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Briefing Material
Oklahoma Medicaid and Its Funding Mechanisms
March 1992

Prepared by

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Office of Management Services
Medical Services Division

What is Medicaid?

Medicaid is a federally supported program that provides health care to persons based on specific eligibility criteria.

The Medicaid program was created by Title XIX of the Social Security Act of 1965.

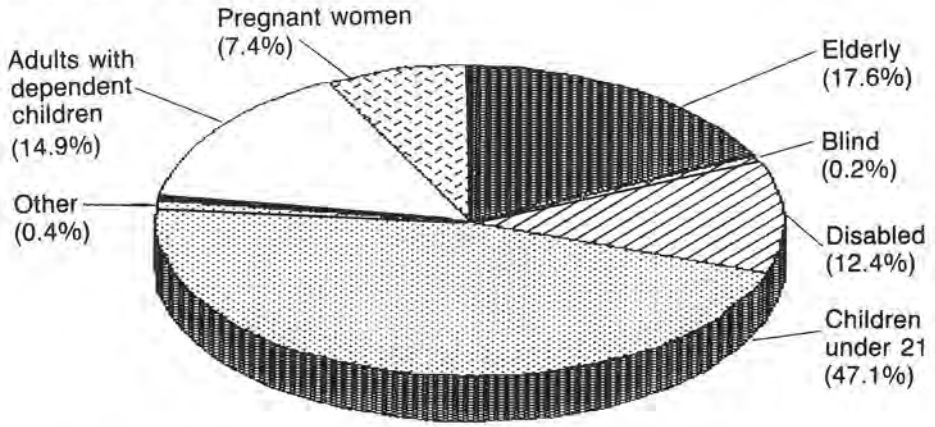
In Oklahoma, the Medicaid program is administered by the Oklahoma Department of Human Services.

Who is eligible for Medicaid?

Medicaid provides health care to income-eligible persons who are:

- Blind
- Elderly
- Disabled
- Pregnant
- Children under 21
- Adults with dependent children

Oklahoma Medicaid Recipients by Category
Federal Fiscal Year 1991



Children under 21—143,424
Elderly—53,629
Adults with dependent children—45,481
Disabled—37,876
Pregnant women—22,569
Other recipients—1,045
Blind—635

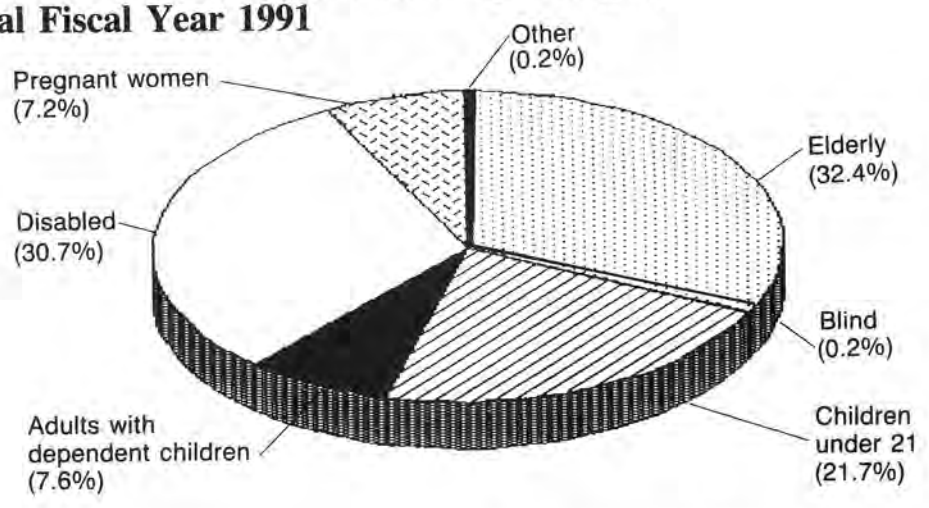
Source: Health Care Financing Administration (HCFA-2082)

Who are the main beneficiaries of the Medicaid program?

Although children under 21 represent almost 50 percent of the recipients, services to the elderly and the disabled represent over 60 percent of expenditures.

