options are available in the topic-specific fact sheets.

States seeking additional flexibility can apply for formal waivers of some federal requirements from the Secretary of the U.S. Department of Health and Human Services (the Secretary). While not the focus of this series, examples of how states use these waivers are included in each section to highlight the breadth of vehicles for flexibility currently available to states.

Eligibility

Medicaid eligibility is typically defined in terms of both categorical eligibility (the populations covered) and financial eligibility (the income levels or thresholds at which the populations can be covered). In addition to



categorical and income eligibility, an individual also must be either a citizen of the United States or a qualified immigrant to be eligible for Medicaid.

Federal statute and regulations require coverage of certain eligibility groups, while others may be covered as a state option. However, the eligibility requirements are not uniform. For example, states must generally cover children and pregnant women up to specified income levels; parents with dependent children with incomes up to a state's 1996 Aid to Families with Dependent Children standards; elderly or disabled individuals who receive Supplemental Security Income (SSI); and certain Medicare enrollees.¹

There are also other pathways to coverage for people with specific health or financial needs. For example, states can choose to cover certain individuals who may spend down their income to qualify for coverage based on high medical expenses. State adoption of the optional eligibility pathways varies considerably—some pathways have been adopted by almost all states, while others are less common. States also have some flexibility to establish specific income and resource (or asset) limits for certain eligibility groups.

Enrollment and Renewal Procedures

Current law takes a fairly uniform approach to application, enrollment, and renewal. Within this structure, states have some flexibility in how they design their applications, how they conduct eligibility verifications, and the processes they adopt to further streamline enrollment and renewal.

States can design their own applications, which can also be used to apply for other services that are not related to health, or use a model application developed by the Secretary. In determining income eligibility for children, pregnant women, parents, and adults without dependent children, states must use modified adjusted gross income (MAGI) standards that use federal tax rules for counting income and household size.² States must verify citizenship and immigration status and financial eligibility, and should rely on electronic data sources to the greatest extent possible when doing so.

For those eligible on the basis of MAGI, states renew eligibility once every 12 months; and for those whose eligibility is based on something other than MAGI, states can redetermine eligibility more frequently. In processing applications, states must meet certain timeliness standards—an eligibility determination must be made within 90 days for those applying on the basis of disability and within 45 days for all others.

States have additional policy options available to streamline enrollment and renewal. For example, states can extend eligibility for children for 12 continuous months, regardless of changes in family income. Using presumptive eligibility, states can allow qualified entities, such as providers, to determine provisional eligibility for certain populations. States can also rely on findings from other programs, such as the Supplemental Nutrition Assistance Program (SNAP, formerly food stamps), to enroll individuals in Medicaid under the Express Lane option.



Benefits

States have broad flexibility to design a package of benefits for their Medicaid enrollees within federal guidelines. Certain benefits, such as inpatient hospital and physician services, are mandatory, while others, such as prescription drugs, may be provided at state option. Some optional services are covered widely, such as prosthetic devices, while others, such as private duty nursing services, are covered less often.

Beyond defining which benefits to cover, states also have the ability to define other coverage parameters, including the breadth of coverage (i.e., amount, duration, and scope), and the tools, such as prior authorization, that they will use to manage enrollees' use of benefits. However, the early and periodic screening, diagnostic, and treatment (EPSDT) requirements for children limit the extent to which states may apply criteria other than medical necessity to covered benefits.

In general, states must offer the same coverage to all enrollees (also referred to as comparability) and offer the same benefits throughout the state (statewide), although there are exceptions for states that implement managed care or expand home- and community-based services (HCBS) in certain geographic areas. In addition, states may enroll state-specified groups in alternative benefit plans (ABPs). These ABPs give states greater flexibility in designing the benefit and permit them to bypass requirements such as statewide and comparability.

Cost Sharing

States can require enrollment fees, premiums, deductibles, coinsurance, or copayments from certain Medicaid enrollees. However, federal guidelines define who may be charged these fees, the services for which they may be charged, and the amounts they may be charged. In addition, the total amount of premiums and cost sharing incurred by all individuals in a Medicaid household may not exceed 5 percent of the family's monthly or quarterly income.

Premiums and other cost sharing can be imposed on adults, parents, and certain aged, blind, and disabled beneficiaries. Pregnant women above 150 percent of the federal poverty level (FPL), individuals age 19 through 21, and individuals below 150 percent FPL who are eligible through a medically needy pathway and under certain disability pathways for children and working adults may also be charged premiums.

Cost sharing is not allowed for emergency services, family planning services and supplies, preventive services provided to children under age 18, and all pregnancy-related services. States may, however, impose cost sharing for outpatient services, inpatient hospital stays, non-emergency use of the emergency department, and prescription drugs.

