



MEDICAID

Medicaid, also known as Title XIX of the federal Social Security Act, is the primary mechanism for financing health care for low-income Americans. Unlike Medicare, which targets the elderly and is 100% federally funded, Medicaid is administered by state governments within certain guidelines set by the federal government.

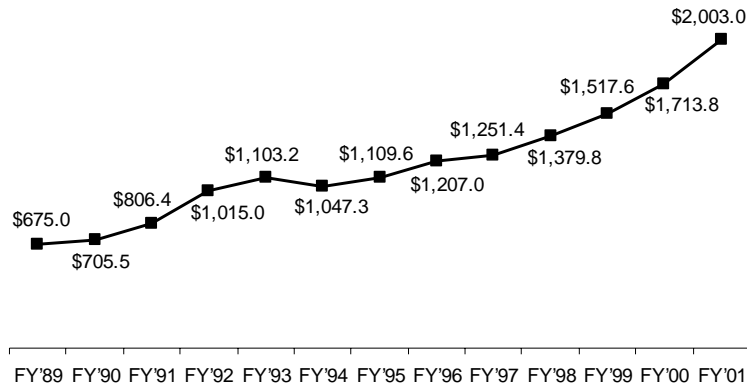
Federal law requires every state to designate a single agency to administer its Medicaid program. Since 1993, the Oklahoma Health Care Authority (OHCA) has been the designated agency in Oklahoma. Prior to that time, the Medicaid program was administered by the state Department of Human Services (DHS). DHS continues to play an important role in the Medicaid program because it certifies eligibility of recipients and operates Medicaid programs serving elderly and disabled populations.

FINANCING

Medicaid is funded through a federal-state partnership. The federal share of the program, also known as the federal medical assistance percentage (FMAP), varies by state in inverse relation to a state's per capita income. Oklahoma's per capita income increased this year, which will cause the federal FY'02 FMAP to decrease from 71.24% to 70.43%. Currently, \$1.00 in state spending on Medicaid health services will draw down an additional \$2.45 in federal funds for most Medicaid services. (The federal match for administrative expenses ranges from 50% to 90%, while some program expenditures are also eligible for matching rates of 80% to 100%).

In FY'00, the state share of the Medicaid program was just under \$464.6 million. Total program dollar expenditures were in excess of \$1.714 billion, or about 17% of total state spending for that year.

Total Medicaid Expenditures FY'89 through FY'01



In FY'01, the Medicaid budget is projected to increase to more than \$2.0 billion, with state appropriations accounting for \$501.2 million.

While OHCA is the main beneficiary of state appropriations for Medicaid, other state agencies (such as DHS, the State Department of Health, Department of Education and Department of Mental Health and Substance Abuse Services, the Office of Juvenile Affairs and the University Hospitals Authority) pay the state match for various services and programs that are covered by Medicaid. Medicaid is also partly funded by taxes on HMOs and long-term care facilities and by rebates from drug manufacturers.

MEDICAID ELIGIBILITY

Medicaid eligibility is established by DHS based on standards set by the state and federal government. Individuals are determined to be Medicaid eligible for six-month periods. Recent efforts to simplify and accelerate the eligibility process have included shortening the application form and eliminating the traditional asset test.

Covering the Uninsured

In general, Medicaid covers low-income mothers and children, the elderly, and people with disabilities. Most healthy working-age adults are ineligible for Medicaid, even if their income falls considerably below the federal poverty level. In Oklahoma, there were 423,905 Medicaid

beneficiaries in August 2000, or about 12.8% of the total population. In the mid-1990s, 28% of Oklahoma's low-income population (defined as 200% of federal poverty level and below) received Medicaid benefits, compared to the national average penetration of 32%.

