Medicaid

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Introduction

Medicaid is the largest health insurance safety net in the United States, providing health insurance coverage to almost 75 million low-income individuals in March 2021 [1]. The Children's Health Insurance Program (CHIP), which provides coverage to children with incomes that exceed Medicaid eligibility, covered an additional 6.8 million children. Medicaid accounts for approximately 17% of all health care spending in the United States with approximately $632 billion in cost reported for 2019, while CHIP cost an additional almost $19 billion [2].

Medicaid covered more than half (58%) [3] of all nonelderly individuals living in poverty, and almost half (48.5%) of all individuals with incomes up to 200% of the federal poverty level in 2019 [4]. The program paid for almost half of all births (49%) and provided health insurance to more than one-third (38%) of all children in 2017 [5]. Further, Medicaid serves many people with chronic illnesses and disabilities, including approximately 45% of nonelderly adults with a disability, 42% of nonelderly adults living with HIV/AIDS, 19% of Medicare beneficiaries, and 62% of nursing home residents.

Both Medicaid and CHIP are administered and financed jointly by the federal and state governments. The federal government sets broad program parameters, giving states flexibility in how they administer the program. States have some flexibility in eligibility, covered services, provider payments, and delivery system design. In addition, states have the option of operating their CHIP program as an extension of Medicaid (e.g., same services, provider payments, and delivery system), or as a stand-along CHIP program. While there are many similarities between Medicaid and CHIP, there are also distinct differences. Most importantly, Medicaid is an entitlement program, meaning that the state and federal government have to pay for services for any individual who meets the state's eligibility rules. In contrast, the stand-alone CHIP program operates as a block-grant program. States can establish waiting lists if they run through their program budget. This chapter provides an overview of the Medicaid program, as it covers far more people with chronic illnesses—both children and adults—than CHIP. However, some information about the CHIP program is included throughout the chapter.

Historical Developments

Medicaid was created in 1965 as Title XIX of the Social Security Act, but the Act has been amended many times since the program was first established [6, 7]. Many of the changes expanded Medicaid to cover more people or services. Other amendments changed provider payment methodologies and extended states' ability to tailor the overall program structure to meet state needs. Essentially, Congress enacted changes over the years to balance the competing tensions of covering unmet needs (coverage and service expansion), ensuring adequate access and quality, and reducing escalating costs.

When Medicaid was first created, it was limited to families receiving Aid-to-Families with Dependent Children (AFDC) and to older adults and people with disabilities covered under state cash payment programs. The program was optional to the states. But, by 1982, all 50 states and the

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District of Columbia operated a Medicaid program [8]. Congress first amended Medicaid in 1967 when it expanded the program to provide coverage to medically needy individuals: those with substantial medical bills, but who earned too much income to qualify for Medicaid. Congress also directed states to provide comprehensive well-child care, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program—to children under age 21 [6].

Congress created the Supplemental Security Income (SSI) program in 1972, nationalizing the states' old cash payment programs for older adults and people with disabilities. At that time, states were required to provide Medicaid to anyone receiving SSI (or, a state option, to a more limited group of individuals who were elderly or disabled). Amendments in the mid-1980s and early 1990s extended coverage to more pregnant people and children, followed by a larger expansion to children in 1997 with the passage of the Children's Health Insurance Program (CHIP). Like Medicaid, CHIP was also optional to states, but all states chose to adopt the program.

The largest coverage expansion since the inception of Medicaid occurred in 2010, as a result of the passage of the Patient Protection and Affordable Care Act (ACA). The ACA included a mandate that all states expand Medicaid to cover adults up to 138% of the federal poverty level (FPL), even if these adults did not meet eligibility for traditional coverage categories. However, a Supreme Court decision later made the expanded coverage optional to the states.

In addition to the coverage expansion, the Act has been amended over time to try to rein in rising health costs. For example, early in the history of the Medicaid program, hospitals and nursing facilities were reimbursed on a "reasonable cost" basis. This began to change in the 1970s and 1980s. Payments to hospitals and nursing homes were changed from "reasonable costs" to payments that were sufficient to cover the costs of "efficiently and economically operated" facilities. In 1981, states were given more flexibility to reduce program costs by implementing Medicaid managed care and by imposing cost sharing requirements (1982).

