

## APPENDIX 2: FEDERAL HEALTH CARE PROGRAMS

### Medicaid

Description	Funding	Eligibility	Benefits	Limitations/Gaps	Enrollment Numbers	Administration
<p>Medicaid (Title XIX) was created in 1965 as the federal program to provide health care coverage for low-income individuals. Medicaid is a state administered program. Each state sets its own guidelines regarding eligibility and services.</p>	<p>Funded with federal and state funds. States have different federal matching rates to fund the services provided under their Medicaid programs.</p> <p>The American Recovery and Reinvestment Act provides \$87 billion for a temporary increase in the federal share of Medicaid costs through 2010. To be eligible for the enhanced federal financing, states must not make changes to restrict eligibility levels or make it more difficult for people to apply for or renew coverage.</p>	<p>Under EPSDT benefit, children in Medicaid are entitled to a comprehensive range of service and supports</p> <p>See Federal Medicaid Eligibility Criteria and Benefits chart below.</p>	<p>See Federal Medicaid Eligibility Criteria and Benefits chart below.</p>	<p>Does not provide health care services for all poor persons, unless they are in one of the designated eligibility groups.</p> <p>Nearly 9 million children remain uninsured; most of these children are eligible for Medicaid.</p> <p>Systemwide shortages of pediatric specialists and dentists result in limited access to these services. Low provider participation and payment rates compound these problems.</p>	<p>Covers almost 60 million Americans.</p> <p>Finances 16% of national health spending.</p> <p>Medicaid covers over a quarter of all children in the U.S. including nearly 1 of every 5 white children and roughly 2 of every 5 African American and Hispanic children.</p> <p>Nearly 4 in 10 children with special needs are covered by Medicaid.</p>	<p>Federal/state program.</p> <p>Federal government establishes general guidelines and Medicaid program requirements established by each state.</p> <p>Administered by the Centers for Medicare and Medicaid Services, US DHHS.</p>

## Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program

Description	Funding	Eligibility	Benefits	Limitations/Gaps	Enrollment Numbers	Administration
<p>EPSDT is the child health component of Medicaid. It is required in every state for all categorically needy individuals under age 21 enrolled in Medicaid.</p>	<p>Funded with federal and state funds.</p>	<p>EPSDT is a required benefit for all “categorically needy” children under 21 who have poverty-level income, receive Supplemental Security Income, or receive federal foster care or adoption assistance.</p>	<p>Federal law defines EPSDT to cover certain screening, diagnostic, and treatment services at periodic intervals and as needed.</p> <p>Services include:</p> <ul style="list-style-type: none"> <li>• Screening;</li> <li>• Vision services;</li> <li>• Preventive and emergency dental;</li> <li>• Hearing; and</li> <li>• Any other health care diagnostic services and treatment.</li> </ul>	<p>Under the Deficit Reduction Act of 2005 states have the option to modify the approach to delivery of services to children enrolled in Medicaid. States can also restructure their benefits under Medicaid without a federal waiver and may enroll certain groups in benchmark or benchmark equivalent benefit packages and wrap-around benefits consisting of EPSDT benefits for any child under age 19 covered under a state plan.</p> <p>The DRA includes a more specific definition of case management and places limits on use of targeted case management and administrative case management.</p> <p>Restricted level of services when transitioning into adult Medicaid.</p>	<p>One in three U.S. children under age 6 is eligible for EPSDT.</p>	<p>US DHHS.</p>