Children make up two-thirds of Oklahoma's Medicaid population while the aged, blind and disabled account for about one-quarter of the population. Enrollment patterns in the Medicaid program, however, do not correspond with expenditure breakdowns. Nationally, only 20% of Medicaid program dollars are spent on children, compared to 70% that is spent to provide services for the aged, blind and disabled populations. This discrepancy reflects the fact that the aged, blind and disabled are more likely to suffer from chronic health problems which may require ongoing medical assistance, episodes of acute care, and eventually long term care.

Medicaid Recipients and Expenditures
Federal Fiscal Year 1996

<u>Percentage of Recipients</u>		<u>Percentage of Expenditures</u>	
Children	48.1	Children	20.1
Adults with Dependent Children/Pregnant Women	21.5	Adults	8.3
Disabled	15.9	Disabled	39.3
Aged	14.0	Aged	32.0
Blind	0.2	Blind	0.2
Other	0.3	Other	0.1

Recipients of AFDC/TANF

Prior to federal adoption of Welfare Reform in 1996, persons eligible for the Aid to Families with Dependent Children (AFDC) program were automatically entitled to health care coverage under Medicaid. Congress severed this automatic link by repealing the AFDC program and creating the Temporary Assistance for Needy Families (TANF) program. Now, eligibility for Medicaid is no longer tied to receipt of cash assistance. However, anyone who meets the AFDC eligibility criteria that were in effect on July 16, 1996, is still able to receive Medicaid. In Oklahoma, the AFDC eligibility threshold is 28% of the federal poverty level, or \$3,962 per year for a family of three in the year 2000. Transitional Medicaid coverage is also guaranteed for families moving off welfare for a period of up to twelve months.

Low-Income Pregnant Women and Children

While most healthy adults are ineligible for Medicaid, the past decade has seen a concerted effort by Congress and the states to improve the health of children and pregnant women. In 1994, 14.2% of children nationally and 20.6% of Oklahoma children lacked health insurance. Among low-income children, the percentage without insurance was even higher. During the early 1990s, Congress mandated a phased-in expansion Medicaid coverage for low-income children and pregnant women. This effort was superseded in Oklahoma by the passage of SB 639 (1997) and the state's Children's Health Insurance Plan.

SB 639 in 1997 increased Medicaid eligibility for pregnant women and children through age 14 to cover families whose income was up to 185% of the federal poverty level. A year later, the expanded eligibility level was expanded to cover families with children aged 15-17. Under the program, an additional 120,000 children were added to the Medicaid program in the first 30 months following implementation. Of these new enrollees, one-third were newly eligible because of the lower income threshold, and two-thirds were Medicaid eligible prior to SB 639 but had not been enrolled. Aggressive outreach by state agencies and community groups has played a large role in attracting eligible families to sign up for the program.

Concurrent with Oklahoma's initiative, President Clinton and Congress announced a \$24 billion new program known as CHIP (Children Health Initiative Plan) to encourage and assist states in insuring low-income children. The program provided enhanced federal matching funds to insure uninsured children up to 200% of the federal poverty level either through a Medicaid expansion (Oklahoma's option) or through a stand-alone CHIP program. Oklahoma is currently receiving an enhanced federal match of 80% for the Medicaid costs of children made eligible by SB 639.

Recipients of Supplemental Security Income (SSI)

SSI is a federal cash assistance program for persons who are over the age of 65, blind or disabled and poor, known as ABD. Receipt of SSI assistance automatically qualifies an individual for Medicaid. As of August 2000, there were 89,000 adult and 10,000 children ABD recipients.

Medicaid Payments for Medicare Premiums

Under 1988 federal legislation, states are required to pay Medicare premiums, deductibles and coinsurance for needy elderly and disabled persons who are dually eligible for Medicare and Medicaid. This group is known as Qualified Medicare Beneficiaries (QMBs). The payments are

cost-effective from the state's standpoint because it is less expensive to pay such out-of-pocket expenses for Medicare eligibles than it is to have them lose their Medicare benefits and fall into Medicaid eligibility.