Other Medicaid changes aimed to ensure access and quality. To address adequate access, the Medicaid Act was amended in 1989 to "assure that payments [to providers] 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 the geographic area" (42 USC §1396a(30)(A)). Congress later amended the Medicaid statute in 1990 to ensure that payments to nursing facilities were sufficient to implement the 1987 nursing home quality reforms. Special payment rules were also implemented to protect safety net hospitals—"disproportionate share hospital" payments—federally qualified health centers (FQHCs), and rural health clinics.

Medicaid Eligibility, Covered Services, and Cost Sharing

Eligibility

Historically, to qualify for Medicaid, an individual must have been a citizen or qualified immigrant and the right "type" of person. Their income must have been below a specified income limit, and they could not have too much money in the bank. For example, Medicaid was limited to certain categories of individuals, including pregnant people, children under the age of 19 (or 21 at state option), parents of dependent children, older adults (age 65 or older), or someone living with a disability. The maximum income someone could have and still qualify varied, depending on the different categories of those eligible (Fig. 44.1). Non-disabled, nonelderly adults without dependent children could not qualify, regardless of how poor they were.

The ACA [9] intended to expand Medicaid to adults with incomes below 138% FPL, regardless of whether they fell into one of the coverage categories. However, the US Supreme Court in *National Federation of Independent Business v. Sebelius* [10] overturned the mandate, making Medicaid expansion optional to the states. As of July 2021, 39 states and the District of Columbia expanded their Medicaid program to cover these newly eligible adults (children were already covered through Medicaid or CHIP). The remaining 12 states have chosen not to expand. The American Rescue Plan Act of 2021 included additional financial incentives to encourage the "hold-out" states to adopt Medicaid expansion, but it is unclear whether those incentives will be sufficient to overcome these states' reluctance to extend Medicaid coverage.

In addition to the mandatory coverage groups, states have options of covering other categories of individuals. For example, 34 states operate a "medically needy" program [11]. This allows states to cover individuals who have high medical bills but have too much income to otherwise qualify for Medicaid. In effect, individuals or families must incur medical bills equaling the difference between their countable income and the state's medically needy income limits. This difference operates similarly to a health care deductible for people with private insurance. The individual is responsible for paying this amount, and then Medicaid pays the remainder of the bills over the individual's coverage period.

Congress also gave states the option to expand coverage to women with incomes below 250% FPL if they were diagnosed with breast or cervical cancer. All states provide this coverage, but the number of people covered is generally small. Congress also set up a separate family planning Medicaid program option—providing coverage for family planning services to certain individuals who meet state

