South Dakota Legislative Research Council

Issue Memorandum 94-18

Overview of Federal Medicaid Regulations

Introduction

The federal government provides for the medical services needs of low-income people through Title XIX of the Social Security Act, known as the Medicaid program. Under this program, the federal government and state governments share the cost of medical care. In South Dakota, the federal government pays approximately 70% of the cost, with the state paying the remainder. In order to receive this money, the state must comply with a variety of federal regulations, which determine who will be eligible to participate in the program and what services will be made available to these recipients. These federal regulations have a profound effect on state budgets, since expansion of required eligibility categories and mandatory services must be paid in part by states.

Eligibility Requirements

The federal government's Medicaid regulations require that states provide Medicaid coverage to individuals who are eligible for certain categorical aid programs. People who are eligible for Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) must be covered under a state's Medicaid program. In addition, states are required to provide Medicaid to some children who are placed in foster care or receive adoption assistance grants.

The SSI program is administrated by the Social Security Administration, and its need standard, or maximum income level for eligibility, is established by the federal government and updated on a yearly basis. States can use more restrictive eligibility factors in determining an individual's eligibility for Medicaid, but they do not have the power to change the need standard for this program. In addition, states are required to provide eligibility for nursing home or alternative care services to individuals with incomes up to 300% of the SSI need standard. Thus, the federal government effectively determines the size of this population, which the state is mandated to cover.

Similarly, states must provide Medicaid eligibility to children who are receiving foster care through a federal grant under Title IV-E of the Social Security Act. In addition, states may extend Medicaid eligibility to all children who are placed outside of the home by the state, including group treatment, foster care, and adoption assistance.

Unlike SSI, states do have the power to establish need standards for the AFDC program. Thus, a state can increase or decrease its Medicaid population by changing the eligibility income level for AFDC. Since both of these programs require the same rate of state matching funds, changes in the AFDC need standard have an effect on the expenditures for both AFDC and Medicaid. This double financial effect makes it expensive for states to raise the AFDC need standard.

Recently, the federal government has added a new category of mandatory eligibility for pregnant women and children. States must now provide Medicaid to pregnant women and children up to age six in families below 133%

of the poverty level, and they must also provide Medicaid to children six or older, born after September 30, 1983, living in families up to 100% of the poverty level. As time passes, states must continue covering more children until the coverage of all children living in poverty is achieved. These new categories have contributed to significant increases in state Medicaid populations over the last few years.

States have few options for restricting Medicaid eligibility under the federal regulations, but they may expand coverage under many of these areas. For example, they may set higher percentages of the poverty level for pregnant women and children to be eligible in order to provide services to a larger population. Also, states have the option of extending coverage to individuals who are medically needy, meaning that these people do not meet the need standard for any categorical program, but they have incurred medical expenses which would reduce their income to an amount below the eligibility levels for one of the categorical programs which have mandatory Medicaid eligibility.

Medicaid Eligibility in South Dakota

The total Medicaid eligible population in South Dakota has almost doubled in the past eight years. The following table shows the changes by eligibility category in four-year increments:

Time	AFDC	Aged/Blind/ Disabled	Foster Care Children	Poor Women & Children	Total
May 1986	17,776	12,881	3,036	0	33,693
May 1990	21,283	15,525	1,227	3,637	41,672
May 1994	22,110	20,238	1,546	15,762	59,656

As the table indicates, much of the growth in South Dakota's Medicaid population has come about because of recent federal legislation requiring states to provide coverage to impoverished pregnant women and children. This category can be expected to grow in the future as children up to age nineteen are added to the program. In the 1994 session, the Legislature acted to provide eligibility to four additional cohorts, which will increase the eligible population by approximately 2,800 in this category.

The growth in the AFDC population has been relatively moderate over the last eight years. South Dakota has chosen to establish a merely adequate need standard for AFDC, which currently equals $476 for a family of three. This comparatively low need standard, which is below the average of all states, limits the population that is eligible for both AFDC and Medicaid, and it is thus doubly beneficial in terms of controlling state social service expenditures.

The aged, blind and disabled category has shown significant growth over the last eight years. This is primarily due to federal policies in the implementation of the SSI program, over which states have no control. The majority of this growth is related to an expanded definition of disability used by the Social Security Administration. In the foster care children category, no significant growth has occurred in recent years. The Department of Social Services has chosen to extend eligibility to all children placed outside of their homes, which, while expanding the eligible population, saves the state money, because the medical care for such children would otherwise have to be paid entirely from state funds.

For the most part, the Department of Social Services has not established liberal standards which would increase the population eligible for Medicaid. For example, they have set a comparatively low need standard for AFDC, have not increased the poverty levels for pregnant women and children, and do not provide eligibility based on medical need. The growth in the population eligible for cateogrical programs such as AFDC and SSI, which is generally not due to state policy decisions, explains less than half of the recent growth in the Medicaid population. Thus, the majority of the increase in this population over the past eight years can be attributed to the establishment of new requirements for coverage of pregnant women and children.

