



**Medicaid 101 Intensive:
*Everything You Wanted to Know About Medicaid***

.....but were afraid to ask

**National Association of States
United for Aging and Disabilities**

August 28, 2017

Welcome to the HCBS Conference

- HCBS is the premiere national conference on LTSS, including Medicaid, the Older Americans Act, and a broad array of programs, services, and supports for older adults and people with disabilities
- Hosted by the National Association of States United for Aging and Disabilities
 - Learn more at: www.nasuad.org
- Don't forget to sign up for:
 - NASUAD's Friday Update: a weekly electronic newsletter that consolidates the federal level news on aging and disability policy
 - <http://www.nasuad.org/newsroom/friday-update>
 - The State Medicaid Integration Tracker: a bi-monthly publication that highlights state LTSS activities, including managed care, health homes, and other important program adoptions and changes
 - <http://www.nasuad.org/initiatives/tracking-state-activity/state-medicaid-integration-tracker>

Today's Agenda

- Section 1: Overview & History of Medicaid
- Section 2: How Medicaid is Administered
- Section 3: Overview of Eligibility
- Section 4: Overview of Services
- Section 5: Medicaid Payments
- Section 6: Medicaid Payment Integrity
- Section 7: Medicaid Waivers
- Section 8: Medicaid LTSS
- Section 9: Managed Care and LTSS
- Section 10: Changing Winds - Current Issues in Medicaid
- Open Q&A with Panelists

Learning Objectives

- Improve knowledge of key features, terminology, and concepts underlying Medicaid;
- Understand Medicaid's key policy, fiscal, and operational components;
- Increase knowledge of Medicaid's LTSS coverage and options;
- Understand Managed Care and Managed LTSS; and
- Provide a solid foundation for HCBS conference attendees to get the most out of Medicaid and LTSS sessions.

Introduction to Speakers

- Jerry Dubberly, Myers and Stauffer LC (Formerly GA Medicaid)
- Barbara Edwards, Health Management Associates (Formerly OH Medicaid & CMS)
- Gary Jessee, Sellers Dorsey (Formerly TX Medicaid)
- Ann Kohler, Marwood Group (Formerly NY, NJ Medicaid)
- David Parrella, Last Best Hope Consulting (Formerly CT Medicaid)
- Dennis Smith, University of Arkansas for Medical Sciences & Special Advisor on Medicaid at Arkansas DHS (Formerly VA, WI, & CMS)
- Carol Steckel, WellCare Health Plans (AL and NC Medicaid, LA DHHS)

Key Terminology

- ACA - The Affordable Care Act
- ADA - The Americans with Disabilities Act
- CMS- Centers for Medicare and Medicaid
- EPSDT- Early Periodic Screening, Diagnostic, and Treatment
- FMAP- Federal Medical Assistance Percentage
- FPL- Federal Poverty Level
- HCBS - Home and Community-Based Services
- HHS- U.S. Department of Health and Human Services
- LTSS- Long-Term Services and Supports
- MCO- Managed Care Organization
- MLTSS- Managed LTSS

- Created in 1965, along with Medicare (P.L. 89-97), under the Social Security Amendments of 1965;
- State & Federal partnership for funding and policy;
- Originally intended to be a health plan for low-income individuals on welfare;
- Does not provide the care – pays medical professionals (providers) to deliver the care;
- Optional program for States – last State (AZ) began participation in 1982;
- Medicaid is unique in that it covers more Americans than any other health insurance program;
- In FY 2015, \$545 billion dollars were spent on the Medicaid program in the states & territories;
 - 17% percent of U.S. health care spending in 2015
- Over 57 million Americans were covered by Medicaid in 2012 – grew to 70 million in 2015

- Medicaid is funded and administered jointly by the Federal Government and states.
- The Federal Government establishes rules and parameters for the program.
- Primary direction is provided through statute and regulation:
 - Social Security Act (Title XIX);
 - Code of Federal Regulations (Title 42)
- The Centers for Medicare and Medicaid Services (CMS) also issues other guidance to states:
 - State Medicaid Director's Letters;
 - State Health Official Letters;
 - Informational Bulletins; and
 - Frequently Asked Questions (FAQs).