## Children’s Health Insurance Program (CHIP)

Description	Funding	Eligibility	Benefits	Limitations/Gaps	Enrollment Numbers	Administration
<p>State CHIP is administered by US DHHS to provide matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid.</p>	<p>Financed with federal and state funds. CHIP provides a capped amount of funds to states on a matching basis. Each state determines the design of its program, eligibility, benefits, payment levels for coverage, and administrative and operating procedures.</p> <p>CHIPRA provides \$33 billion in additional federal funds to extend and expand CHIP for 4.5 years.</p> <p>A cigarette and tobacco tax increase will fund the program’s expansion.</p>	<p>CHIP statute defines low-income children as those at or below 200% of poverty. Under CHIPRA, states will no longer receive full CHIP matching rates for covering children in families with incomes greater than 300% FPL. They can cover these children with federal approval but will receive a lower Medicaid matching rate.</p> <p>Starting January 1, 2010, states must apply the Medicaid citizenship documentation requirement to children who apply for CHIP coverage. States now have the option to use CHIP funding to subsidize qualified job-based coverage for children who are eligible for CHIP.</p> <p>CHIPRA allows states to cover pregnant women through state plan amendments. It eliminates the five year waiting period for legal immigrant children and pregnant women who are eligible for Medicaid or CHIP.</p>	<p>Title XXI allows states to expand coverage for children primarily through one of three ways:</p> <ul style="list-style-type: none"> <li>• Separate child health insurance program;</li> <li>• Medicaid program; and</li> <li>• Through a combination of these programs.</li> </ul> <p>States choosing to expand their Medicaid program must follow Medicaid requirements regarding benefit structure. Section 1115 waivers will allow States to modify the Medicaid requirements within expansion programs. Under CHIPRA, states are required to include dental coverage in their CHIP benefit packages as well as guarantees mental health parity.</p>	<p>CHIP enrollment is a complicated process which is separate from other social services.</p> <p>To address the issue of knowledge gaps and access, CHIPRA includes \$100 million in funding that will be used to promote CHIP and Medicaid outreach and enrollment for eligible children in areas with high percentages of uninsured children.</p>	<p>7.4 million children were enrolled in CHIP at some point during 2008.</p> <p>During 2008, there were 334,616 adults covered with CHIP funds.</p> <p>CHIPRA provides \$33 billion in additional federal funds to extend and expand CHIP for 4.5 years to enable states to reach an additional 4.1 million children who would otherwise be uninsured, with no waiting period for the first time.</p>	<p>The statutory authority for CHIP is under title XXI of the Social Security Act. States are given flexibility in designing their CHIP eligibility requirements and policies within broad federal guidelines.</p> <p>Administered by the Centers for Medicare and Medicaid Services, US DHHS.</p>

## Medicare

Description	Funding	Eligibility	Benefits	Limitations/Gaps	Enrollment Numbers	Administration
<p>Medicare was established in 1965 as the health insurance program for people aged 65 or older, some people with disabilities under age 65, and people of all ages with end-stage renal disease.</p>	<p>Funding comes partially from payroll taxes, known as FICA taxes. FICA comprises Social Security tax and Medicare tax. High-income Social Security beneficiaries also pay income tax on their Social Security income, some of which goes toward Medicare. This money goes into a trust fund used to pay doctors, hospitals, and private insurance companies when Medicare patients use these services.</p>	<p>Individuals are eligible for Medicare if they are:</p> <ul style="list-style-type: none"> <li>• U.S. citizens or have been a permanent legal residents for five continuous years;</li> <li>• 65 years or older</li> <li>• Under 65, disabled and have been receiving either Social Security benefits or the Railroad; and</li> <li>• Retirement Board disability benefits for at least 24 months from date of entitlement (first disability payment), or they get continuing dialysis for end stage renal disease or need a kidney transplant, or they are eligible for Social Security Disability Insurance and ALS-Lou Gehrig's disease.</li> </ul> <p>Many beneficiaries are dual-eligible and qualify for both Medicare and Medicaid. In some states for those making below a certain income, Medicaid will pay the beneficiaries' Part B premium and drugs not covered by Part D.</p>	<p>The different parts of Medicare help cover specific services if certain conditions are met.</p> <p>Part A helps cover inpatient care in hospitals, skilled nursing facilities, hospice, and home health care.</p> <p>Part B helps cover doctors' services and outpatient care and some preventive services to maintain good health and keep certain illness from getting worse.</p> <p>Part C is a health coverage choice run by private companies approved by Medicare. It includes Part A, Part B, and usually other coverage, including prescription drugs</p> <p>Part D helps cover the cost of prescription drugs and may lower prescription drug costs and protect against higher costs in the future.</p>	<p>Medicare is not available to all people with severe disabilities. Benefits package is inadequate for most people with disabilities.</p> <p>The program provides coverage for primary care and hospital services, but Medicare benefits package is notably lacking coverage for prescription drugs and long term care services and supports.</p> <p>The program also has limited coverage for medical equipment that limits access to home health services for persons who are homebound.</p> <p>Many individuals with disabilities need Medicaid as a wraparound for the additional benefits.</p>	<p>Total 2008 Medicare beneficiaries:</p> <ul style="list-style-type: none"> <li>• 44,831,390 (15% of U.S. total population)</li> </ul> <p>Distribution of 2006 beneficiaries by eligibility:</p> <ul style="list-style-type: none"> <li>• Aged: 83.7%</li> <li>• Disabled: 16%</li> </ul> <p>Distribution of 2005 dual eligible enrollment:</p> <ul style="list-style-type: none"> <li>• Partial: 1,708,992</li> <li>• Full: 7,098,168</li> <li>• Total: 8,807,160</li> </ul>	<p>Centers for Medicare and Medicaid Services, US DHHS.</p>