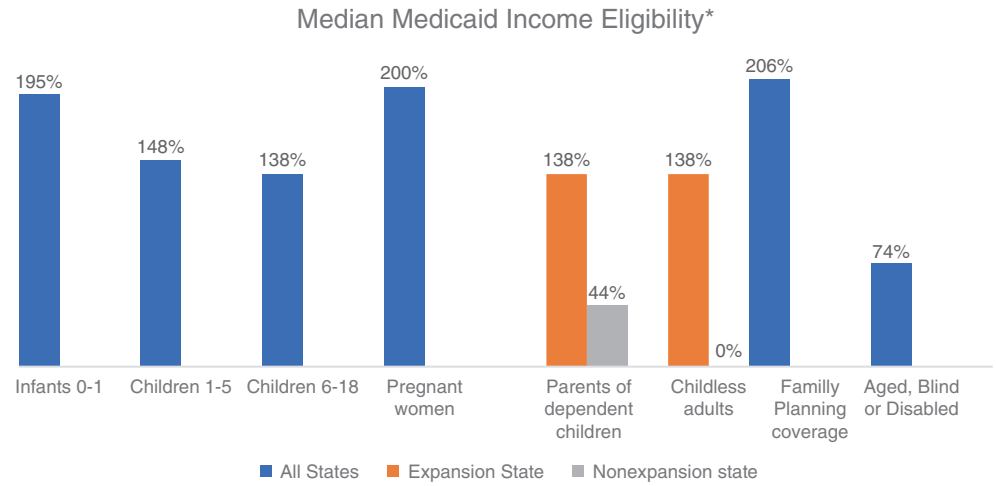

Fig. 44.1 Median Medicaid Income Eligibility by Eligibility Category (As of January 1, 2021). States generally have higher median incomes in their CHIP programs. For example, the median CHIP income limits is: 217% (0–1 year old), 216% (1–5 year old), 155% (6–18 year old), and 262% for pregnant women. (Sources: Brooks T, Gardner A, Tolbert J, Dolan R, Pham O. Medicaid and CHIP Eligibility and Enrollment Policies as of January 2021: Findings from a 50-State Survey. Kaiser Family Foundation. March 8, 2021. Tables 1, 2, 4. https://www.kff.org/report-section/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2021-findings-from-a-50-state-survey-tables/; Medicaid Eligibility through the Aged, Blind and Disabled Pathway (2018 data). State Health Facts. Accessed August 10, 2021. https://www.kff.org/medicaid/state-indicator/medicaid-eligibility-through-the-aged-blind-disabled-pathway/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)

eligibility criteria [12]. States have flexibility in establishing the income limits for this program. As of November 2021, 26states participated in this Medicaid program [12].

Covered Services

Congress identified certain services that the states must cover in their Medicaid programs ("mandatory services") and other services that are optional to the states ("optional services"). The required services are similar to what most private insurance plans cover, such as inpatient and outpatient hospital services, physician and nurse practitioner visits, family planning, home health, lab and x-ray service. States are also required to cover services provided in rural health clinics and FQHCs (See Fig. 44.2). States must also cover certain services that are not typically covered in private plans, including long-term care services provided in nursing facilities and non-emergency medical transportation. In addition, states must cover Early, Periodic Screening, Diagnosis and Treatment (EPSDT) for children under age 21. EPSDT is similar to well-child care provided by private insurers. But, it also requires states to cover *any Medicaid allowable service*, including optional services that are needed to ameliorate health problems identified in the EPSDT screening.

Of note, states are not mandated to cover prescription drugs ("optional service"), but all states do. In addition, most states provide some coverage of dental, podiatry, and psychological services; physical, occupational, and speech therapy; dentures, prosthetics, eyeglasses, hearing aids, and medical equipment; hospice, personal care services, and PACE (Program of All-Inclusive Care for the Elderly) in their Medicaid programs. A smaller subset of states covers other services such as chiropractic treatment and case management. States are required to cover some specified behavioral health services but have the option to cover a broader array of these services [13]. Nationwide, Medicaid is the largest payor for mental health services in the country, and also a major payor for substance use disorder services [14].

States do not have to provide the same services for adults in the Medicaid expansion population. The ACA mandated that states cover ten essential services that are part of the ACA for the expansion population, such as inpatient and outpatient services, lab and x-ray services, prescription drugs, and behavioral health services. States can cover other Medicaid mandatory or optional services, but are not required to do so. Similarly, stand-alone CHIP need not provide all the same services as does Medicaid. It must provide coverage that is comparable to services covered in commercial health insurance plans and must cover behavioral health and dental services. However, unlike Medicaid, CHIP programs are not required to provide EPSDT services, non-emergency medical transportation, or long-term care services.

Cost Sharing

States may charge some Medicaid enrollees premiums or other out-of-pocket costs. However, certain groups are exempt from any cost sharing, including pregnant people (for preg-

