

FAQs about State Medicaid Agencies for CDC's 6|18 Initiative Participants

Q: What is Medicaid?

A: Medicaid is a public health insurance program primarily for low-income individuals that is jointly funded by states and the federal government. States administer Medicaid programs in accordance with federal standards, with significant flexibility to determine program characteristics such as: eligible populations, benefits, health care delivery models, and payment structures. Medicaid programs cover a wide array of health services, with enrollees paying little or no out-of-pocket costs. In addition to covering traditional clinical services, Medicaid increasingly finances a wide range of community-based programs and services aimed at keeping populations healthy, such as: health education classes, counseling, transportation, home visiting programs, meals, and more. The Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS) implements Medicaid at the federal level. CMS is also a 6|18 Initiative partner, providing guidance to teams about federal Medicaid policies.

Medicaid currently insures one in five Americans — roughly 73 million individuals. It covers the majority of long-term care services in the U.S., as well as 40 percent of children and almost half of all births. Overall, Medicaid accounts for [17 percent of national health care expenditures](#). Medicaid enrollees have [higher rates of preventable chronic diseases](#) than other populations, so are especially likely to benefit from 6|18 Initiative prevention interventions.

Q: Who qualifies for Medicaid?

A: Medicaid provides health coverage for certain “mandatory” populations, including:

- Children through age 18 in families with incomes below 138 percent of the federal poverty level (FPL);
- Children in foster care or an adoption assistance program;
- Pregnant women with incomes below 138% FPL;
- Parents whose incomes are within the state’s eligibility limit for cash assistance that was in place prior to welfare reform; and
- Most seniors and persons with disabilities who qualify for the Supplemental Security Income (SSI) program.

IN BRIEF

This resource addresses questions that public health officials participating in CDC's 6|18 Initiative may have about Medicaid. The responses to these questions provide high-level information about how Medicaid operates at the state and federal levels, as well as its role within the 6|18 Initiative.

States may also cover “optional” populations, including:

- Children, pregnant women, and parents with incomes above mandatory coverage income limits;
- Seniors and persons with disabilities with incomes above mandatory eligibility standards;
- “Medically needy” people whose incomes exceed the state’s regular Medicaid eligibility limit but who have high medical expenses; and
- Low-income, non-disabled adults without children, following passage of the Affordable Care Act (ACA) in 2010 (also known as “Medicaid expansion”).

In states that did not expand Medicaid, adults over 21 without dependent children who are not disabled, pregnant, or elderly are generally not eligible for the program, regardless of how low their income is. Teams pursuing 6|18 Initiative interventions in states that expanded Medicaid may tailor their focus to best meet the health needs of the “newly eligible” adult Medicaid population; states that did not expand Medicaid may consider interventions best-suited to support “traditional” populations like children, pregnant women, and individuals with disabilities.

Q: What benefits does Medicaid cover?

A: All state Medicaid programs are required to cover a number of mandatory health benefits, including some benefits related to 6|18 Initiative interventions, such as family planning services and tobacco cessation counseling for pregnant women. Additional mandatory benefits include:

- Inpatient and outpatient hospital services;
- Early Periodic Screening, Diagnostic, and Treatment Services (“EPSDT”) for children; †
- Physician, nurse midwife and nurse practitioner services;
- Rural health clinic and federally qualified health center services;
- Laboratory and x-ray services;
- Free-standing birth center services;
- Transportation to medical care; and
- Long-term care, including both nursing home care and many home and community-based long-term services and supports.

States are also free to cover a range of “optional” health services. Optional benefits include: prescription drugs, physical therapy, eyeglasses, and dental care. 6|18 Initiative programs/benefits like asthma home visiting programs, the National Diabetes Prevention Program, and home blood pressure monitors would also be considered optional benefits. States may cover additional benefits that are not designated as either mandatory or optional if CMS grants the state a waiver to do so. For both mandatory and optional benefits, states have significant flexibility in establishing the amount, duration, and scope of the service provided. For example, Medicaid programs that cover tobacco cessation services can place a number of limits/barriers on the benefit, such as: instituting prior authorization requirements, limiting the number of covered quit attempts per year, and only covering certain types of medications and counseling services.