## TRICARE

Description	Funding	Eligibility	Benefits	Limitations/Gaps	Enrollment Numbers	Administration
<p>TRICARE is the health care program serving active duty service members, National Guard and Reserve members, retirees, their families, survivors, and certain former spouses worldwide. As a major component of the Military Health System, TRICARE brings together the health care resources of the uniformed services and supplements them with networks of civilian health care professionals, institutions, pharmacies, and suppliers to provide access to high-quality health care services while maintaining the capability to support military operations.</p>	<p>The ultimate responsible organization for administration of TRICARE is the U.S. Department of Defense Military Health System, which organized the TRICARE Management Activity (TMA). TMA contracts with several large health insurance corporations to provide claims processing, customer service, and other administrative functions to the TRICARE program.</p>	<p>Active duty service members and retirees of the seven uniformed services, members of the National Guard, their family members, and survivors.</p> <p>Unmarried biological and adopted children up to age 21, up to age 23 if enrolled in college full-time.</p> <p>A child may be covered beyond the normal limits if he or she is severely disabled and the condition existed prior to the child's 21st birthday.</p> <p>When an active duty service member dies while serving more than 30 days, his or her biological and adopted children will remain eligible for TRICARE as "transitional survivors" until they reach the eligibility age limit.</p>	<p>Beneficiaries can use any civilian health care provider that is payable under TRICARE regulations. The beneficiary is responsible for payment of an annual deductible and coinsurance, and may be responsible for certain other out-of-pocket expenses.</p> <p>US Family Health Plan is a TRICARE prime option that offers benefits to active duty family members and all military retirees and their eligible family members, including those 65 years of age and over, regardless of whether or not they participate in Medicare Part B.</p>		<p>Eligible beneficiaries: 9.4 million</p> <p>Military facilities worldwide:</p> <ul style="list-style-type: none"> <li>• 63 military hospitals</li> <li>• 413 medical clinics</li> <li>• 413 dental clinics</li> </ul>	<p>The ultimate responsible organization for administration of TRICARE is the U.S. Department of Defense Military Health System, which organized the TRICARE Management Activity.</p>