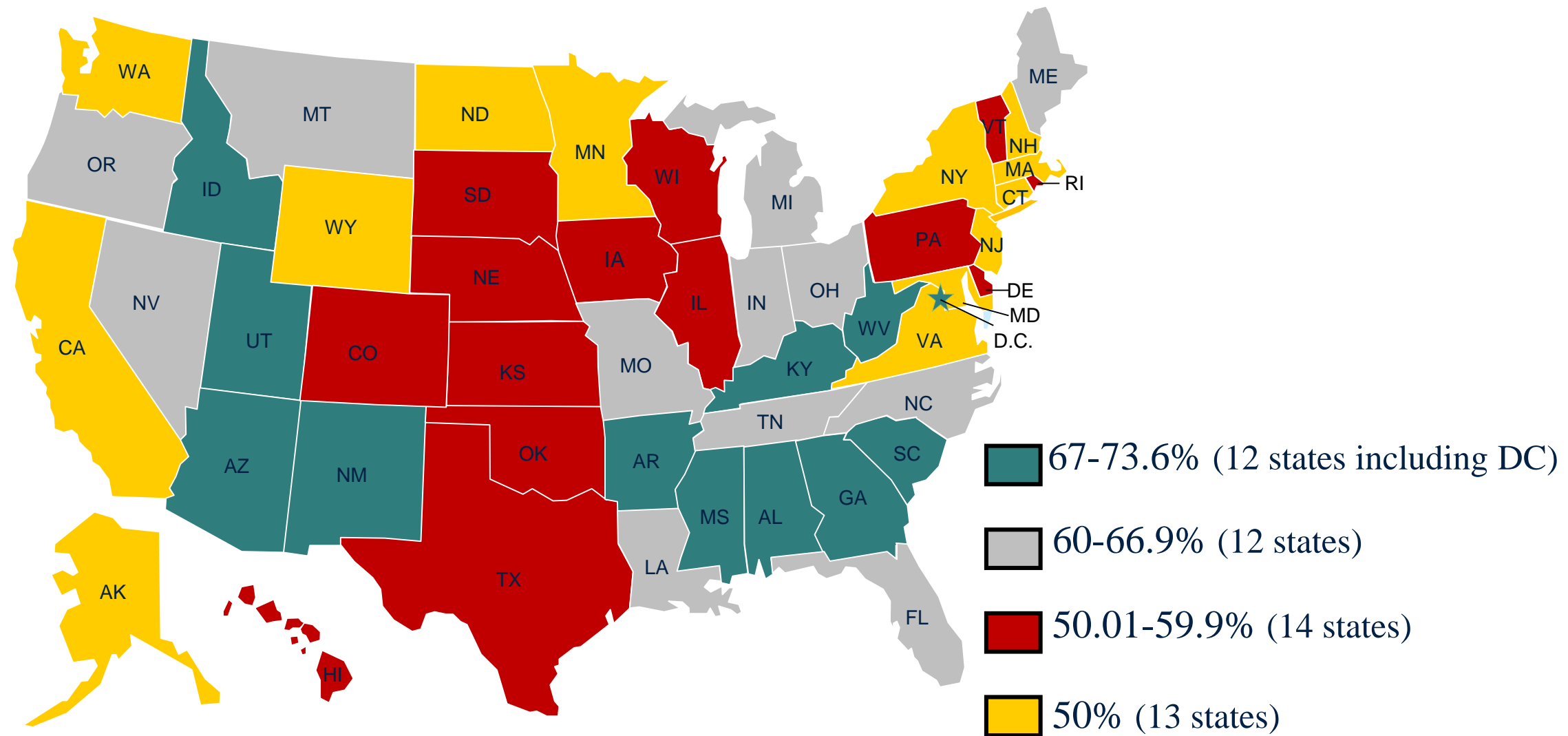
- Federal law and regulation (administered by CMS) specify core requirements all states must meet to receive federal funding.
- Within federal guidance, states define how they will run their program:
 - State laws and regulations;
 - State budget authority and appropriations
 - Medicaid State Plan; and
 - Waivers.
- Subject to review/approval by CMS, states have flexibility regarding eligibility levels, benefits, provider payments, delivery systems and other aspects of their programs.
- Each state must have a “single state agency” that administers Medicaid.

- Every state must have an approved “Medicaid State Plan” that describes its program; the program must be operated according to the State Plan.
- Among other components, the state plan delineates:
 - Groups of individuals to be covered;
 - Services to be provided;
 - Methodologies for providers to be reimbursed; and
 - Administrative activities.
- States must submit and receive approval of a “State Plan Amendment” (SPA) to change how its Medicaid program is operated.