† All Medicaid-enrolled children under age 21 are guaranteed a set of comprehensive services through a pediatric benefit package called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). This benefit requires states to provide children with regular screenings; vision, dental, and hearing services; and any other medically necessary services, regardless of whether that treatment is part of the state’s traditional Medicaid benefit package. States cannot impose any amount, duration, or scope limitations on this benefit.

The federal government prohibits or limits cost-sharing for certain populations and services, including prohibiting premiums for Medicaid enrollees with income less than 150% FPL and limiting total out-of-pocket costs to no more than 5% of family income (though some states have obtained waivers allowing them to charge premiums or co-pays not otherwise allowable under federal law). As [Medicaid cost sharing can reduce the use of necessary services](#), 6|18 Initiative interventions call for reducing or eliminating cost sharing for evidence-based prevention services.

Q: How can I learn more about a specific state's covered benefits, eligibility criteria, or other program characteristics?

A: For more information about the characteristics of a particular state Medicaid program, see [Kaiser Family Foundation's State Health Facts](#) webpage. The site has information on state-by-state Medicaid benefits, eligibility limits, spending, Section 1115 waivers, and more.

Q: Why do some Medicaid programs not cover preventive health benefits?

A: Per federal Medicaid statute, many preventive services are "optional" benefits, so states are not required to cover these services. Medicaid directors and state legislators have difficult decisions to make about which optional benefits to provide to which populations. They often face competing pressures: on the one hand, to cover more services and enrollees to improve health care access and outcomes for low-income Americans; on the other hand, to control costs and meet strict budgetary targets. For certain preventable health conditions, some data suggest that investing in prevention can reduce Medicaid spending by preventing expensive emergency department visits and hospitalizations. For example, [6|18 Initiative participants](#) have worked to demonstrate that [covering asthma home visiting services for certain populations can lower Medicaid costs](#). In order for Medicaid leaders to buy the argument that covering certain prevention benefits can save money, they will likely want to see compelling, state-specific data demonstrating a short-term return-on-investment.

Q: What are Medicaid State Plan Amendments and how are they used?

A: Each state maintains a document called a state plan, which is an agreement between the state and the federal government describing how the state will administer its Medicaid program. If a state want to pursue change to its Medicaid program that complies with existing federal law, it can pursue the change through a State Plan Amendment (SPA) — a modification to its state plan (changes that do not comply with federal law must be proposed through a waiver process, described below). Requesting federal approval for a SPA is a relatively simple and straightforward process, and once approved, SPAs do not need to be renewed. SPAs are also not subject to budget neutrality requirements, meaning that they do not need to be budget neutral to the state or federal government. 6|18 Initiative teams have used SPAs to: unbundle reimbursement for postpartum insertion of long-acting reversible contraception from Medicaid's maternity care bundled payment; enable Medicaid-enrolled pharmacists to provide tobacco cessation services; and remove co-pays from tobacco cessation medications.

Q: What are Medicaid waivers and how are they used?

A: States can request waivers from the federal government to pursue changes to their Medicaid programs that would not otherwise be allowed under federal law. If approved by the federal government, states are granted flexibility through a waiver to test new and innovative approaches to operating their Medicaid programs. When operating a waiver, states must adhere to a number of federal requirements, including budget neutrality and regular reporting and evaluation.

Some Medicaid waivers are used for specific purposes; 1915(b) waivers, for example, enable states to implement managed care programs, while 1915(c) waivers allow states to offer home and community-based services in place of institutional care. Section 1115 waivers, on the other hand, are used for a wide range of demonstrations to alter a program's eligibility criteria, benefits, cost-sharing requirements or payment structures. Section 1115 waivers last for five years (with the option for renewal) and are expected to be budget neutral to the federal government. States are currently using Section 1115 waivers to test a variety of payment and health care delivery models, including: instituting new eligibility conditions (e.g., work requirements) and implementing alternative payment models. States implementing 6|18 Initiative interventions while pursuing a Medicaid waiver should consider different opportunities to promote alignment between the two initiatives; some states may even be able to use the waiver as a vehicle to cover a new prevention service or program. A past 6|18 team pursuing a Section 1115 waiver to launch a Medicaid accountable care organization (ACO) program and implement other Medicaid reforms worked to align ACO tobacco control quality metrics with the state's 6|18 Initiative priorities.