	Federal Fiscal Year 1991		
	Percentage of Expenditures vs. Recipients		Average Expenditure Per Recipient
Elderly	32%	18%	$ 4,915
Disabled	31%	12%	6,606
Children under 21	22%	47%	1,231
Adults with dependent children	8%	15%	1,360
Pregnant women	7%	7%	2,616
Blind	0.2%	0.2%	2,659
Others	0.2%	0.3%	1,340

Oklahoma Medicaid Expenditures by Category
Federal Fiscal Year 1991



Elderly—$263.6 million
Disabled—$250.2 million
Children under 21—$176.5 million
Adults with dependent children—$61.8 million
Pregnant women—$59.0 million
Blind—$1.7 million
Other recipients—$1.5 million

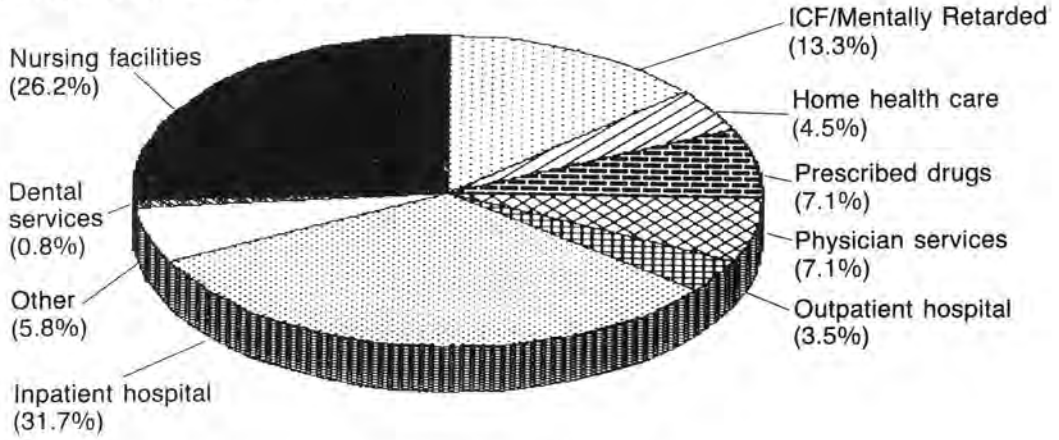
Source: Health Care Financing Administration (HCFA-2082)

What services are covered by Medicaid?

Medicaid provides coverage of:

- Hospital and clinic visits
- Doctor and dentist visits
- Child health screening
  —Vision
  —Dental
  —Hearing
  —Immunizations
- Prescription drugs
- Nursing home care
- In-home health care
- Services for the mentally retarded
- Family planning
- Psychiatric care
- Lab and X-ray services
- Medical care transportation services

Oklahoma Medicaid Expenditures by Type of Service
Federal Fiscal Year 1991



Inpatient hospital—$258.4 million
Nursing facilities—$213.5 million
ICF/Mentally Retarded—$108.6 million
Prescribed drugs—$58.1 million
Physician services—$58.0 million
Other—$46.1 million
Home health care—$36.5 million
Outpatient hospital—$28.4 million
Dental services—$6.9 million

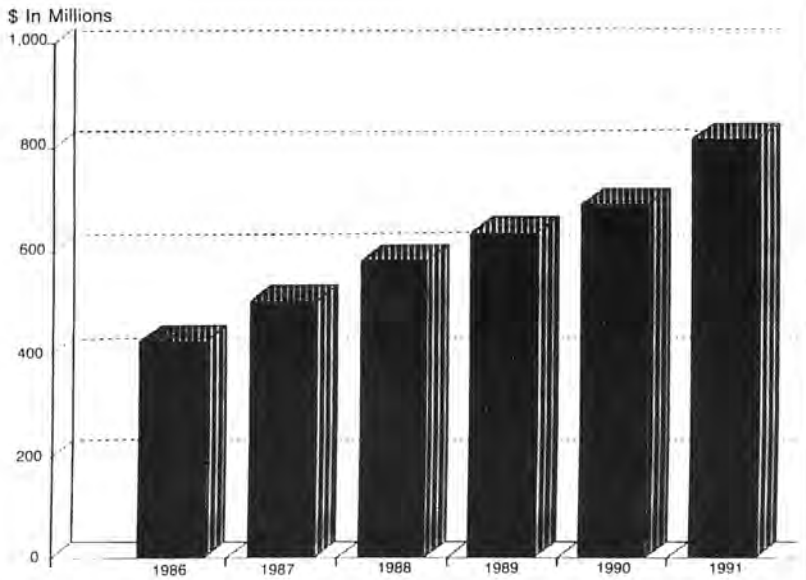
Source: Health Care Financing Administration (HCFA-2082)

Why have Medicaid expenditures escalated?