Mandatory Services	Optional Services		Medicaid Expansion Required Services
• Early, Periodic Screening, Diagnosis and Treatment (EPSDT) • Family planning services • Federally qualified health centers and rural health clinics • Freestanding birth centers • Home health services • Hospital Services, Inpatient and Outpatient • Laboratory and x-ray services • Non-emergency medical transportation • Nursing facility services for individuals over age 21 • Practitioners, including physicians, certified pediatric and family nurse practitioners, and nurse midwives • Tobacco cessation counseling for pregnant women	• Community supported living arrangements • Clinic services • Critical access hospital • Dental services, dentures • Health homes for enrollees with chronic conditions • Homeand community-based services Critical access • Hospice • Institutional services, including inpatient hospital and nursing facility services for individuals 64 or older in an institution for mental diseases, inpatient psychiatric services for individuals under age 21, and intermediate facility services for individuals with intellectual disabilities • Optometry services and eye glasses • Therapy services including physical therapy, occupational therapy, and speech, hearing, and language therapy	• Other diagnostic, screening, preventive, and rehabilitative services, including respiratory care for ventilator dependent individuals • Other licensed practitioner services, including chiropractic • Personal care services • Prescription drugs • Primary care case management services • Private duty nursing services • Program of All Inclusive Care for the Elderly (PACE) services • Prosthetic devises • Services furnished in a religious non medical health care institution • Targeted case management services • Tuberculosis-related services	• Ambulatory patient services • Emergency services • Hospitalization • Pregnancy maternity and newborn care • Mental health and substance use disorder services (in parity with physical health services) • Prescription Drugs • Rehabilitative and habilitative services • Laboratory services • Preventive and wellness services and chronic disease management • Pediatric services including oral and vision care

Fig. 44.2 Mandatory and Optional Services for Traditional Medicaid and Medicaid Expansion Populations. (Source: Mandatory and Optional Benefits. Medicaid and CHIP Payment and Access Commission. Accessed August 10, 2021. https://www.macpac.gov/subtopic/mandatory-and-optional-benefits/; Dear State Medicaid Director. Essential Health Benefits in the Medicaid Program. SMDL #12-003, ACA#21. Center for Medicare and Medicaid Services. Nov. 20, 2012. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/SMD-12-003.pdf)

nancy related services), most children, and those in long-term care nursing facilities. For others, the amount that can be charged depends on the individual's income. Generally, the state can only charge nominal copays for Medicaid enrollees with incomes below 100% FPL [15]. Nominal copays are limited to $4 for most services, or $75 for inpatient hospital services. Those with higher incomes can be charged premiums, copays of up to 20% of the cost of the services, and copays for non-emergency use of the emergency room (if certain other conditions are met). Families with children with CHIP coverage that have incomes above 150% can also be charged premiums or other out-of-pocket costs, as long as total costs do not exceed 5% of family income [16].

Impact of Medicaid Expansion on Health Outcomes

Studies that have looked at the impact of Medicaid expansion on the uninsured have generally found positive associations between expansion and access to health services and health outcomes [17, 18]. For example, studies have shown greater access to care for people with cancer, chronic disease, and other disabilities. Comparably, studies have shown increased access to services for pregnant people, for people living with HIV/AIDS, and for people with mental health or substance use disorder problems. Research has also shown an association between Medicaid expansion and decrease in

all-cause mortality, as well as mortality related to specific health conditions including certain types of cancer, cardiovascular disease, or liver disease. Medicaid expansion was also shown to reduce racial, ethnic, and socioeconomic disparities for certain health conditions. Not surprisingly, Medicaid expansion also reduced catastrophic health costs for enrollees, and also helped improve provider payer mixes.

Provider Payments

States have a lot of flexibility in setting provider payment amounts, as long as the payments are designed to promote efficiency, quality and access [19]. The payments should be sufficient to ensure Medicaid enrollees have comparable access to providers to that of others in the same geographic area. Provider payments can vary based on the level of care, underlying condition, and intensity of services. Payments to hospitals, including supplemental payments, are generally comparable to Medicare [20]. However, Medicaid payments to physicians have historically been less than what Medicare pays for similar services. On average, Medicaid reimbursement rates to physicians were only 72% of Medicare rates for 27 common procedures in 2019 [21]. Because of low Medicaid reimbursement rates, approximately 71% of physicians reported that they were willing to accept new Medicaid patients. In contrast 91% of physicians reported willingness to accept new privately insured, and 90% reported a willingness to accept new Medicare patients [22]. Despite lower physician participation rates, Medicaid enrollees report similar ability to access providers as do those with private insurance, and much higher than the uninsured [23].