Medically Needy Persons

As an option under the Medicaid program, Oklahoma provides short-term medical coverage for individuals who do not meet other income or need criteria but who have such high medical bills that their incomes, in effect, are reduced to an established eligibility level.

Before becoming eligible for assistance, a person must actually incur medical bills and "spend down" his or her resources to an established minimum level (\$2,000 in cash resources or on equivalent and less than \$259 a month in income). In 1998, some 13,000 Oklahomans qualified for Medicaid as "medically needy."

Health Care for Uninsured Working Families

SB 639 (1997), the maternal and child health Medicaid expansion, contained a Phase II provision that was later rescinded. In the bill, the Legislature ordered the OHCA to extend Medicaid eligibility on a cost-sharing basis to low-income adults and children with incomes up to 250% of poverty by December 1, 1998.

Unlike existing categories of Medicaid recipients, these individuals would be required to buy Medicaid coverage at a cost set on a sliding scale (based on age and income). This proposal was designed to address the consistently high numbers of Oklahomans who are not offered or cannot afford employment-based health insurance coverage and who face prohibitive premiums as purchasers of private insurance. In 1997, some 550,000 Oklahomans, or 19.2% of the state's population, were without health insurance, the eleventh highest rate in the nation.

Phase II of SB 639 was rescinded so that a joint legislative task force could be set up to examine other possible approaches to expanding health insurance coverage.

Among the options considered were expanding Medicaid eligibility for low-income working adults up to the poverty level; allowing a subsidized buy-in to Medicaid, the state employee health plan, or other insurance programs; and subsidizing employer coverage with Medicaid, CHIP or state-only funds. No action was taken on this issue in the 2000 legislative session, but access to affordable, quality health insurance seems likely to remain a major challenge for the coming years.

MEDICAID AND MANAGED CARE

In response to dramatic growth rates in the Medicaid program during the late 1980s and early 1990s, the Legislature created the Task Force on Medicaid and Welfare Reform. The task force's report recommended the transition of Oklahoma's Medicaid program from a fee-for-service type system to one based on managed care principles. As a result, in 1993 the Legislature enacted the Oklahoma Medicaid Healthcare Options Act, which directed the newly-created OHCA to develop and implement a statewide, comprehensive system of managed health care delivery for Medicaid recipients. The objectives of this system are:

- to improve both the quality of Medicaid patient care and access to care through a greater emphasis on preventive services delivered by primary care providers; and
- to control Medicaid health care costs by reducing inappropriate utilization of services (such as non-emergency visits to hospital emergency rooms) while instilling greater budget predictability by shifting cost risk to managed care organizations.

Urban vs. Rural Medicaid Options

In the Medicaid system, §1115(a) waivers allow states to implement many program components that would otherwise not be permissible under federal statutes or regulations. Within certain parameters, this permits states to create programs with features that are unique or innovative. For example, Oklahoma was granted a statewide waiver under which different programs could be established in the rural and urban areas of the state, unlike most other states in which only one managed care model was permitted. Oklahoma was given permission to establish creative integrated rural systems to test various approaches to building a rural managed care infrastructure. In addition, Oklahoma was allowed to waive the usual federal requirement that limited the composition of health plans to no more than 75% Medicaid enrollees. This enabled the State to accept certain Medicaid-only health plans, such as Heartland Health Plan, based out of the University of Oklahoma Health Sciences Center."

Urban Model: In urban areas of the state (defined as 12 counties in and around Oklahoma City, Tulsa and Lawton, with four counties to be added in January 2001), the OHCA contracts with health maintenance organizations (HMOs) to deliver a comprehensive package of benefits to Medicaid recipients in return for a "capitated," per-client monthly payment. Under this program, known as SoonerCare Plus, each recipient

is guaranteed the right to choose from multiple health plans (HMOs) and to select a primary care physician who is affiliated with the plan. This primary care physician provides a "medical home" for the recipient and serves as his or her first point of contact for services. With few exceptions, all services must be accessed within the HMO network of providers. There were some 145,000 recipients in the SoonerCare Plus program as of August 2000.