Medicaid expenditures have escalated by 93 percent since 1986 due to increases in the:

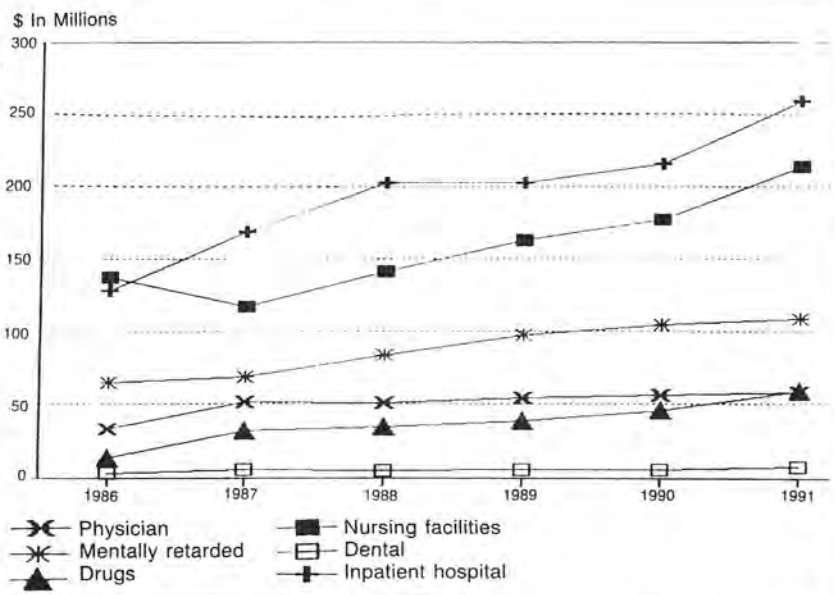
- Number of persons eligible for Medicaid services:
  - —26 percent increase in number of Medicaid recipients
  - —Additional federally mandated eligibility groups
- Types of services covered by the Medicaid program:
  - —Federally mandated program expansions
- Health care costs for Medicaid services:
  - —Health care inflation growth at twice the rate of the consumer price index

Oklahoma Medicaid Service Expenditures Federal Fiscal Years 1986-1991



Sources:
1986-1990—Pharmaceutical Benefits Under State Medical Assistance Program
1991—Health Care Financing Administration (HCFA-2082)

Oklahoma Medicaid Service Expenditures By Type of Service Federal Fiscal Years 1986-1991



Sources:
1986-1990—Pharmaceutical Benefits Under State Medical Assistance Program
1991—Health Care Financing Administration (HCFA-2082)

How is the Medicaid program funded?

Funding of the Medicaid program is shared by the states and the federal government.

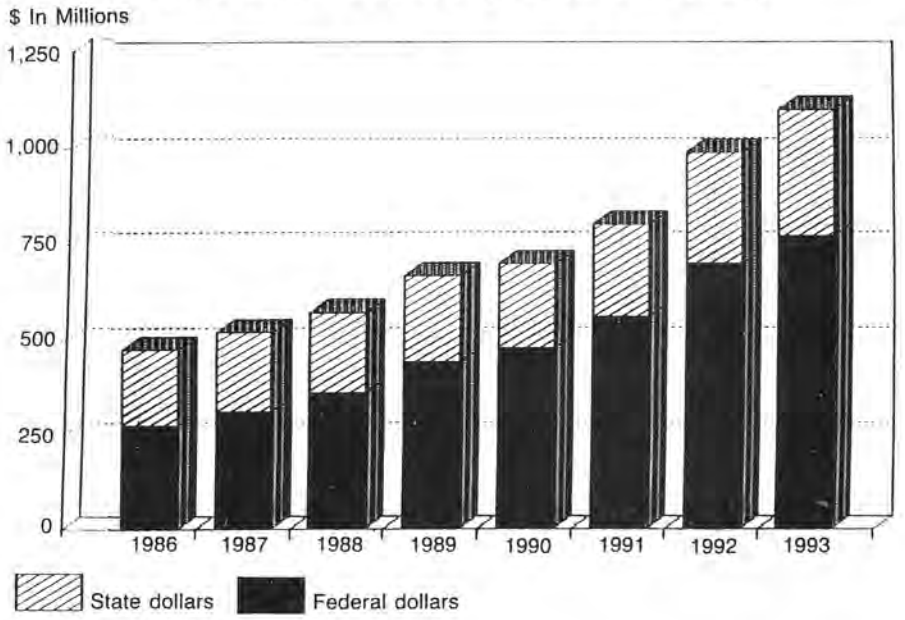
The percentage of funds provided by the federal government is called the Federal Medical Assistance Percentage (FMAP) or federal match.