## Indian Health Service (IHS)

Description	Funding	Eligibility	Benefits	Limitations/Gaps	Enrollment Numbers	Administration
<p>Indian Health Service (IHS), an agency within US DHHS, is responsible for providing federal health services to American Indians and Alaska Natives. This relationship, established in 1787, is based on Article I, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders.</p>	<p>With the passage of the Indian Health Care Improvement Act in 1976, IHS was authorized to bill for services provided to American Indians and Alaska Natives who are beneficiaries of CMS programs. IHS receives in excess of \$650 million annually in revenue from CMS for services provided to Medicaid, Medicare, and CHIP eligible patients. Enrollment in these programs also provides payments for referral services previously paid for by IHS Contract Health Services.</p> <p>The Medicaid program acts as:</p> <ul style="list-style-type: none"> <li>• An insurance program covering physician, hospital, and other basic health care services for eligible Native Americans, especially families with children;</li> <li>• A source of revenue for IHS and tribal-operated clinics and hospitals;</li> <li>• A purchaser of managed care products;</li> <li>• A source of financial assistance for low-income elderly and disabled Native Americans to meet Medicare premium and cost-sharing obligations; and</li> <li>• A source of coverage for nursing home care and other long-term care services for frail elderly and disabled Native Americans. The structure of the Medicaid program provides financial incentives for states to encourage beneficiaries to use tribal health facilities. The federal government's share of these costs ranges from 50% in wealthier states to nearly 80% in the poorest states. On average, the federal government pays 57% of a state's Medicaid costs.</li> </ul>	<p>Eligible if not otherwise excluded by provision of law, and is:</p> <ul style="list-style-type: none"> <li>• Of Indian and/or Alaska Native descent;</li> <li>• An Indian of Canadian or Mexican origin recognized by any Indian tribe or group as a member of an Indian community served by the Indian health program;</li> <li>• A non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through postpartum; or</li> <li>• A non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard.</li> </ul> <p>Although Medicaid is administered and financed in part by the states, Native Americans who meet the Medicaid eligibility requirements of the state in which they reside are, as a matter of law, entitled to Medicaid coverage. This is true whether a Native American lives on or near a reservation or in an urban area, and whether or not a Native American is eligible for IHS services</p>	<p>Health services are provided directly by IHS, through tribally contracted and operated health programs, and through services purchased from private providers. Because of high rates of poverty among Native Americans, Medicaid is an important publicly funded health program for Native Americans. Medicaid also assists low-income elderly and disabled Indians who are eligible for Medicare in meeting their premium and cost-sharing obligations.</p>	<p>Most urban Indians who are members of federally recognized tribes do not have access to services through IHS facilities because the hospitals and clinics run by IHS or tribes under contract with IHS are located primarily on reservations in rural areas.</p> <p>Many urban Indians are not enrolled members of federally recognized tribes and IHS generally does not consider these individuals as eligible for services provided by its hospitals and clinics.</p> <p>The American Indian and Alaska Native population is increasing at a greater pace than the capacity of the Indian health system to provide services. IHS is a discretionary service subject to annual appropriation amounts. The combination of an increasing population and extended life expectancy, changes in community disease patterns from acute to chronic diseases, limited resources for purchasing medical services at the local level, increasing costs, and limited resources result in denial of health services.</p>	<p>Currently provides health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 557 federally recognized tribes in 35 states.</p> <p>Federal system consists of 31 hospitals, 63 health centers, and 30 health stations. In addition, 34 urban Indian health projects provide a variety of health and referral services.</p> <p>There are an estimated 2.3 million Native Americans (American Indians and Alaska Natives) in the U.S. About half of the Native American population lives on or near reservations; the other half resides in other rural areas and in urban areas.</p> <p>The Native American population includes 554 tribes recognized by the federal government as well as other tribes, largely in California, that do not have federal recognition.</p>	<p>The IHS is the principal federal health care provider.</p>

