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MEDICAID

Title XIX of the Social Security Act is the statutory provision that created Medicaid, a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low income and resources. One of its crucial roles is the financing of health and long-term care services for low-income individuals with disabilities. According to the Congressional Budget Office, Medicaid is the single largest source of health care financing—public or private—in the United States. Currently Medicaid covers approximately 36 million individuals.

Medicaid became law in 1965 as a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible and needy persons. The services that Medicaid covers in most states, ranging from health services to personal attendant care to prescription drugs, are often critical to the ability of individuals to improve their capacity to function and become self-sufficient. Medicaid is also the primary public payer for long-term care, particularly in nursing homes. Medicaid's eligibility rules and benefits are generally structured to provide coverage for those with high levels of medical need and low income and assets.

■ ELIGIBILITY

Three basic groups are eligible for Medicaid:

- Low-income children and low-income parents with children;
- Adults aged 65 and older who are receiving cash assistance through the Supplemental Security Income Program (SSI); and
- People who are disabled, most of whom are eligible because they are receiving cash assistance through the SSI program. The remainder generally qualify

because they have incurred large medical expenses (i.e., hospital, prescription drugs, nursing home charges) thereby meeting their “spend down” obligation.¹

Many people carry the misconception that Medicaid provides medical assistance to all poor persons. Even under the broadest provision of the Federal statute, Medicaid only becomes available to the very poor if they qualify for one of the groups specified by law.

In general, an individual must be an American citizen or a legal alien, meet state income or resource standards, and fit into a covered eligibility category. A person who is disabled, as defined by the Social Security Act, fits into a covered eligibility category.

The Social Security Act defines disability as “the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.”

■ SERVICE COVERAGE

Federal guidelines require coverage of a broad range of basic services. These include:

- Hospital care (inpatient and outpatient);
- Nursing home care;
- Physician services;
- Laboratory and X-ray services;
- Family planning services;
- Health center (FQHC) and rural health clinic (RHC) services; and
- Nurse practitioner services.

States also have the option of covering additional services and receiving federal matching funds for those services, which includes:

- Prescription drugs;
- Personal care and other community-based services for individuals with disabilities;
- Dental and vision care for adults;
- Diagnostic services;
- Clinic services;

¹ The Medicaid Act allows states to offer “medically needy” programs. A majority of the states have elected this option, thereby allowing individuals to spend down their incomes on necessary medical and remedial expenses as well as on premiums, deductibles, and co-payments charged or fixed by Medicare and other health insurance. Within these federal guidelines, states have considerable flexibility in establishing their own financial eligibility criteria.

- Transportation services; and
- Rehabilitation and physical therapy services.

Within broad federal guidelines and certain limitations, states are given the responsibility of deciding the amount to be spent and duration of services offered under a Medicaid program, subject to the following restrictions:

- A sufficient level of services must be provided to reasonably ensure the purpose of the benefits; and
- A limitation on a particular program may not have the effect of discriminating among beneficiaries based on medical diagnosis or condition.

Under Sec. 1915 of the Social Security Act, States may also request “waivers” to pay for otherwise uncovered home and community-based services (HCBS) for Medicaid eligible persons who might otherwise be institutionalized. As long as these services are cost-effective, states have few restrictions on the services that may be covered.

Six services may be provided under this program, namely:

- Case management;
- Homemaker/home health aide services;
- Personal care services;
- Adult day health;
- Rehabilitation; and
- Respite care.

States have the flexibility to design each waiver program and select a combination of waiver services that best meets the needs of the population they wish to serve. HCBS waiver service may be provided statewide or may be limited to specific geographic subdivisions. States may also target specific illnesses, such as children with AIDS.

■ MEDICAID AND MANAGED CARE

States have become increasingly reliant on managed care programs to contain rising Medicaid costs and to improve quality of care. In 1991, only 1 percent of the Medicaid population was enrolled in managed care. By 2000 that figure had risen to 54 percent, or 16.8 million beneficiaries. Forty-eight states and the District of Columbia now operate at least one managed care program.

Medicaid managed care typically means that a state Medicaid program will contract with a private managed care company to provide health care for Medicaid

recipients. The promise is that Medicaid recipients are no longer forced to rely on government clinics or the emergency room of a hospital to obtain health care. By placing Medicaid recipients in the private system, they become indistinguishable from privately insured patients.

One of Medicaid's crucial roles as a safety net program is the financing of health services for low-income individuals with disabilities. About one of every six persons on Medicaid can be classified as a "younger" person with a disability—that is, a child or an adult under age 65 who qualifies for Medicaid coverage because of a disability. Because people with disabilities are a costly population to serve, state Medicaid programs have encouraged enrollment of younger persons with disabilities into their managed care programs.