While states have considerable flexibility in setting provider payments, they are required by statute to have special payment systems for FQHCs and rural health clinics, and for disproportionate share hospitals ("DSH"). States are required to pay FQHCs and rural health clinics using a prospective cost basis, or an alternative payment method which is no less generous [24, 25]. These payments are generally higher than the traditional fee-for-service payments to other physicians and clinics. In addition, states must pay safety net hospitals a supplemental DSH payment to help offset some of the hospitals' uncompensated care costs [26]. States determine the eligibility criteria for DSH hospitals but must target hospitals with a disproportionate number of Medicaid and uninsured patients. The total DSH payments in fiscal year 2019 was $19.7 billion.

Delivery System

When Medicaid was first created, the statute gave enrollees freedom to choose any provider who participated in Medicaid. Individuals could not be "locked into" any particular provider for services. Over the years, Congress has given states more authority to require Medicaid enrollees to obtain care from specific providers, generally through managed care arrangements. There are three primary managed care arrangements: (1) primary care case management, (2) prepaid health plans, and (3) managed care organizations. In primary care case management (PCCM) programs, enrollees select a primary care medical home, which serves to manage and coordinate the patients care. The state generally continues to pay providers on a fee-for-service basis but gives primary care providers an additional case management fee to help pay for care coordination. States can also contract with "prepaid health plans" to provide a subset of services—either outpatient services only, or both outpatient and inpatient care. Typical prepaid ambulatory or inpatient health plans cover services such as transportation, dental, or behavioral health. States can also contract with a managed care organization (MCO) to manage and provide most or all of the Medicaid covered services. This is the most common Medicaid managed care arrangement.

Forty states contracted with MCOs to provide services to some or all of their Medicaid enrollees in 2019 [27]. On average, about 80% of a state's Medicaid population is enrolled in one of the MCOs operating in those states, although the actual percentage varies from 5 to 100%. In addition, 12 states operate a primary care case management program (PCCM), including 5 states that operate both MCOs and PCCM programs. Only 4 states had no managed care arrangements in 2019 (Alaska, Connecticut, Vermont, and Wyoming).

In addition to contracts with MCOs, a number of states have started to move into value-based arrangements with providers. In 2018, there were 10 states with Accountable Care Organization (ACO) arrangements [28]. States with ACOs generally pay these organizations either through a shared savings arrangement, or through global capitation, with requirements that the organizations meet certain quality standards.

Financing

Medicaid is jointly financed between the federal and state government, with the federal government contributing between 50 and 80% of the cost of covered services for eligible individuals. The federal match rate—known as the Federal Medical Assistance Percentage or FMAP—is based on the state's per capita income. States with lower per capita income receive a higher federal match rate. As an example, for federal fiscal year (FFY) 2022, the state's underlying FMAP rate ranged from a low of 50% in 12 states to a high of 78.31% in Mississippi [29]. The FMAP rate for CHIP services is 30% higher than for Medicaid, ranging from 65 to 84.82%.

In addition to the regular FMAP rates for Medicaid and CHIP, the federal government has different match rates for selected covered individuals, services, or program costs. For example, the federal government pays 90% of the costs of those newly made eligible under the ACA (e.g., in Medicaid expansion states). The federal government typically pays 50% for most administrative expenses (such as determining Medicaid eligibility) but pays 90% for certain other administrative expenses such as implementation of a Medicaid information system or a state Medicaid fraud control unit, or for family planning services [30].

Medicaid Expenditures

Overall, Medicaid spending closely tracks enrollment. Program costs go up when more people enroll, and down when there are fewer people on the program. While this relationship generally holds true, the actual costs that a state incurs for its Medicaid program is dependent on many factors including number of enrollees, types of eligibles, covered services, and provider payment amounts. On average, costs for older adults (65 years or older), and people with disabilities is much higher than for other enrollees—about seven times higher than for children and almost five times higher than for parents in FY 2014 [31]. Because of the variation in eligibility, program design, and provider payments, the average cost per full-time eligible individual ranged across the states from a high of $13,611 in North Dakota to a low of $5916 in Nevada in FFY 2018 [32].