## Federally Qualified Health Centers (FQHC)

Description	Funding	Eligibility	Benefits	Limitations/Gaps	Enrollment Numbers	Administration
<p>The FQHC benefit under Medicare was added in 1991 and includes safety net providers such as community health centers, public housing centers, outpatient's health programs funded by Indian Health Service, and programs serving migrants and the homeless. The main purpose of the program is to enhance the provision of primary care services in underserved urban and rural communities.</p>	<p>FQHCs must use a sliding fee scale with discounts based on patient family size and income in accordance with federal poverty guidelines. The beneficiary is responsible for paying the coinsurance, which is 20%, except for mental health treatment services, which are subject to the 62.5% outpatient mental health treatment limitation.</p> <p>FQHCs must be open to all, regardless of ability to pay.</p> <p>FQHCs also receive Enhanced Medicare and Medicaid reimbursement, Medical malpractice coverage.</p> <p>Eligible for various other federal grants and programs. Medicare pays FQHCs an all-inclusive per visit payment amount based on reasonable costs.</p>	<p>FQHCs must provide primary care services for all age groups. FQHCs must provide preventive health services on site or by arrangement with another provider.</p>	<p>Services include:</p> <ul style="list-style-type: none"> <li>• Dental;</li> <li>• Mental health and substance abuse;</li> <li>• Transportation services necessary for adequate patient care;</li> <li>• Hospital and specialty care.</li> <li>• Physician services and supplies, physician assistant, certified midwife, clinical psychologist, clinical social worker, and visiting nurse services to the homebound;</li> <li>• Drugs furnished by and incident to services of a provider;</li> <li>• Outpatient diabetes self management training;</li> <li>• Nutrition therapy;</li> <li>• Health education;</li> <li>• Eye and ear examinations;</li> <li>• Well child care and periodic screenings;</li> <li>• Immunizations;</li> <li>• Family planning;</li> <li>• Blood pressure, hearing, cholesterol, and TB testing;</li> <li>• Prenatal and post-partum care; and</li> <li>• Breast exams.</li> </ul>	<p>Services not covered include eyeglasses, hearing aids, dental services, certain lab services, durable medical equipment, ambulance services, x-rays and other diagnostic tests, technical components of preventative services, prosthetic devices, and artificial limbs/braces.</p>	<p>In 2007:</p> <ul style="list-style-type: none"> <li>• Total FQHCs: 1,067</li> <li>• Total patients served: 16,050,835</li> <li>• Total encounters or visits: 63,036,475</li> </ul>	

## Supplemental Security Income (SSI)

Description	Funding	Eligibility	Benefits	Limitations/Gaps	Enrollment Numbers	Administration
<p>Supplemental Security Income (SSI) is a federal income supplement program. It is designed to help aged, blind, and disabled people who have little or no income and provides cash to meet basic needs for food, clothing, and shelter. SSI makes monthly payments to people with low income and limited resources who are age 65 or older or who are blind or disabled. Children under age 18 can qualify if they meet Social Security's definition of disability for children.</p>	<p>Federal income supplement program funded by general tax revenues (not Social Security taxes).</p>	<p>Social Security provides benefits to children with disabilities. A child who is eligible for federal SSI cash benefits is also eligible, depending on the state, for state supplemental payments, Medicaid, food stamps, and other social services. Child must meet two sets of eligibility criteria: financial criteria and medical criteria.</p> <p>To meet SSI definition of disability, a child's impairment must result from anatomical, physiological, or psychological abnormalities that are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.</p>	<p>A child who is eligible for federal SSI cash benefits is also eligible, depending on the state, for state supplemental payments, Medicaid, food stamps, and other social services. However, not all SSI beneficiaries automatically qualify for Medicaid.</p>	<p>Not all physical and mental impairments meet the standard of disability. People with several disability conditions only meet the criteria once the condition is in an advanced stage, which is problematic since treatment is often more effective if it is received early in the course of disease or condition.</p>	<p>All beneficiaries receiving SSI in 2009: 4,953,000.</p> <p>Number of disabled under age 65 receiving SSI in 2009: 4,070,000.</p> <p>Number of children under 18 receiving SSI in 2009: 1,174,000.</p>	<p>Administered by the U.S. Social Security Administration.</p>