Q: Why do some Medicaid policy changes take many months – if not years – to implement?

A: As many proposed Medicaid policy changes impact the state's budget, states often invest significant time upfront conducting fiscal analyses of the proposal to better understand its anticipated costs or savings. In some cases, states may also need legislative approval before moving forward with a Medicaid policy change. States may also be very deliberate when proposing Medicaid policy changes because miscalculations or oversights could negatively impact Medicaid enrollees and result in the state having to pay money back to the federal government.

If a state submits a SPA, CMS has 90 days to approve or deny the request. However, CMS can "stop the clock" at any point by requesting additional information. Depending on the nature of CMS' request and the state's capacity to respond, this process can be relatively quick or quite lengthy. Once the state submits the requested information, a new 90-day clock begins. The approval process for some waivers (particularly Section 1115 waivers) can be much longer, depending on their content. For comprehensive 1115 waivers that significantly alter a state's Medicaid program, the approval process could take years, as the federal government carefully considers all aspects of the waiver's design and may engage in prolonged negotiations with the state. In 2017, CMS released guidelines detailing new processes to expedite the SPA and Section 1115 waiver review process, which has [resulted in reduced approval times](#).

Q: How is Medicaid financed?

A: States and the federal government finance Medicaid jointly, with federal law requiring that the federal government reimburse states for a percentage of all eligible Medicaid expenses. The fixed federal matching percentage (known as the "FMAP") for each state is determined by a formula and is based on states' average per capita income relative to the national average, with poorer states receiving a higher federal match rate. The federal match rate varies from 50% to 76% by state and is updated yearly. Some populations and services qualify for an enhanced federal match rate. For example, the federal government paid 100% of the costs for newly eligible adults in states that expanded Medicaid from 2014 - 2016; the rate that is gradually phasing down to 90% by 2020.

The state portion of Medicaid funding is often made up of a mix of state general revenues (at least 40% of a state's share must be financed with state funding), local government funds, and other funding sources (such as health care-related taxes). Total state and federal Medicaid spending was [\\$576.6 billion for FY 2017](#). In 2016, Medicaid was the second largest line item in states budgets (after education), accounting for 15.6% of total funding. Federal Medicaid funds are also the largest source of federal revenue in state budgets.

Q: What are key differences between how Medicaid agencies and state public health departments are financed?

A: While both Medicaid and public health departments rely on a combination of federal and state funding to operate, funding flows in different ways. In general, state Medicaid programs receive federal funds through an open-ended federal matching structure based on services delivered to enrollees. This funding is available without any predetermined limits, so if the need for Medicaid services increases, so too will the amount of federal funding available to the state. Public health departments, on the other hands, rely on federal grants, contracts and cooperative agreements — which tend to be limited in their amount and duration. Public health agencies therefore have a limited pool of federal funds to draw down from, which are often allocated for specific types of programs and activities.

Q: How are health services delivered to Medicaid beneficiaries under fee-for-service and managed care arrangements?

A: Traditionally, states reimbursed Medicaid providers under fee-for-service (FFS) arrangements, meaning the state would pay a provider directly for each covered service received by a Medicaid beneficiary. While some states still employ FFS arrangements — particularly for disabled and high-cost individuals, such those using long-term care services and supports — most Medicaid programs now contract with Medicaid managed care plans to oversee the provision of covered benefits and to manage contracts with Medicaid providers. As of 2015, [almost 80 percent](#) of Medicaid enrollees were enrolled in some form of managed care-up from 56 percent in 2000.

Under a standard managed care arrangement, states pay MCOs a fixed per member per month payment (also known as “capitation”) to provide enrollees with a set of predetermined benefits and access to a network of contracted providers. Many states have shifted toward managed care arrangements because they enable states to better predict and control future costs. Managed care can also facilitate greater accountability for outcomes and more focus on care coordination and care management. Additionally, MCOs generally have more flexibility to cover non-traditional services that may improve health outcomes. As MCOs play an increasingly large role in Medicaid service delivery — and are often open to investing in programs that improve health and control costs — many 6|18 Initiative teams have chosen to work with MCOs to expand or enhance coverage of prevention benefits.