Medicaid spending per enrollee has historically grown at a much slower pace than national health expenditures or private insurance (and generally lower than Medicare) (see Fig. 44.3). Between 2016 and 2019, Medicaid spending per enrollee grew an average of 3.4% per year, Medicare grew an average of 3.1%, national health expenditures per capita grew 3.9%. In comparison, private health insurance per enrollee grew 4.8% during this same period [33]. Across the states, Medicaid spending constituted almost 16% of *state-only* spending (e.g., from state general revenues and other state funds). When including the federal Medicaid funds that flow through the states, Medicaid accounts for almost 29% of total state budgets. Paying Medicaid costs can be challenging to states, particularly in economic downturns. Typically, enrollment in the Medicaid program grows during recessions, as more people lose their jobs or cut hours of employment and become eligible. But state revenues generally shrink during economic downturns. This countercyclical nature of the Medicaid program creates particular problems for states that must balance their budget every year, unlike the federal government which can operate deficits. If states are required to pay for increased Medicaid costs during an economic downturn, they have less money to pay for other necessary services.

States have responded to economic downturns by instituting policies aimed at reducing Medicaid costs or increasing revenues through provider taxes. For example, states have tried to reduce program costs by freezing provider payments, imposing higher premiums or cost sharing, and incentivizing Medicaid enrollees to participate in wellness initiatives. States have also developed complex care management programs to target high-cost enrollees, employed primary care medical home models, tightened eligibility for long-term care services and expanded home and community-based services, and employed different strategies to rein in rising pharmaceutical costs [34, 35].

The federal and state governments have also taken various actions to address the growing costs of prescription drugs. In 1990 Congress established the Medicaid Drug Rebate Program (MDRP). Drug manufacturers must agree to provide drug

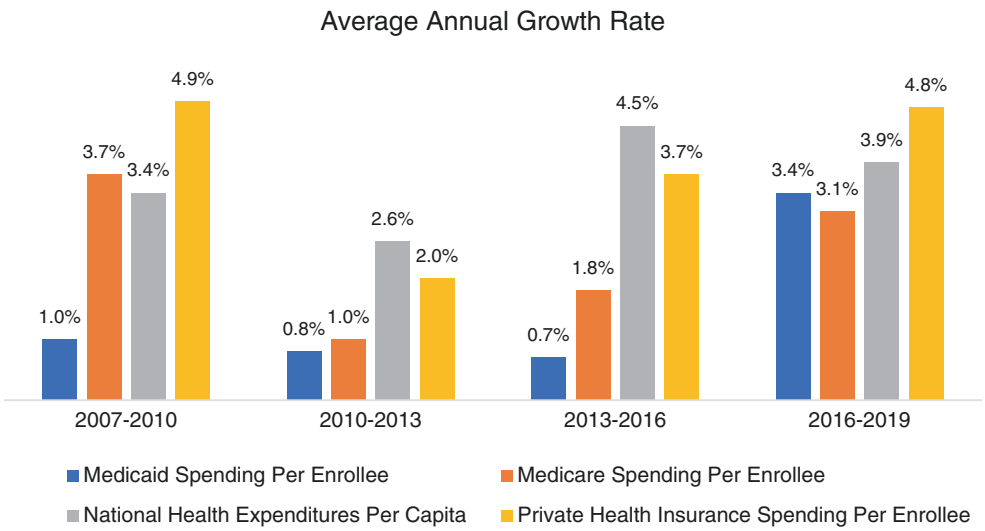

Fig. 44.3 Medicaid Spending Per Enrollee Over Time (2007–2019). (Source: Rudowitz R, Williams E, Hinton E, Garfield R. Medicaid Financing: The Basics. Kaiser Family Foundation. May 7, 2021. Fig. 6. https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/. Datasource: Kaiser Family Foundation estimates based on National health Expenditure Data from the Centers for Medicare and Medicaid Services Office of the Actuary)