The formula used to establish the federal match rate is designed to provide a higher percentage of federal dollars to states with lower per capita incomes and a lower percentage to states with higher per capita incomes.

By law, the federal match rate may range from 50 percent to 83 percent.

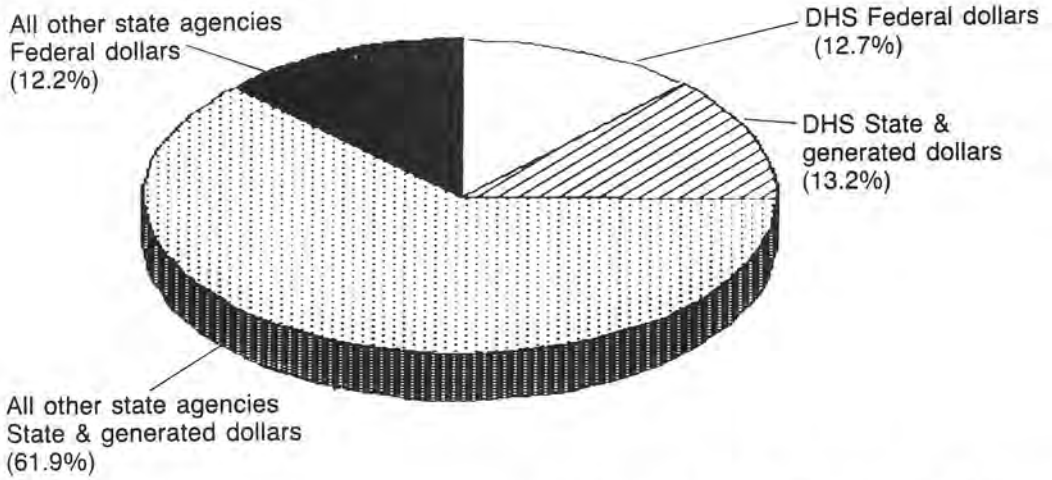
Oklahoma federal match rates: 1991—69.65 percent
1992—70.74 percent
1993—69.67 percent

Oklahoma Medicaid Service Expenditures
State Fiscal Years 1986-1991 (Projected 1992-1993)



Source: DHS Finance Division

State of Oklahoma Budget—Total Source of Funding State Fiscal Year 1991

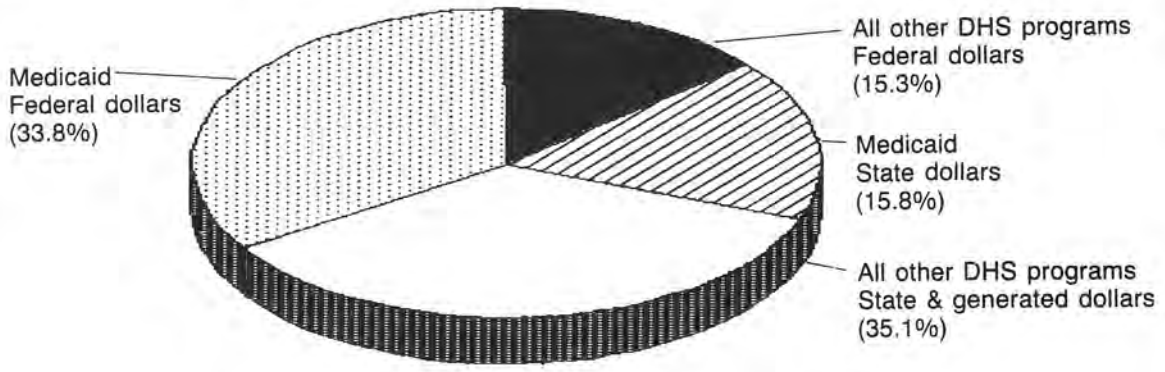


All other agencies state
& generated dollars—$4,189.1 million
DHS state & generated dollars—$892.5 million

