

September 21, 2004

Medicaid Frequently Asked Questions

Background

Q: What is Medicaid?

A: Medicaid is a voluntary Federal program that provides participating States with matching funds to offset some of the costs of health care for eligible individuals.

Q: Is Medicaid run by the Federal government or by the States?

A: State Medicaid agencies administer their own plans but must meet Federal guidelines set by the Centers for Medicare and Medicaid Services (CMS). CMS is an agency within the U.S. Department of Health and Human Services.

Q: Does every State have a Medicaid plan?

A: Yes, all 50 states and the District of Columbia participate in Medicaid.

Q: Do all States receive the same amount of money from the Federal government?

A: No. The Federal government matches at least 50% of the program costs for all States but some States with low per capita income levels receive even more. The highest reimbursement amount is currently 83%.

Benefits

Q: What benefits does Medicaid provide?

A: Benefits under Medicaid fall into two categories: mandatory and optional. States *must* provide the mandatory benefits in order to receive the Federal matching funds. Mandatory benefits include, for example,

- Inpatient and outpatient hospital services
- Physicians' services (MDs and DOs)
- Laboratory and X-ray services
- Services through Federally qualified and rural health care centers
- Nurse midwife and nurse practitioner services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21
- Nursing home services

Optional services are benefits that a State *may* choose to include under its plan. Optional benefits are also eligible for Federal matching funds. Some examples of optional benefits are:

- Dental services
- Chiropractic services
- Vision screening
- Psychological services
- Home health care
- Physical therapy
- Podiatry

Q: Are all Medicaid beneficiaries entitled to psychological services?

A: No. As an optional benefit, States are not required to include psychological services in their Medicaid plans. About half of the States offer services by a psychologist in independent practice as a benefit for adults. While the remaining States may cover psychological services offered through a clinic, hospital, or community health center, they do not allow psychologists to directly bill Medicaid.

Q: Do the States that include psychological services in their optional benefits all provide the same level of coverage?

A: No. States that offer psychological services may have varying coverage limitations. Massachusetts and Washington cover psychological evaluations but not treatment. Other restrictions that States have placed on psychological services include:

- Kansas: Only 4 hours of psychological testing over 2 years
- New Hampshire: Psychotherapy limited to 12 sessions per year

Q: What about psychological services for children?

A: Children covered by Medicaid have access to psychological services as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits. EPSDT services, which include screening and treatment for mental conditions, are mandatory. States must offer EPSDT services to all Medicaid-eligible children under age 21.

Eligibility

Q: Who is eligible for Medicaid?

A: Medicaid provides health care for certain low-income individuals. The three primary groups enrolled under Medicaid are low-income parents and children, the elderly and the disabled. To determine eligibility, an individual's income is compared to a specified percentage of the Federal poverty level. In some cases, individuals with incomes too high to qualify for Medicaid may become eligible by "spending down", meaning they incur large medical, hospital, or long-term care expenses.

Q: Are the standards for eligibility the same in every State?

A: Not all standards are the same. Federal guidelines require that all States cover pregnant women, infants and children under the age of 6 if their family income falls below a certain percentage of the Federal poverty level. Beyond that, the States may vary the income and resource requirements that individuals must meet in order to be eligible for Medicaid. Individuals who fall outside of the limits under the Federal guidelines may still be eligible for coverage in States that have been granted waivers.

Waivers

Q: What difference does it make if a State has a waiver?

A: Waivers let States use the Medicaid matching funds in ways that ordinarily would not be allowed under the Federal guidelines. Waivers were developed to grant States the flexibility to determine how to best meet their needs while still maintaining the fundamental goals of the Medicaid program. Through waivers, States have:

- Expanded coverage for adults without dependent children
- Implemented managed care plans
- Required premium payments by individuals at higher income levels
- Used savings achieved from reducing coverage for people already eligible for Medicaid to offset the cost of new coverage
- Lowered costs by reducing benefits, increasing cost sharing, and capping enrollment for newly eligible groups
- Subsidized health coverage provided through employers or in the individual market

Q: So States can use waivers to both increase and decrease coverage?

A: That's correct. In some cases States have decreased coverage for existing beneficiaries in order to increase eligibility for others. States that already have waivers may be able to make further changes without the Federal government's approval.

Action at the State and Federal levels

Q: Are States likely to change their Medicaid plans?

A: Many States have suffered recent economic losses and are looking for ways to reduce spending. Under Medicaid, each State must first pay to furnish care before seeking partial reimbursement through matching Federal funds. The money spent on Medicaid usually comes out of the State's general revenues, which are used to fund a wide variety of expenses.

Q: Could cuts in spending affect psychological services?

A: Definitely. Over the last three years, numerous States have reduced optional benefits, including mental health and psychological services. To illustrate, psychological services were severely reduced last year under Medicaid plans in Ohio and Texas. In Maine, the legislature rejected a proposal to eliminate independent psychological services and instead limited the number of visits to 16.

Q: My state Medicaid plan includes psychological services. Should I still be concerned about possible cutbacks?

A: Yes. Just because your state currently offers psychological services as an optional benefit doesn't mean it always will. If states need to cut or limit the costs of their Medicaid plans, optional benefits will continue to be at risk. To reduce the risk of cutbacks, psychologists need to support state psychological association efforts to educate policymakers about the importance of psychological services for Medicaid beneficiaries.

Q: What can I do to protect psychological services under Medicaid?

A: Work with other health care and patient organizations in your State to monitor actions by the Governor's office and the State Medicaid agency. Typically, these entities are involved in developing the Medicaid budget before it is presented to the State legislature. You should also pay close attention to any discussion of a waiver as the public's input may be requested before an application is filed with CMS. It is easier to suggest changes when proposals are first being developed, rather than after CMS or State officials have approved them.

Q: What is the APA Practice Organization doing about Medicaid?

A: APAPO is addressing Medicaid in several ways. The Government Relations office will monitor Federal legislative proposals and alert its Federal Advocacy Coordinators

to significant developments appropriate for grassroots advocacy. Government Relations will also review actions by CMS, including approval of waiver applications and proposed changes to Medicaid regulations.

APAPO's office of State Advocacy will track Medicaid legislation at the state level and research access under Medicaid to psychological services for children. State Advocacy will also consult with the State and Territorial Psychological Associations and facilitate CAPP grants to respond to proposed eliminations of optional Medicaid services.

Q: Is APAPO trying to have psychological services included as a mandatory benefit?

A: To have psychological services included as a mandatory benefit would require a change in Federal law. APAPO has considered lobbying Congress on this issue but believes that attaining this goal is highly unlikely in the current political climate. APAPO will continue to monitor the situation at the Federal level and will look for opportunities to influence Medicaid legislation in ways that will benefit psychology.