Q: What are strategies for engaging Medicaid managed care organizations about enhancing coverage or utilization of 6|18 Initiative interventions?

A: As most Medicaid programs contract with managed care organizations to cover some or all enrollees and benefits, MCOs are important 6|18 partners, especially when a state is looking to expand coverage of a prevention benefit. Benefits covered by MCOs are defined by the state during the contract procurement process, but depending on state practice states may also be able work with MCOs during the contract period to modify or enhance benefits through contract amendments, clarification memos, and/or the development of new performance improvement projects.

6|18 team members — in close collaboration with Medicaid leadership — can engage Medicaid MCOs about 6|18 Initiative priorities and objectives by: inviting MCO representatives to participate in 6|18 Initiative events or meetings, presenting at existing MCO meetings, and scheduling one-on-one conversations. MCOs, like state Medicaid leadership, will be looking for compelling data about the problem at hand (i.e., why a change is needed) and potential financial impacts of such a change (i.e., the anticipated costs/savings for a set of enrollees over a specified time period). Strategies for effective MCO engagement include:

- Conducting a survey of all Medicaid MCOs to better understand how MCOs are currently covering benefits and to assess common opportunities and barriers;
- Ensuring the 6|18 Initiative “ask” is aligned with the state’s bigger picture priorities;
- Engaging multiple MCOs to promote alignment and consistency across plans;
- Signaling openness to MCO leadership about different coverage approaches and strategies; and
- Sharing regular information between 6|18 teams and MCOs.

Q: How are Medicaid agencies structured within state governments?

A: Medicaid can either function as its own standalone agency or operate as a branch within a larger state agency. According to [NAMD survey data](#), in FY 2017, Medicaid was structured as an independent agency in 13 states (29 percent) and was a division within a larger umbrella agency in 29 states (64 percent). In two states, Medicaid was a sub-division within a division of a larger umbrella agency, and in one state, Medicaid was separated across two divisions of a larger umbrella agency. Regardless of how an agency is structured within a state or how responsibilities may be divided across contracted partners or sister agencies, states must designate a “single state agency” to administer its Medicaid program and interface with CMS. Past 6|18 Initiative states that operate independent Medicaid agencies have noted fewer existing connections with public health departments, whereas those that operate under the same umbrella agency as public health have described more engaged and productive working relationships.

Q: How are states working to reform their Medicaid programs?

A: CMS and state Medicaid agencies have instituted a number of Medicaid managed care reporting and quality improvement requirements that have helped states track beneficiary health outcomes, manage utilization, and improve the quality of care. Additionally, many state Medicaid programs are pursuing a number of payment and delivery system reform initiatives that aim to improve health outcomes and control costs by better aligning payment with quality and focusing more on prevention and population health. Examples of such reforms include: patient-centered medical homes, accountable care organizations, physical and behavioral health integration strategies, and value-based purchasing arrangements that tie provider payments to performance metrics.

Q: How are Medicaid directors selected?

A: In [FY 2017](#), 30 of 45 surveyed Medicaid directors were politically appointed (with seven participating in a formal confirmation process), while 15 were civil servants or career executives. Two-thirds of the politically appointed directors and almost half of the non-politically appointed directors reported to a political officeholder, such as the governor or the state’s Secretary of Health. About two-thirds of Medicaid directors had prior work experience within the state’s Medicaid program before becoming director. The median tenure for Medicaid directors is just over two years.

Q: How do federal health care reform efforts affect Medicaid agency priorities and activities?

A: State Medicaid agencies and their directors must be aware of and responsive to both state and federal policy proposals and political circumstances. Programs need to manage ongoing operations in accordance with existing state and federal regulations, but also [keep apprised of new federal reform proposals](#) that could significantly impact state budgets and health plan/provider payment structures. Some Medicaid agencies have conducted assessments and simulations to gauge the potential impact of proposed federal legislation. Additionally, Medicaid directors and their staff are often called upon to inform the governor, elected representatives, and health care stakeholders about federal reform models, which can divert attention and resources away from day-to-day program management.

