

OMAP Appendix D

How Traditional Medicaid Works

OMAP Appendix D is a background discussion of the federal Medicaid program, how it operates, how it is growing and why.

What is Medicaid?

Medicaid (Title XIX of the Social Security Act) is a federal entitlement program that pays health care expenses for the poor.

How is the Medicaid program paid for?

The current federal match rate is 61.12 percent. For every program dollar spent, 61.12 cents are federal funds and 38.88 cents are State funds.

The federal match rate is adjusted annually according to a formula that compares a state's per capita income to the national average.

There currently is no cap on the total expenditure that may be reimbursed by the federal government for allowable state Medicaid program expenditures.

How must the program be administered?

Federal law requires that a single state agency administer the Medicaid program. The Department of Human Services is that agency in Oregon.

Federal law only allows certain governmental agencies to determine an individual's eligibility for benefits. The agencies permitted to determine eligibility are agencies that administer public assistance (welfare) programs. In Oregon, DHS Children, Adults and Families and DHS Seniors and People with Disabilities offices are mainly responsible for determining Medicaid eligibility.

Who must be served?

The following groups are entitled to Medicaid:

- ◆ Families receiving Temporary Assistance for Needy Families (TANF) payments
- ◆ Children in foster care if maintenance payments are made from federal funds (Title IV-E)
- ◆ Pregnant women and children under age 6 with family income under 133 percent of the federal poverty level
- ◆ Children ages 6 to 19, with family income up to 100 percent of the federal poverty level
- ◆ Aged, blind, and disabled persons receiving supplemental security income (SSI)
- ◆ Emergency medical services for certain aliens
- ◆ Low-income Medicare beneficiaries (below 135 percent of the federal poverty level) are entitled to have their Medicare premiums (SLMB) and co-payments paid for by Medicaid (QMB).

Other groups may be covered at the state's option. Oregon covers the following groups:

- ◆ Persons in nursing facilities or home- and community-based care who do not receive SSI, with income up to 300 percent of the SSI level
- ◆ Women who have been screened for breast or cervical cancer, under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program, and who need treatment, including a pre-cancerous condition of the breast or cervix.
- ◆ Pregnant women with family income between 133 and 185 percent of the federal poverty level.

- ◆ The Seniors and People with Disabilities Employment Initiative is a program that removes barriers to employment for low-income persons with disabilities. Participants are supported in their effort to work by maintaining necessary levels of public support. This enables participants to be more independent at the same cost to the state, or less.

Certain medical services must be covered

Federal law requires certain types of medical services must be covered for most Medicaid beneficiaries:

- ◆ Inpatient and outpatient hospital care (excluding inpatient services for mental disease);
- ◆ Services of physicians, certified nurse practitioners, and nurse midwives;
- ◆ Rural, migrant and community health centers (*e.g.*, Federally Qualified Health Centers);
- ◆ Early periodic screening, diagnosis and treatment for children under age 21;
- ◆ Family planning services and supplies;
- ◆ Nursing facility and home health services;
- ◆ Laboratory and x-ray services;
- ◆ Pregnancy related services or other conditions that might complicate pregnancy;
- ◆ Transportation to medical care (both emergency and non-emergency).

Optional services

States may also get federal funds for optional services provided to Medicaid adult beneficiaries:

- ◆ Dental care;
- ◆ Prescription drugs;
- ◆ Prosthetic devices;
- ◆ Physical, occupational, and speech therapies;
- ◆ Chiropractic and naturopathic services;
- ◆ Organ transplants;
- ◆ Case management services;
- ◆ Optometry/ophthalmology services and eye glasses;
- ◆ Services in institutions for the developmentally disabled;
- ◆ Home- and community-based care services;
- ◆ Rehabilitative and clinic services, including mental health and chemical dependency services;
- ◆ Hospice services.

Additional federal requirements

- ◆ Federal laws and regulations require a statewide program.
- ◆ Generally, all covered Medicaid services must be available to all Medicaid beneficiaries.
- ◆ Children may be covered for more services than adults.

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- ◆ Medicaid beneficiaries must be allowed freedom to choose among medical providers. Oregon received waivers of this provision to operate a managed care program even before the Oregon Health Plan was implemented.
- ◆ The state is not permitted to deny, reduce, or limit services based on type of illness or condition. Oregon received waivers of this provision to operate with the Health Services Commission’s prioritized list.
- ◆ The state must provide a “reasonable” amount of any Medicaid service that it covers.
- ◆ Payments to medical providers must be sufficient to ensure that providers will serve Medicaid beneficiaries.