All other agencies federal dollars—$825.3 million
DHS federal dollars—$861.5 million

Source: DHS Finance Division

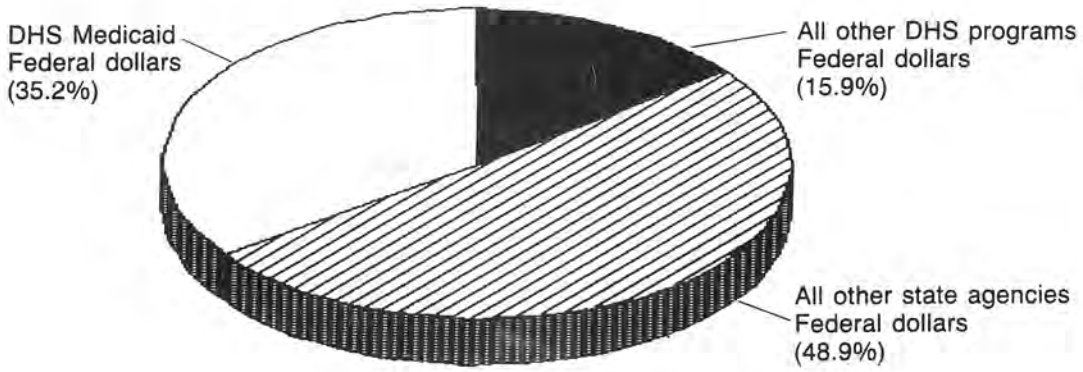
Oklahoma DHS Budget—Total Source of Funding State Fiscal Year 1991



Medicaid federal dollars—$593.4 million
All other DHS programs federal dollars—$268.0 million
Medicaid state dollars—$277.5 million
All other DHS programs state & generated dollars—$615.0 million

Source: DHS Finance Division

State of Oklahoma Budget—Total Federal Dollars
State Fiscal Year 1991



All other state agencies federal dollars—$825.3 million
DHS Medicaid federal dollars—$593.4 million
All other DHS programs federal dollars—$268.0 million

Source: DHS Finance Division

What is the impact of increased Medicaid expenditures on DHS?

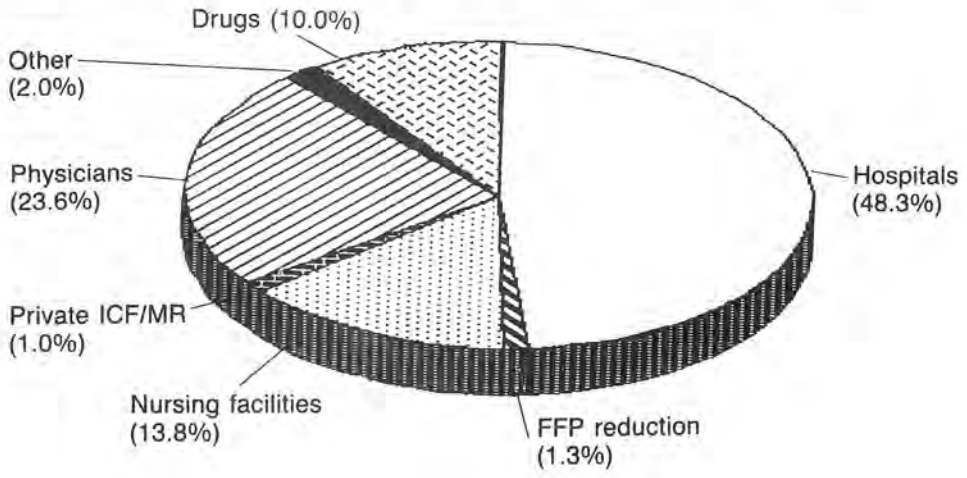
The following information compares the Governor's proposed budget allocation of funds in excess of the DHS state fiscal year 1992 base with the DHS budget request for program maintenance for state fiscal year 1993.