rebates to the state and federal governments for their drugs to be covered in states' Medicaid programs [36]. The rebate amount is determined by many factors such as, whether a drug is generic or has a brand name. Furthermore, the MDRP Act gave Medicaid a "Most Favored Nation" status with regard to pharmaceutical prices. That means that with only a few exceptions, pharmaceutical companies must pass onto to the Medicaid program the lowest cost negotiated with other payors [37]. Some states have gone further to reduce drug costs by limiting dispensing fees to pharmacists, requiring generic substitution unless the prescriber specifies why the brand name drug is medically necessary, or by requiring a supplemental rebate to be listed on the state's preferred drug list [38].

In addition, states have increased revenues to offset the state's share of Medicaid costs through provider taxes and intergovernmental transfers from other governmental entities. In state fiscal year 2019, all states had at least one provider tax, including 43 with hospital taxes, 45 with nursing facility taxes, and 35 with taxes on intermediate care facilities for people with intellectual disabilities [39]. Congress has also stepped up to help the states during recent economic downturns by increasing the federal match rate. For example, as part of the Families First Coronavirus Response Act of 2020, Congress increased the regular FMAP rate to all states by 6.2 percentage points during the COVID-19 public health emergency [33]. In response, states were required to meet certain maintenance of effort requirements, to ensure that people on Medicaid did not lose benefits and to prevent states from restricting eligibility.

Medicaid Waivers

States must generally operate their Medicaid program the same throughout the state (i.e., the "statewideness" requirement). However, Congress gave states the authority to seek waivers of certain program requirements, including statewideness—with permission from the Centers for Medicare Medicaid Services (CMS) [40]. There are three primary Medicaid waivers. Freedom of choice or 1915(b) waivers allow states to implement managed care arrangements and to lock patients into particular primary care providers (42 USC §1915(b)). These are the waivers states have historically used to create primary care case management programs or to contract with managed care organizations.

States can also seek home and community-based services (HCBS) or 1915(c) waivers to enable the state to provide additional home and community-based services to people who would otherwise qualify for institutional care (42 USC §1915(c)). In 2018, 48 states and the District of Columbia operated 265 waivers covering more than 1.8 million people [41]. States can operate more than one waiver, covering different eligibility groups and services (e.g., children with complex medical conditions who would otherwise need long-term hospitalization, people living with HIV/AIDS, people with traumatic brain injury, frail adults or those with disabilities, people with mental illness, or people with intellectual and developmental disabilities).

These waivers must generally be cost neutral to the federal government, which means that the state must demonstrate that the costs of providing home and community-based services are no more than what it would have cost the state to provide institutional care to these individuals. Most states target their 1915(c) waivers to older adults and people with disabilities, or people with intellectual and developmental disabilities. These HCBS offered through 1915(c) waivers do not operate as an entitlement. That means that the state can limit the number of eligible individuals whom it will serve. As a result, there were there are reports that over 800,000 people were on waitlists in 40 states in 2018 [42].

In addition, the state can seek a Section 1115 research and demonstration waiver if they want to test new models of care that promote the objectives of the Medicaid program (42 USC §1115). This waiver is often broader in scope than 1915(b) or (c) waivers. In August 2021, there were 63 approved 1115 waivers operating in 45 states [43]. In addition, 26 states had 30 waivers pending. If the state can demonstrate savings through the new program design, it can use the savings to reduce program costs, or to offer additional services or cover new eligibles.

States have used this authority to expand services or people covered, or to develop targeted managed care systems. For example, in 2021, 18 states have approved 1115 waivers to expand the array of community-based services (e.g., housing, employment or peer support) for people with behavioral health conditions, 32 states cover the costs of substance use disorder services provided in Institutions for Mental Diseases (IMDs), and 13 states have waivers to establish capitation arrangements with managed care providers offering long-term services and supports [43].