Delivery Systems

States determine how Medicaid services will be delivered to enrollees—through fee-for-service (FFS) arrangements, through managed care plans, or a combination of approaches. Although the vast majority of



Medicaid beneficiaries are enrolled in some form of managed care, the use of managed care varies widely by states, both in terms of the arrangements used and the populations served.

Medicaid programs use three main types of managed care delivery systems: comprehensive managed care, primary care case management (PCCM), and limited-benefit managed care. Under comprehensive managed care, states contract with managed care plans to cover all or most Medicaid-covered services. Plans are paid a capitation rate, a fixed dollar amount per member per month, to cover a defined set of services. Through PCCM arrangements, enrollees have a designated primary care provider who is paid a monthly case management fee to assume responsibility for managing and coordinating their basic medical care. Finally, in limited-benefit managed care, states contract with plans to manage specific benefits such as mental health and substance abuse services or to provide services for a particular subpopulations.

Regardless of the type of managed care arrangement, beneficiaries must be provided with a choice of managed care plan and an opportunity to appeal managed care coverage decisions.

Premium Assistance

States have the option of using Medicaid funds to purchase group health coverage such as employer-sponsored health insurance, or non-group coverage if the coverage is cost effective. States cannot, however, offer premium assistance for high-deductible health plans or flexible savings arrangements.

States can require individuals to enroll in group health coverage under premium assistance, but cannot mandate enrollment in premium assistance using individual coverage. States must also continue to provide all services covered under traditional Medicaid and provide wraparound coverage if the health plan cost sharing exceeds state plan requirements.

Provider Payment

States have considerable flexibility to design their own Medicaid payment methods and set their own payment rates. Under fee-for-services arrangements, states make direct payments to providers; and under managed care arrangements, they make capitation payments to managed care plans. Federal statute, however, does require states to pay federally qualified health centers under a prospective payment system that established a fixed, per-visit rate based on the health center's costs.

In general, provider payments under fee-for-service Medicaid must be sufficient enough to provide access to care equivalent to the general population and be consistent with the principles of efficiency, economy, and quality of care. States use a variety of methods when establishing fee-for-service payment rates for different types of providers. Under Medicaid managed care, states pay managed care organizations a capitated payment for each person enrolled in the plan and the plan is responsible for paying providers for the services that an enrollee uses. Capitation rates are developed based on utilization and cost data for the applicable Medicaid population and must be actuarially sound to cover the costs of the services provided.



In addition to establishing base payment rates, states often make supplemental payments, or lump-sum payments not directly tied to particular service, to providers. States are required to make disproportionate share hospital (DSH) supplemental payments to hospitals that serve a high share of Medicaid and low-income patients. States can also make non-DSH supplemental payments to providers up to the upper payment limit of what Medicare would have paid in the aggregate for services provided to a particular class of providers.

Appeals

State Medicaid programs are required to have a process for beneficiaries to appeal adverse decisions. These include decisions made by the state in determining eligibility for or coverage of specific services under fee for service, or decisions made by a health plan related to coverage of services under managed care arrangements. States retain some flexibility in the design and implementation of the appeal process.

States must provide a fair hearing when a claim for assistance is denied or not acted upon in a timely manner; however, states can choose the timeframe for requesting a fair hearing (within 90 days). States can also choose to offer a local evidentiary hearing before a fair hearing and may do so in some localities but not others. States also have the option to reinstate benefits or extend the appeals timeframe if the beneficiary requests it, or if the health plan can prove that additional time would be helpful to the beneficiary. The state may allow a provider or authorized representative to request an appeal or state fair hearing on behalf of beneficiaries. States may also offer and arrange an external medical review.

Endnotes

¹ Aid to Families with Dependent Children (AFDC) is the cash assistance program that was replaced by Temporary Assistance to Needy Families program in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193). PRWORA also eliminated the link to cash assistance for low-income families and children with regard to Medicaid eligibility.

² Federal rules under the ACA require states to determine Medicaid eligibility for non-disabled children, pregnant women, parents, and adults without dependent children under age 65 using modified adjusted gross income (MAGI) based on Internal Revenue Service (IRS) rules. MAGI methods do not apply to individuals whose eligibility is determined on the basis of age or disability, those whose eligibility for Medicaid does not require a Medicaid determination of income (such as individuals receiving Supplemental Security Income (SSI) or Title IV-E foster care), those in need of long-term services and supports (LTSS), and certain individuals applying for Medicare cost sharing assistance or medically needy pathways. For non-MAGI populations, states must apply the financial methodologies and requirements of the cash assistance program most closely categorically related to the individual's status.