Q: What types of issues do Medicaid agencies prioritize?

Medicaid agencies are [currently prioritizing](#) the following issues:

- Delivery system and payment reform;
- Data systems and information technology;
- Behavioral health reform;
- Sustainability;
- Managed care contracting and procurement;
- Long-term care; and
- Section 1115 waivers.

While the Medicaid director often drives an agency's focus, Medicaid agencies react to guidance, incentives and directives from a variety of sources, including: the governor, the state Health and Human Services secretary, the state legislature, and the federal government. Other stakeholders, such as providers, health plans and consumers, can also help shape policy priorities through responses to public comment requests, town halls, and one-on-one meetings. When developing 6|18 Initiative action plans, teams should have a clear sense of existing Medicaid programs and priorities, then ensure that 6|18 activities align with, complement, or enhance the state's Medicaid goals.

Q: How do Medicaid agencies interact with other state agencies?

A: Many Medicaid agencies [collaborate with other states agencies](#) to promote cross-agency goals and to operate programs for specific enrollee sub-populations, such as: children with special health care needs, individuals with intellectual or developmental disabilities, and individuals with behavioral health or substance use disorders. These collaborative relationships enable Medicaid to tap into other agencies' expertise and resources, providing more complete, appropriate and effective care. Relationships with other state agencies also help Medicaid address population health needs and better tackle the social determinants of health. For example, many Medicaid agencies partner with state Departments of Education, Corrections and Housing to address non-clinical factors that impact health. In some states, Medicaid also has a long history of working with the state public health department. In states with less robust cross-agency connections, the 6|18 Initiative can help establish and strengthen a Medicaid-public health partnership.

Q: How does Medicaid interact with the Indian Health Service? How can tribes use Medicaid as a vehicle for improving population health?

A: American Indians and Alaska Natives (AIANs) who meet state eligibility standards can enroll in Medicaid and access health care from any providers who accept Medicaid, including (but not limited to) facilities operated by the Indian Health Service (IHS). Currently, Medicaid and the Children's Health Insurance Program (CHIP) insure over a million AIANs.

Medicaid is a key source of funds for IHS-operated facilities, as the federal government covers 100 percent of costs for Medicaid-enrolled AIANs who receive care at IHS facilities. Whereas federal IHS operating funds are fixed and appropriated once a year, Medicaid funding is allocated based on enrollee utilization (without appropriation limits) and is distributed on a rolling basis throughout the year. Medicaid dollars help IHS facilities meet basic operational needs like provider salaries, supply costs and administrative costs, but may also help facilities invest in additional services and programs to improve the health and well being of AIAN populations. States and territories can consider opportunities to promote 6|18 Initiative interventions specifically for AIAN populations, including through partnerships with local AIAN organizations and IHS providers or administrators.

Q: How does Medicaid operate in the U.S. territories?

A: All five U.S. territories—American Samoa, Commonwealth of the Northern Mariana Islands (CNMI), Guam, Puerto Rico and the U. S. Virgin Islands—operate Medicaid and CHIP programs. The territories' Medicaid programs [differ from state programs](#), and from each other, in a number of notable ways:

- **Federal funding:** The federal government has historically paid [50 percent of territories' Medicaid expenses](#), which is the lowest FMAP available to states (FY 2019 state FMAP rates range from 50% to 76%). With the ACA's passage, the territorial FMAP was temporarily raised to 55%. Additionally, federal funding for territories' Medicaid programs is capped, meaning that the federal government sets a yearly funding limit for each territory and stops reimbursing for Medicaid claims once that limit is met. Most territories exhaust their federal Medicaid funds long before the year's end.
- **Eligibility:** The territories are able to establish their own eligibility criteria for certain populations and can use a local poverty level to determine income eligibility.
- **Benefits:** Like states, the territories are required to cover a set of mandatory benefits and can then choose to cover additional optional benefits. CNMI and American Samoa operate under a Section 1902(j) waiver (available specifically to them) that waives the mandatory benefits requirement. While the other three territories do not operate under such a waiver, only Guam currently offers all 17 mandatory Medicaid benefits.
- **Delivery system:** Puerto Rico is the only territory that currently contracts with Medicaid managed care plans, which cover all Puerto Rican Medicaid beneficiaries; the other four territories operate fee-for-service programs.