The DHS projected budget needs for state fiscal year 1993 as of Mar. 1, 1992:

	In Millions of Dollars		
Medicaid Services	DHS Request	Governor's Budget	Difference
Hospitals	$ 25.9	$ 2.8	$ 23.1
Nursing Facilities	6.9	0.3	6.6
Private ICF/MR	0.6	0.1	0.5
Physicians	12.3	1.0	11.3
Drugs	5.1	0.3	4.8
Change in Fed. Financial Participation	5.6	5.0	0.6
Other	6.4	5.5	0.9
Medicaid Total	**62.8**	**15.0**	**47.8**
All Other DHS Programs Total	**61.5**	**25.6**	**35.9**
Total	**$ 124.3**	**$ 40.6**	**$ 83.7**

Source: DHS Finance Division

Oklahoma Medicaid Budget Needs by Category
State Fiscal Year 1993, as Projected on March 1, 1992



Source: DHS Finance Division

Oklahoma Medicaid Funding Solutions

- Reduce the number of persons eligible for Medicaid services
- Reduce the types of services covered by the Medicaid program
- Reduce payments to providers for Medicaid services
- Increase state and federal Medicaid revenues

Who would be affected by a reduction in Medicaid eligible recipients?

By state option, Oklahoma has extended eligibility to two groups: the categorically needy who do not receive a cash payment and the medically needy.

Elimination of these two groups of eligibles in federal fiscal year 1991 would have eliminated:

	Recipients	Expenditures
Categorically needy		
Not receiving cash payments	52,186	$407.1 million
Medically needy	13,578	35.9 million
Total	**65,764**	**$443.0 million**

Who would be affected by a reduction in Medicaid eligible services?

By state option, Oklahoma has extended eligibility for services to include the following types of services: pediatric skilled nursing facilities, intermediate care facilities for the mentally retarded, dental services, mental hospital services for the elderly or children, prescription drugs, waivered services, non-technical medical care and clinic services.

Elimination of these services in federal fiscal year 1991 would have:

	Affected Recipients	Reduced Expenditures
Categorically needy		
Receiving cash payments	195,077	$125.3 million
Not receiving cash payments	52,186	140.1 million
Medically needy	13,578	24.3 million
Total	**304,659**	**$289.7 million**

Who would be affected by a reduction in Medicaid provider payments?

During December 1991, DHS paid Medicaid claims of $83 million to more than 14,000 providers in Oklahoma and neighboring states including:

Inpatient hospitals	242
Outpatient hospitals	253
Pharmacies	837
Physicians	4,883
Dentists	487
Optometrists	344
Other practitioners	309
Medical suppliers	340
Non-technical medical care	5,876
Nursing facilities	382
Lab and X-ray services	212

How are state and federal Medicaid revenues increased?

Under a new federal law, states may use health care provider fees to fund a portion of the Medicaid program. Revenues generated by health care provider fees may not be used to fund more than 25 percent of the state share of Medicaid expenditures.

Each state dollar generated through health care provider fees, which is used as the state share of Medicaid expenditures, will return more than two federal dollars to the state.

What are health care provider fees?

Health care provider fees are fees, assessments or charges which:

- Apply at least 85 percent of the burden to health care providers
- Are broad-based:
  - —Must apply to entire classes of providers
  - —Must be uniform
- Do not include a hold-harmless provision:
  - —Cannot guarantee offset or waiver of charges to providers
  - —Cannot guarantee payment except under the Medicaid program
  - —Cannot vary payment based solely on charges paid to providers

Who would be included in health care provider fees?

The new federal law defines classes of providers in terms of services offered.

Eligible classes of providers include:

- Inpatient hospital services
- Outpatient hospital services
- Nursing facility services
- Intermediate care facilities for the mentally retarded
- Physicians' services
- Home health care services
- Outpatient prescription drugs
- HMO services

A permissible fee may include one or several classes of providers.

What types of fees could be assessed?

Assessments could include:

- License fees:
  Examples:
  —Hospital facility license fees
  —Nursing home bed license fees
  —Physician license fees
- Receipts or sales charges:
  Examples:
  —Hospital gross receipts
  —Pharmaceutical sales
- Unit assessments:
  Examples:
  —Assessment per patient day
  —Assessment per prescription

Are other states using health care provider fees?