The state managed care programs generally fall into one of two classifications: Primary Care Case Management (PCCM) program and MCO program on a capitated basis.

Primary Care Case Management

Primary Care Case Management is a Medicaid care delivery model that lies between FFS and risk-based managed care. It builds on the standard managed care model by matching beneficiaries with PCPs who coordinate care for the enrollee and who serve as gatekeepers for specialty and other services. Primary care providers who participate in the PCCM program generally receive a monthly management fee, with services paid on a FFS basis. Unlike capitated managed care, the provider is not at financial risk for the services provided.

The advantage of the PCCM program is that beneficiaries with disabilities can benefit from the careful management expected from the PCP. Medicaid beneficiaries consume a sizable share of Medicaid dollars and are frequent users of health services. Any mechanism that can provide better continuity and coordination of care could improve health care for this population.

The disadvantage of the PCCM program is that it restricts choice by placing access to specialists within the purview of the primary care provider/gatekeeper. Another problem is that the beneficiary's previous PCP might not be part of the plan's network of providers. This may require Medicaid beneficiaries to see a new PCP who is unfamiliar with their histories.

Managed Care Organizations on a Capitated Basis

MCOs on a capitated basis is a health care organization (i.e., an HMO) that receives a fixed amount in consideration for making available specified health services to a covered Medicaid beneficiary.

Providing health plans for a lump sum creates incentives to furnish care efficiently and to invest in resources that could prevent costly hospitalizations and emergency room use. This arrangement is intended to promote better disease and disability management and, because the amount received is fixed, there is incentive to use monies more creatively.

On the downside, capitated plans use a network of medical providers, making it likely that some of a beneficiary's previous providers will not be included in the plan. This may cause individuals to sever their relationship with a provider who is not part of the network, creating considerable discontinuity in treatment.

Employment and Medicaid

Many individuals with disability rely on Medicaid coverage that comes with SSI for their health insurance. Given the choice of not working, or working fewer hours, and retaining SSI eligibility and Medicaid versus earning a higher income, becoming SSI ineligible, and losing coverage, most recipients would invariably choose to work fewer hours. To counteract this work disincentive, options have been developed for SSI recipients that provide work incentives and allow recipients to continue their Medicaid eligibility.

Earned Income Exclusion

This program allows a portion of a person's salary to be excluded when figuring the SSI payment amount. Up to \$85/month of income has no impact on the SSI check. After that, the check is reduced \$1 for every \$2 one earns.

For example, Joe Smith earns \$553 in earned income.

\$ 553	Earned Income
<u>– 85</u>	Disregarded income
\$ 468	Divided by 2 = \$234 (countable income)
\$ 630	SSI benefit (varies by state)
<u>– 234</u>	Income to be deducted
\$ 396	Monthly SSI check

Impairment-Related Work Expenses

This incentive allows an SSI recipient to deduct from his/her earnings any disability-related expenses that are necessary to maintaining a job, such as personal care assistance or special transportation costs.

Plan for Achieving Self-Support (PASS)

Under the PASS program, one can save for or set aside SSI or other income for work goals, such as education, vocational training, purchase of adaptive equipment, etc. Plans are reviewed every 12 months.

Section 1619b Continued Medicaid Eligibility

This incentive allows individuals to keep Medicaid insurance even if their earnings become too high to continue receiving SSI benefits. If one needs Medicaid in order to work, Medicaid benefits will continue until the individual's annual income is greater than a state threshold level. In 2001 this threshold level ranged from \$16,467 in Arkansas to \$34,036 in Arizona.

Ticket to Work and Work Incentives Improvement Act

The Ticket to Work and Work Incentives Improvement Act allows states to make the following changes to Medicaid:

- Expand Medicaid availability to individuals between the ages of 16 and 64 who, because of income earned from work, are ineligible to receive SSI; and
- Extend Medicaid to employed persons with disabilities whose medical condition has improved, but who have continued to have a "severe medically determinable impairment" as defined by the federal Health and Human Services Regulations.

The decision to make these changes to Medicaid is determined by each state. The status of a state's legislation pursuant to this Act can be provided by its Department of Insurance.

Persons in states exercising these options, who previously would not have qualified for Medicaid now:

- Are permitted to buy into Medicaid coverage by paying premiums and other cost-sharing charges on a sliding fee-scale based on income.
- May be required by the state to pay the full premium if their incomes exceed 250 percent of the federal poverty level.
- Are guaranteed that premiums may not exceed 7.5 percent of income if their incomes are between 250 percent and 450 percent of the federal poverty level.

For individuals with annual adjusted gross incomes (as defined by the Internal Revenue Service) exceeding \$75,000, states are required to charge 100 percent of the premiums imposed. However, the statute does permit states to subsidize the premium cost for individuals using state funds.