Rural Model: In rural areas (61 counties projected as of January 2001), OHCA contracts directly with primary care physicians who serve as case managers coordinating referrals for hospitalization and specialty care. Under this program, known as SoonerCare Choice, each Medicaid recipient has the right to choose a primary care physician, who receives a monthly capitation payment for each recipient under his or her care. This payment covers the cost of providing primary care – including certain lab, X-ray and emergency services, and such preventive services as immunizations and well-child screens – along with case management services, such as specialty referral and general care coordination. In rural areas, all other services – e.g., inpatient hospital care, pharmaceuticals or dental services – are paid to providers on a fee-for-service basis. There are no HMOs involved in SoonerCare Choice. There were about 138,000 recipients in the SoonerCare Choice program as of August 2000.

Schedule for Transitions to Managed Care

The Medicaid program is being transformed incrementally from fee-for-service to managed care. In addition to the separate programs for urban and rural areas of the state described above, different client groups have been scheduled to be brought into managed care at different times. This schedule, set in statute, accommodates the complications that arise in coordinating the care of the elderly and disabled, who, compared to the healthy adult and child populations, tend to access a greater number and range of medical services and have existing relationships with medical providers.

Implementation of the Medicaid managed care program has unfolded as follows:

- July 1, 1995, to June 30, 1996 – enrollment of AFDC and AFDC-related populations (low-income mothers and children) in urban areas.
- October 1, 1996 – enrollment of AFDC and AFDC-related populations in rural areas.

- July 1, 1997, to July 1, 1998 – enrollment of some 600 AFDC and AFDC-related clients identified with Special Behavioral Health Needs.
- July 1, 1999, to April 1, 2000 – enrollment of the Aged, Blind or Disabled populations (about 32,000 individuals) in both urban and rural areas, except those listed below. ABD members are served by the same HMOs (urban) or primary care providers (rural) as the AFDC-related population, but have an enhanced benefit package that stresses case management of special needs.
- July 1, 2001 (scheduled) – members of the Aged, Blind or Disabled population who are either:
 - ✓ institutionalized (nursing facilities, state institutions for the mentally retarded or mentally ill), or
 - ✓ recipients of home and community-based waived services for the developmentally disabled or elderly, or
 - ✓ dually eligible for Medicare and Medicaid, or
 - ✓ state custody children.

These categories comprise about 70,000 current recipients. The date for moving this population into managed care has been deferred several times and will likely be delayed further. Moving to managed care for this population is especially challenging because its member need both long-term care services and acute medical services, or their medical care involves multiple funding streams.

During the first four complete calendar years under managed care for the AFDC population (1996-1999), the Health Care Authority determined that the Medicaid program saved \$748.9 million over the anticipated cost without managed care. Of these savings, \$524.3 million accrued to the federal government and \$224.6 million to the state. In FY'00, capitation payments totaled \$213 million to health plans for recipients in the fully capitated urban managed care program and \$20.6 million to primary care providers in the partially-capitated rural program. In total, capitation payments accounted for roughly 14% of the total Medicaid budget.

Oklahoma 2001 Healthcare Initiative

The 2000 Legislature voted to spend \$36 million of national tobacco settlement revenue for the Oklahoma 2001 Healthcare Initiative. The Medicaid program received an appropriation of \$32.8 million of this sum. This allocation of tobacco settlement funds, with its promise of nearly \$2.50 in matching federal funds for every state dollar, aimed to

bring Medicaid reimbursement levels closer to rates paid by Medicare and private insurance, and to bolster the state's health care infrastructure.