Medical Service Requirements

As with eligibility, the federal government prescribes which services must be covered under a state's Medicaid program, and it also allows states a choice regarding whether other services should be covered. Mandatory services include physician visits, inpatient and outpatient hospital treatment, laboratory and X-ray services, nursing home care, home health services, and family planning services. In order to participate in the Medicaid program, states must provide all of these services to everyone who is eligible for the program.

In recent years, Congress has added an additional service requirement which has significantly expanded the services that must be provided by state Medicaid programs. The Early and Periodic Screening and Diagnosis and Treatment (EPSDT) provisions of the federal Medicaid regulations require that states must provide screening and treatment services for all eligible children, even if these services are not available to eligible adults. This requirement forces states to offer comprehensive services to Medicaid children, which, though potentially beneficial, has made the program significantly more expensive for states.

In addition to the mandatory services, federal regulations include a list of services which states may choose to cover if they wish. This list includes chiropractic treatment, private duty nursing, clinic services, dental treatment, optometric treatment, hearing treatment, physical therapy, prescription drugs, screening services, mental health services, and home and community based services. By choosing to offer many or few optional coverages, states can provide a comprehensive or limited range of services to adults who are on Medicaid. However, because of the new mandates in EPSDT, states must provide all of these services to children on Medicaid.

Services Provided Under South Dakota's Medicaid Program

The bulk of the services provided under South Dakota's Medicaid program are those which are mandated by federal regulations. These services are responsible for the majority of the cost of the program, and the expansion of required services, particularly EPSDT, has increased costs in recent budgets.

In addition to the mandated services, the Departments of Human and Social Services provide a large number of the optional services which are allowed under federal regulations. For example, South Dakota Medicaid recipients, through the Department of Social Services, can receive treatment in a clinic, rehabilitation after illnesses, and a variety of specialized services from chiropractors, podiatrists, optometrists, audiologists, and dentists. The South Dakota Medicaid program also provides coverage for prescription drugs, with a co-payment that was increased from $1 to $2 by the 1994 Legislature.

The following chart shows the amount budgeted in Fiscal Year 1995 for various optional services offered by the Department of Social Services. These numbers indicate the funding committed by the state as well as the amount of federal dollars which are accessed by offering these services:

Service	General Funds	Federal Funds	Total Funds
Podiatrist	$ 8,713	$ 18,885	$ 27,598
Prescription Drugs	4,750,120	10,296,190	15,046,310
Optical	110,457	239,423	349,880
Chiropractor	63,566	137,784	201,350
Dental	549,706	1,191,622	1,741,228
Optometrist	229,315	497,054	726,369
Renal Disease	250,961	0	250,961
Total	5,962,838	$12,380,958	$18,343,796

Optional services provided under South Dakota's Medicaid program also include services for the mentally retarded, mentally ill and the developmentally disabled, which are administrated by the Department of Human Services. In addition, the Department of Social Services, Division of Adult Services and Aging has obtained a waiver from the federal government to provide a variety of home and community based services to senior citizens who might otherwise be placed in

expensive institutional care. These services, though technically optional, provide benefits greater than their cost because they serve clients more affordably than would otherwise be possible.

The South Dakota Medicaid program is more costly than absolutely necessary because it covers most of the services which are allowed as options under the federal medicaid regulations. However, some of the more expensive optional services, such as the community and home based services for seniors, are offered as an alternative to mandated forms of care such as nursing home services. Other optional services, including treatment by specialists, are provided as a comprehensive range of benefits for adult Medicaid recipients, who, unlike children, are not mandated to receive coverage under EPSDT. Of these services, the most expensive is prescription drug coverage, which will cost $4,750,120 in general funds in Fiscal Year 1995. Thus, South Dakota's program provides a generous level of benefits, but most of the optional services which are provided are relatively inexpensive. Eliminating some of these services would not greatly reduce the cost of South Dakota's Medicaid program.

Conclusion

The federal Medicaid program is designed to cover the medical services needs of the low-income population. The costs are shared between states and the federal government, but, in order to receive federal money, states must comply with certain requirements regarding program eligibility and services. These requirements give states some room to expand eligibility and services, as well as delineating what must be provided and whom must be covered. In recent years, Congress has acted to expand eligibility for poor children and to require that more services be provided to them. These actions have combined to cause significant increases in the cost of state Medicaid programs.

In South Dakota, the Medicaid program has followed very closely the federal minimum requirements, particularly in regard to eligibility. Because of mandated expansions, the eligible population has increased considerably and will continue to do so for a few more years. South Dakota provides a generous package of benefits to its recipients; coverage includes several services which are optional under federal regulations. These optional services include efforts to divert recipients from more costly care, so the number of services which could be cut without some negative impact is limited.

This issue memorandum was written by Jeff Bostic, Fiscal Analyst for the Legislative Research

Council. It is designed to supply background information on the subject and is not a policy statement made by the Legislative Research Council.