Understanding Medicaid

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Q: What are the mandatory and optional benefits in Medicaid?

Within Medicaid, there are both mandatory and optional benefits. It might sound self-explanatory what that means, but I'm going to but about the detail of each. So mandatory benefits are those that, by federal law, state Medicaid programs are required to offer to folks who are enrolled in Medicaid, and those can include specific things like medical care, but also specialized Medicaid benefits like EPSDT, or early and periodic screening for children. Optional benefits, which again self-explanatory, are those that states opt into offering, so that states aren't required to necessarily offer those, but they can through their state plans expand to offer those benefits and receive federal match to offer those benefits. And oftentimes, those benefits become so ubiquitous, they are assumed to be mandatory because they're offered in pretty much every program and that could include things like pharmacy. Every state Medicaid program offers pharmacy, which is technically an optional benefit. Also through different kinds of waiver authorities, long-term services and supports.

Q: How long is a person eligible for Medicaid?

The way an individual may become eligible for Medicaid is often through one of three pathways: they're either categorically needy, financially needy or medically needy, and under those circumstances, they may or may not have a different pathway or different eligibility for different benefits and different structures under the Medicaid program. So for example, a woman who is potentially lower-income may be just above the financial eligibility levels and categorical eligibility levels if she does not have children and is not pregnant. However, when she becomes pregnant, there is an enhanced financial eligibility that kicks in and she then becomes categorically needy for Medicaid. So the Medicaid will then cover her pregnancy, delivery and then care sixty days, up to sixty days after she delivers her baby and if she remains financially needy after that time, she may remain on the Medicaid program or she may no longer be eligible for the Medicaid program because that categorical need of being pregnant has now ended. But now because she is a caretaker or a mother of a small child and is lower income, she may remain categorically eligible under that sense. Oftentimes, women become eligible through the Temporary Assistance for Needy Families program, TANF, which itself is a lever - if you are eligible for TANF, you are eligible for Medicaid. TANF itself is a time-limited program, so a person is eligible for 60

months, or five years, which could or could not be continuous, so once your eligibility for TANF ends, technically your eligibility for Medicaid ends as well.

Q: How does Medicaid support pregnant women?

Medicaid covers almost half of all births in the United States and by virtue of that is a strong support system - is one of the primary support systems for pregnant women in the United States. Women who are lower-income and become pregnant are often covered through Medicaid even if they were not financially eligible for Medicaid prior to becoming pregnant. There is an enhanced financial eligibility threshold for women who are pregnant. Medicaid will then cover her medical care throughout her pregnancy and her delivery and up to 60 days after giving birth to her baby.

Q: Can someone be eligible for both Medicare and Medicaid?

Yes, someone can be both eligible for Medicaid and Medicare and receive services and coverage from both programs at the same time. An individual who is lower-income or potentially categorically or medically eligible for Medicaid, and turns 65 and ages into the Medicare system, is then both enrolled in Medicare and Medicaid simultaneously. There are also different circumstances where a person who is aged and or potentially enrolled in Medicare for other medical eligibility reasons become lower income or meet some other type of disability or categorical or medical necessity threshold, that provides them access to Medicaid. And colloquially those folks are often called “dual eligibles” because they are dually eligible for both Medicare and Medicaid and those programs do cover different types of benefits, so there often is not necessarily a doubling up.

Q: How are Medicaid services paid for in a managed care setting?

In Medicaid managed care, an individual's managed care organization acts as their insurer, so if you go to the doctor and receive services, your doctor would then submit a claim to your Medicaid managed care organization with which you are enrolled and the Medicaid managed care organization would pay that doctor the negotiated rate for which they've previously, you know, come under a contract to arrange – very similar to how commercial insurance and Medicare works as well. The state, along with their dollars that are federally matched, are then paying the Medicaid managed care organization to offer those services, typically in a capitated or at-risk environment.