AHIP

Medicaid 101

Program Overview

Nearly 75 million low-income Americans depend on Medicaid for health care. Medicaid covers Americans at all stages of life, including low-income children and families, pregnant women, older adults, and people with disabilities. Introduced in 1965 as part of the Social Security Act, Medicaid is a federal and state partnership, jointly funded and administered by states within a federal framework. At a total cost of $592.2 billion in 2017, Medicaid is the largest payer of health care services in the country.[1]

Who is covered by Medicaid?

Medicaid is the primary source of coverage for low-income people, providing health care for one in five Americans. Medicaid is an entitlement program, meaning anyone who meets the eligibility requirements has the right to enroll. To be eligible, a person must qualify under a specific eligibility category and meet income requirements set by their state.

State Medicaid programs are required to cover certain groups of people, including low-income children and their parents, pregnant women, people with disabilities, and older adults. States have the flexibility to expand eligibility to include additional groups. Under the Affordable Care Act (ACA), states have the option to expand their Medicaid programs to cover low-income, nonelderly, childless adults. As of 2019, 35 states and U.S. territories have expanded Medicaid to cover these adults.

Medicaid also covers low-income children through a program called the *Children's Health Insurance Program (CHIP)*. Some states operate CHIP as a part of Medicaid, while others operate CHIP as a separate program. Nationwide, approximately 6.6 million children are enrolled CHIP in 2019.[2]

In addition to these groups, Medicaid is the primary source of coverage for people who need long-term care, nursing home, and home-based supportive services.

Is Medicaid the same as Medicare?

No; Medicaid is a joint state and federal program that provides health coverage for people with very low incomes. Medicare is a federal program that provides health coverage for people over age 65 and people under age 65 who have a disability, regardless of income. However, certain low-income individuals are dually eligible for both programs. For these people, Medicare is the primary payer for medical services, and Medicaid provides assistance in paying for premiums, out-of-pocket cost sharing, and coverage of long-term services and supports.

Is Medicaid the same as public assistance?

No; public assistance programs provide low-income people with cash benefits. Medicaid is health insurance coverage that covers the cost of medical, behavioral health, and long-term care services for people with low incomes. It is paid for by state and federal governments.

1 Department of Health and Human Services. 2017 Actuarial Report of the Financial Outlook for Medicaid. 2017.
2 Centers for Medicare and Medicaid Services. March 2019 Medicaid & CHIP Enrollment. March, 2019

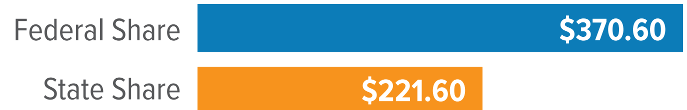
How does Medicaid work?

Medicaid is a state and federal partnership. The federal government sets core requirements for minimum eligibility standards and mandatory benefits. Within these parameters, states have flexibility to design a Medicaid program that best meets their needs and the needs of their residents. States can specify who is eligible, what is covered, how care is delivered, and how providers are paid. Most states designate a single agency to administer their Medicaid program.

The federal government pays for at least half of each state's Medicaid program, using a formula called the *Federal Medical Assistance Percentage (FMAP)* to determine the federal share. In general, states with lower per capita incomes receive more federal funds. In 2017, total federal expenditures for Medicaid were $370.6 billion or 63% of the total across all 56 state and territorial Medicaid programs.[3] The FMAP is also higher in certain cases, such as for the adult expansion population added under the ACA.

State and Federal Medicaid Funding

(billions of dollars, 2017)



State flexibility

State flexibility is a hallmark of the Medicaid program. Each state has the ability to tailor its Medicaid program within federal parameters. As a result, Medicaid programs vary from state to state, sometimes widely. There is a saying in Medicaid that, "If you've seen one Medicaid program, you've seen one Medicaid program." Each state can adapt its Medicaid program to best meet the needs of its residents.

One area of state flexibility relates to delivery systems. States may cover benefits through a traditional fee-for-service model, a managed care arrangement, or both. In states with Medicaid managed care (MMC), the state contracts with a private health plan, or managed care organization (MCO), and pays a fixed monthly payment per person (called a capitated rate) to cover Medicaid services for the MCO's enrollees. States are increasingly looking to managed care to achieve savings, promote better outcomes, and facilitate better quality and performance measurement and reporting.

For more information on Medicaid, please refer to other briefs in AHIP's Medicaid 101 series

- Medicaid Eligibility and Enrollment
- Medicaid Managed Care
- Medicaid Administration and Financing
- Medicaid Prescription Drug Coverage
- Children's Health Insurance Program (CHIP)
- Long Term Services and Supports (LTSS) in Medicaid

3 Department of Health and Human Services. 2017 Actuarial Report of the Financial Outlook for Medicaid. 2017.