States have also sought or obtained waivers intended to limit services or eligibles, or to charge higher costs to enrollees. For example, 12 states have obtained waivers to restrict eligibility or enrollment, including waiving retroactive eligibility—which normally allows Medicaid to cover expenses up to 3 months prior to the enrollee's application date. Other states have sought waivers to lock enrollees out of Medicaid for a specific period of time if they fail to meet certain program rules, including work requirements or paying premiums [43]. Other states have obtained waivers that authorized them to stop covering non-emergency medical transportation, or to charge higher copays above the statutory limits. Some states have also obtained waivers to charge higher premiums than would otherwise be allowed. Federal courts have blocked some of the approved waivers that have restricted coverage or eligibility. However, others are still in effect.

Impact of Medicaid for Persons with Chronic Illnesses

Medicaid enrollees are far more likely to report having one or more chronic illnesses and have more functional limitations than are those with private insurance. For example, children on Medicaid are more likely to have been diagnosed with ADHD/ADD, asthma, or autism, or an intellectual or other developmental disability than those who have private insurance [44]. Nonelderly adults (ages 19–64) on Medicaid are more likely than those with private insurance to have been diagnosed with hypertension, coronary artery disease, heart attack, stroke, diabetes, arthritis, or asthma, and to report limitations with basic or complex activities. They are also more likely to be obese or a current smoker and are more likely to report having a functional limitation.

Medicaid's home and community-based services (HCBS) are especially important for individuals with complex and chronic illnesses. All states are required to provide home health services, which include nursing services, home health aide services, medical equipment and supplies, and often include physical, occupational, or speech therapy services [45]. States can also offer personal care services that help individuals with activities of daily living (such as bathing, dressing, toileting, or transferring), or with instrumental activities of daily living (such as meal preparation, shopping, using the telephone, or medication management) [46]. In FY 2018, 34 states offered personal care services. In addition, states have the option of covering additional HCBS through 1915(c) waivers discussed earlier in the Chapter [47]. In general, HCBS help individuals remain in their homes in the community and reduce the need for institutionalization.

States have also designed other initiatives aimed at those with multiple co-morbidities. For example, some states have established Medicaid health homes to provide more comprehensive care management, transitional services, and referrals to community and social supports for people with multiple chronic illnesses [48]. In 2021, 21 states and the District of Columbia offered at least one Medicaid health home model [49]. States have also instituted complex care management for high-cost Medicaid enrollees (e.g., enrollees with complex health problems and psychosocial needs that have high costs and are high utilizers). Data are mixed on how well these initiatives help improve health outcomes or reduce unnecessary expenditures.

In addition, low-income populations are more likely than others to have unmet social needs that impair health. Studies show that those with unmet social needs are also more likely to have chronic illnesses and experience greater access barriers [50].

Some states have used Medicaid funding to address unmet social needs, such as food or housing insecurity or transportation [51]. For example, North Carolina obtained an 1115 waiver that gave the state the authority to use federal and state Medicaid funds to pay for unmet social needs that affect health [52]. This was the first of its kind—this 1115 waiver authorized the state to use up to $650 million over 5 years in Medicaid funding to pay for selected services to address housing insecurity, food insecurity, non-medical transportation, and interpersonal violence. The pilot program will start serving high-risk individuals who have both underlying health problems and unmet social needs in the spring of 2022.

Final Comments

The Medicaid and CHIP programs provide comprehensive health insurance coverage to some of the most vulnerable people in the United States. On paper, the program covers a wide array of services with limited cost sharing. Further, there is sufficient flexibility in program design to allow states to tailor services to its population. However, it is not a perfect program. In some states, Medicaid enrollees experience difficulties finding treating providers because of low-reimbursement rates. The entitlement nature of the program protects enrollees—but creates challenges to states, particularly during economic downturns. And depending on the leadership at the state and national level, the program acts as a "hot-button" issue for politicians who want to rein in government spending. Nonetheless, studies have shown that the program provides needed health insurance to millions of low-income individuals who could not otherwise afford insurance. The program has been shown to improve access, reduce out-of-pocket spending, and improve health outcomes. And it is a valuable funding source to health care providers, who would otherwise be faced with much larger uncompensated care burdens if the program ceased to exist.

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