## Federal Medicaid Eligibility Criteria and Benefits

Eligibility Groups	Eligibility Criteria	Benefits
Categorically Needy	<ul style="list-style-type: none"> <li>• Families who meet states' Aid to Families with Dependent Children eligibility requirements;</li> <li>• Pregnant women and children under age 6 whose family income is at or below 133% of federal poverty level.</li> <li>• Children ages 6 to 19 with family income up to 100% of FPL.</li> <li>• Caretakers.</li> <li>• SSI recipients or in certain states, aged, blind, and disabled people who meet requirements that are more restrictive than those of the SSI program.</li> <li>• Individuals and couples who are living in medical institutions and who have monthly income up to 300% of the SSI income standard.</li> </ul>	<p>Entitled to following services unless waived under section 1115 of Medicaid law:</p> <ul style="list-style-type: none"> <li>• Inpatient hospital (excluding institutions for mental disease);</li> <li>• Outpatient hospital including FQHCs, rural health clinic, and other ambulatory services;</li> <li>• Other laboratory and x-ray;</li> <li>• Certified pediatric and family nurse practitioners;</li> <li>• Nursing facility services for age 21 and older;</li> <li>• Early and periodic screening diagnosis and treatment for children under age 21;</li> <li>• Family planning services and supplies;</li> <li>• Physicians' services;</li> <li>• Medical and surgical services of a dentist;</li> <li>• Home health services for beneficiaries who are entitled to nursing facility services under the states' Medicaid plan;</li> <li>• Nurse mid-wife services;</li> <li>• Pregnancy related services and service for other conditions that might complicate pregnancy; and</li> <li>• 60 days postpartum pregnancy related services.</li> </ul>
Medically Needy	<p>The family's income is too high to be eligible as categorically needy. If a state has a medically needy program, it must include pregnant women through a 60 day postpartum period, children under age 18, certain newborns for one year, and certain protected blind persons.</p>	<p>States must provide at least the following services when the medically needy are included under the Medicaid plans:</p> <ul style="list-style-type: none"> <li>• Prenatal and delivery services;</li> <li>• Postpartum pregnancy related services for beneficiaries under age 18 and who are entitled to institutional and ambulatory services defined in a state's plan; and</li> <li>• Home health services.</li> </ul> <p>States may include any other service described under Medicaid law subject to any limits based on comparability of services. States may provide different services to different groups of medically needy.</p>
Special Groups	<ul style="list-style-type: none"> <li>• Medicare beneficiaries.</li> <li>• Qualified working disabled individuals.</li> <li>• States may also improve access to employment, training, and placement of people with disabilities who want to work through expanded Medicaid eligibility.</li> <li>• Time limited eligibility group for women who have breast or cervical cancer and people with TB who are uninsured.</li> <li>• Long term care.</li> </ul>	<p>There are two eligibility groups related to specific medical conditions that states may include under their Medicaid plans. One is a time limited eligibility group for women who have breast or cervical cancer, the other is for people with TB who are uninsured. Women with breast or cervical cancer receive all plan services; TB patients receive only services related to the treatment of TB.</p> <p>All states provide community long term care services for individuals who are Medicaid eligible and qualify for institutional care. Most states use eligibility requirements for such individuals that are more liberal than those normally used in the community.</p>
Other	<p>States may also, under state's option, provide Medicaid to:</p> <ul style="list-style-type: none"> <li>• Children under ages 21, 20, 19 or under age 9 who are full time students;</li> <li>• Caretaker relatives or legal guardians who live with and take care of children;</li> <li>• Aged persons age 65 and older;</li> <li>• Blind persons;</li> <li>• Disabled persons; and</li> <li>• Person who would be eligible if not enrolled in a HMO.</li> </ul>	