Q: How can 6 | 18 teams work to promote Medicaid coverage of an existing pilot program?

A: 6|18 teams looking for Medicaid reimbursement for an existing prevention pilot program can present Medicaid leadership with a business case for Medicaid financing. Ideally, the business case would provide detailed financial information about the program's operating costs and any calculated savings, without overselling the program's potential benefits. This would help Medicaid and public health make an informed decision about whether or not to cover the service or benefit. Medicaid agencies run on annual budget cycles just like public health, so Medicaid leaders are especially interested in data on how policies will impact current and future budgets. Relevant information to present could include:

- How the service is currently being used;
- Whether there is demand in the current Medicaid population;
- Upfront/start-up costs and ongoing operational costs;
- Demonstrated savings, with a focus on short-term impacts (and if applicable, an ROI calculation); and
- Examples of other states' experiences implementing a similar program.

To facilitate the preparation of a detailed business case, 6|18 teams (including public health officials) can work to share relevant data across agencies and build communication channels with Medicaid leadership. Scheduling phone calls and in-person meetings to discuss opportunities for collaboration can help build trust and set the stage for ongoing interactions.

Q: What are the key steps in creating a 6 | 18 program cost analysis to make the case for coverage to Medicaid leaders?

A: 6|18 Initiative teams wishing to cover a new prevention benefit in Medicaid or enhance coverage of an existing benefit can develop a cost analysis that quantifies the policy change's financial impact. In some cases, this could occur after an initial pilot or demonstration program (often initiated by the public health department). Important factors to

consider include: state budgeting periods, MCO contracting periods, and whether savings and investments are allocated over different budgets/agencies. Key steps in developing a cost analysis, as outlined in [this CHCS brief](#), include:

- Identifying the cost analysis' target audience and intended impact;
- Clearly specifying the intervention's timeframe and population, as well as other program variables and data parameters;
- Identifying the resources and partners necessary to conduct the analysis;
- Running the numbers to determine costs avoided or saved; and
- Packaging the findings in a compelling way for the intended audience.

Q: How can 6 | 18 teams works to promote alignment and collaboration between Medicaid and public health?

A: 6|18 Initiative teams can employ a number of strategies to promote effective cross-agency communication and collaboration, such as:

- **Creating a Medicaid-Public Health Liaison Staff Position:** This individual could work to promote strategy alignment and collaboration between the two agencies and serve as a contact point to improve inter-agency communication.
- **Promoting Shared Understanding:** Setting aside time for foundation setting or training can help team members operate on equal footing, while drawing from expertise of each member. Teams can hold trainings or brown bag sessions to facilitate this.
- **Hosting Frequent Meetings Early On.** Hosting frequent meetings during the initial launch of the Initiative allows teams to establish a strong foundation from the outset. Initial team-building activities can include: developing an action plan, defining shared goals and outcomes, outlining tools and resources to be shared, and building structures for collaboration.
- **Designating Lead Staff.** Identifying a lead staff person from both Medicaid and public health can help establish effective 6|18 team leadership.

ADVANCING IMPLEMENTATION OF THE CDC'S 6 | 18 INITIATIVE

Through support from the Robert Wood Johnson Foundation, the Center for Health Care Strategies, in collaboration with a number of [partners](#), is coordinating technical assistance to facilitate state Medicaid and public health implementation of the Centers for Disease Control and Prevention's (CDC) 6|18 Initiative. The CDC's 6|18 Initiative promotes the adoption of evidence-based interventions that can improve health and control costs related to six high-burden, high-cost health conditions — tobacco use, high blood pressure, inappropriate antibiotic use, asthma, unintended pregnancies, and type 2 diabetes. For more information and additional resources, visit www.618resources.chcs.org.