SECTION
PROGRAM DESCRIPTION

SUBJECT
Medicaid Overview

MEDICAID OVERVIEW

Medicaid pays for comprehensive, guaranteed benefits with little or no cost sharing to some of the nation's most vulnerable populations: low-income families, the disabled, and the elderly. Because the populations served have a wide range of significant health needs, the services that states can cover range from basic health services for those for whom private coverage is unavailable or unaffordable to long-term care services for those with chronic health needs. Though each state's Medicaid benefits package differs in the type and scope of covered services, every eligible individual entitled to Medicaid coverage is guaranteed a minimum set of benefits.

The purpose of the Medicaid Program is to provide Medicaid eligible and medically needy persons with ongoing and preventive medical care necessary for maintaining their health and promoting their own self-care. The Medicaid Program was created in 1965 by Congress through Title XIX of the Social Security Act and was implemented in Montana in 1967 through Title 53, Chapter 6 of the Montana Codes Annotated and Section 46.12 of the Administrative Rules of Montana. The Montana Department of Public Health and Human Services is the designated single state agency for administering the Medicaid Program.

Medicaid eligibility is limited to individuals who fall into specified categories. The federal Medicaid statute identifies over 25 different eligibility categories for which federal matching funds are available. These statutory categories can be classified into five broad coverage groups; children; pregnant women; adults in families with dependent children; individuals with disabilities; and the elderly. Fitting into a Medicaid eligibility category is essential to qualifying for Medicaid coverage.

Because Medicaid assistance is limited to those in financial need, the program also imposes financial eligibility requirements. These requirements take two basic forms: income tests and resource (or assets) tests. These financial requirements vary from category to category. There are Medicaid eligibility categories for which individuals may qualify by "spending down"- that is, the costs of health care that an individual has incurred are deducted from the income that an individual receives in determining whether he or she qualifies for Medicaid. The spend-down approach is called "medically needy".

Medicaid eligibility, once established, is not indefinite. Federal Medicaid regulations require that states re-determine the eligibility of a Medicaid beneficiary at least once every 12 months. This re-determination, like the initial eligibility process, is designed to ensure that a beneficiary continues to meet each of the financial and non-financial requirements for eligibility.

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FEDERAL REQUIREMENTS

To receive federal funds for the program, the state must follow the federal regulations in 42 CFR, Parts 430 to 460. The regulations provide for two types of Medicaid Programs: mandatory and optional. Mandatory programs must be offered for states to receive federal Medicaid funds. Federal Medicaid funds are available for optional programs if a state legislature authorizes the expenditure of state funds.

STATE PLAN

States define the extent and scope of services provided, service standards, and rates of payment to providers. The Department provides these details to CMS in a State Plan that can be amended at any time. Services available to all Medicaid consumers are called State Plan services. Medicaid benefits are not the same from state to state.

At the state level, eligibility policy choices are reflected in state decision as to which optional eligibility categories and which income and resource criteria to adopt. There are certain categories of individuals that all states electing to participate in Medicaid must cover (mandatory services). There are other categories of individuals for which states may receive federal matching funds if they choose to extend Medicaid coverage to them (optional services). However, the availability of federal matching funds for a particular category of individuals does not necessarily mean that a state will cover that category, since the state must still contribute its own matching funds toward the costs of coverage. Optional services may vary from state to state.

(Excerpts of this policy were taken from The Medicaid Resource Book – The Kaiser Commission on Medicaid and the Uninsured)