Every state is considering or implementing a provider fee program. Twenty-five states are currently using health care provider fees to fund their Medicaid programs. However, only four of these states have broad-based programs. These four states are:

New York

- 5.5 percent charge on all hospital bills paid by third-party payors, such as insurance companies

  Will generate $6.7 billion annually
- 0.6 percent charges on all revenue of health care providers except individual practices, such as private physicians' offices

  Will generate $200 million annually

Maine

- 6 percent gross receipts charge on all hospital revenue

  Will generate $83 million annually

New Hampshire

- 8 percent gross receipts charge on all hospital revenue

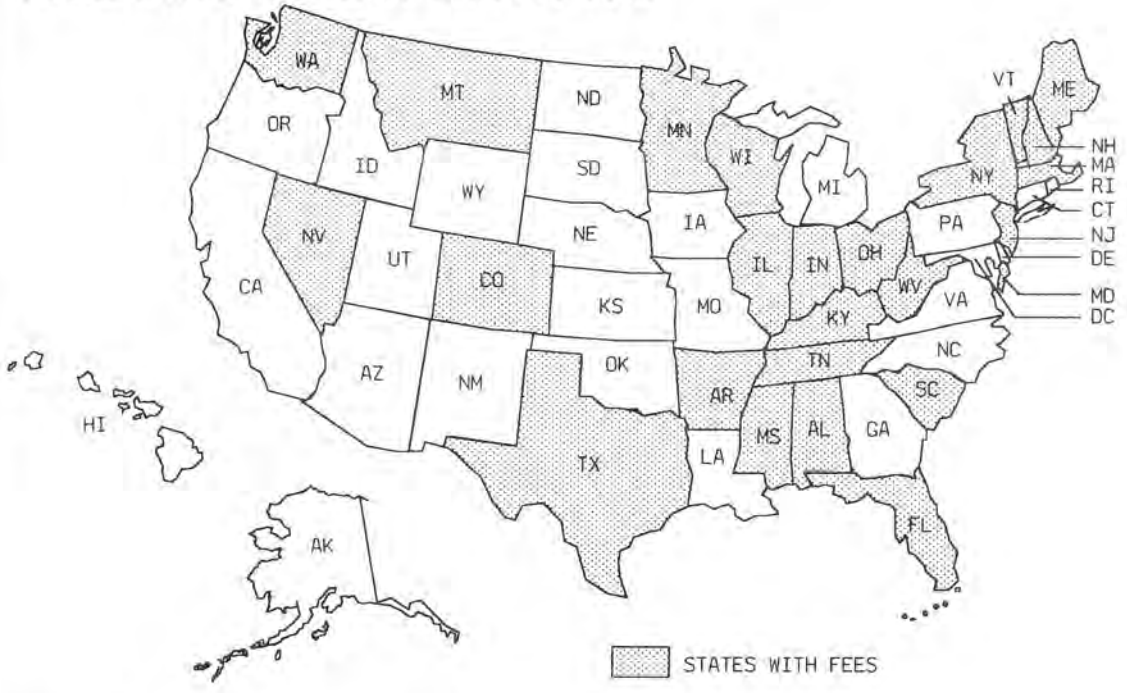
  Will generate $214 million annually

Florida

- 1.5 percent charges on net revenue of all hospitals

  Will generate $175 million annually

States with Health Care Provider Fees



Source: DHS Office of Management Services

How much revenue could Oklahoma generate through health care provider fees?

The new federal law limits the use of provider fees to 25 percent of the state share of Medicaid expenditures.

Provider fee programs in use by Florida, Maine and New Hampshire are based on net and gross receipts of all hospitals.

Oklahoma hospitals:	Gross Operating Revenues:	$3.4 billion annually
	Net Operating Revenues:	$2.3 billion annually

If Oklahoma implemented provider fee programs similar to those in use by Florida, Maine and New Hampshire, revenues for Oklahoma would be:

- $272 million—8 percent gross hospital receipts charge (New Hampshire)
- $204 million—6 percent gross hospital receipts charge (Maine)
- $35 million—1.5 percent net hospital receipts charge (Florida)

What happens if the health care provider fee is implemented?

For every state dollar generated by health care provider fees which is used for Oklahoma's share of Medicaid expenditures, two dollars will be returned to the state in federal matching funds.

Health care providers will have to meet the additional costs by:

- Reducing profits
- Cost containment

To avoid further distress on health care providers, additional revenues can be used to:

- — Supplement the DHS budget to eliminate the Medicaid shortfall
- — Reduce cost shifting to Medicaid and other insurances by improving Medicaid payments on behalf of health care consumers

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