The bulk of spending went toward provider rate increases in the fee-for-service program and increased capitation rates for managed care. In addition to rate increases of 18% for physicians and other medical practitioners and 12% for hospitals, beneficiaries included dentists (60%), ambulance services (40%), behavioral health counselors (10%), and providers of home health services to the elderly and disabled (hourly wage increases of 13% to 15%). Funding was also provided to extend coverage of inpatient hospital stays from 12 to 24 days and broaden eligibility for the state's home- and community-based waiver for developmentally disabled individuals without cognitive impairment.

SERVICES PROVIDED BY MEDICAID

Unlike Medicare, which charges its recipients monthly premiums and includes co-pays and deductibles, Medicaid is a system of essentially free health insurance coverage for eligible beneficiaries. However, Medicaid involves some cost to clients: providers can charge co-payments for certain services (e.g., \$1 for doctors' visits or prescription drugs), and nursing home residents must "spend down" their own resources to a certain level before Medicaid begins paying their bills.

Mandatory Services

State Medicaid programs must, under federal law, offer certain services to qualify for federal funding, including:

- inpatient and outpatient hospital care;
- physician services;
- medical and surgical dental services for children (adults are covered only for reconstructive dental surgery);
- mental health services for children;
- nursing facility services;
- home health care for persons eligible for nursing home care;
- family planning services and supplies;
- laboratory and X-ray services;
- pediatric and family nurse practitioner services;
- nurse-midwife services;
- transportation;

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, a program for regular check-ups and services for children under the age of 21; and
- community health services.

Optional Services

Oklahoma policymakers have chosen to cover the following optional services under Medicaid:

- prescription drugs;
- mental health services for adults;
- non-emergency transportation services;
- Intermediate Care Facilities for the Mentally Retarded (ICFs/MR);
- tuberculosis-related services;
- rehabilitative Services;
- targeted case management services;
- medical nutritional therapy; and
- community-based programs for the elderly poor and the disabled who are at-risk of institutionalization (Long-Term Care below).

Caps on Medicaid Services

In order to control spiraling costs in the early 1990s, Medicaid benefits were capped for certain services. Coverage was limited to three prescription drugs and one doctor's visit per month (a limit of twelve hospital inpatient days was lifted as part of the Oklahoma 2001 Healthcare Initiative). These restrictions do not apply to participants in health maintenance organizations in the urban managed care program, to children, to residents of nursing facilities and other institutions, or to participants in the ADvantage and Home and Community-Based Waiver programs.

Long-Term Care

Medicaid is the nation's primary insurer of long-term health care services for individuals with chronic, non-acute needs. In fact, about 70% of all residents in Oklahoma nursing homes are Medicaid clients. Long-term care services range from personal care, rehabilitative therapies, chore services, and home-delivered meals to durable medical equipment and environmental modification. With the graying of the baby-boom generation and advances in medical technology contributing to a rapidly expanding senior population, providing adequate and affordable long-term care will be one of the great challenges confronting state and federal policy makers in the new century.

Medicaid payments for long-term care falls into two general categories:

Institutional Care: This includes such facilities as nursing homes, Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), or state hospitals for the mentally retarded. The state pays private institutional providers a per diem to cover the full range of patients' needs, including room and board. Part of the revenue for nursing homes and ICFs/MR payments is raised by daily per-bed fees imposed on all licensed facilities, which are matched with federal funds.

Home- and Community-based Programs: Through several Medicaid waivers administered by DHS, the state contracts with private agencies to provide needed services set out in an individual care plan. The largest waiver programs are the Home-and-Community Waiver for the developmentally disabled and the ADvantage Waiver for the aged and disabled. All 50 states have developed waivers as a way to allow those who do not need 24-hour nursing care to live fuller, more independent lives outside of institutions.

Eligibility for Medicaid long-term care services is based on a combination of medical and financial criteria. Medically, individuals must be certified as needing a "nursing home level of care" to be eligible either for institutional placement or participation in one of the long-term care waivers. Financially, Medicaid recipients' incomes must be below 300% of the SSI eligibility threshold, which translates to monthly income of roughly \$1,500 per person and \$2,000 in non-exempted assets.