- HHS calculates a “Federal Medical Assistance Percentage” (FMAP) – the Federal share of any medical costs paid by Medicaid;
 - Different for each state;
 - Based upon per capita income of residents;
 - FFY17: Minimum of 50% & Maximum of 74.63%;
 - Average FMAP across the U.S. is 59.4% (not including ACA enhanced match rate)
 - Adjusted on a 3-year cycle, and published annually
- All states receive a 50% match for administrative costs.
- Certain other expenses, such as information systems and family planning, receive higher match rates.



Federal Matching Funds (FFY 2017) for Pre-ACA Covered Populations



Source: Office of the Secretary, DHHS "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, CHIP, and Aid to Needy Aged, Blind or Disabled Persons for October 1, 2016 Through September 30, 2017;" Federal Register, Vol 80., No. 227

- For newly eligible individuals, states received 100% federal funding in 2014-2016; and, unless the law is changed, will receive 95% in 2017; 94% in 2018; 93% in 2019; and 90% in 2020 and subsequent years.

HealthCare.gov

- For those previously enrolled, as well as those previously eligible but not enrolled, states receive pre-ACA federal match funding.

Medicaid.gov
Keeping America Healthy

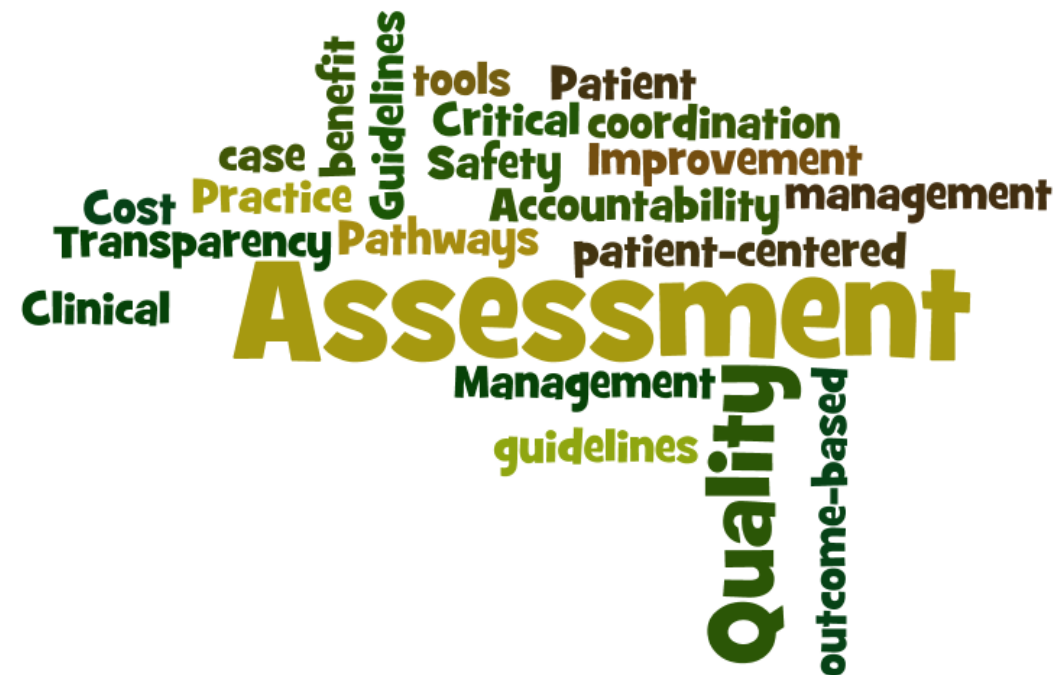
- Recognized sources of state funding include:
 - General Fund revenues;
 - Special Fund revenues (e.g., special health care fund, tobacco settlement funds, etc.);
 - Permissible Taxes and Provider Assessments;
 - Intergovernmental Transfers; and
 - Certified Public Expenditures.
- CMS verifies that state funding sources meet statutory and regulatory requirements prior to authorizing FMAP payments.

Role of Providers

- Medicaid contracts with a broad range of providers to care for beneficiaries, including: hospitals, skilled nursing facilities, health centers, physicians, dentists, behavioral health providers, pharmacists, home health providers, durable medical equipment providers, laboratories, transportation, and others.
- Providers must meet state and federal licensing/contracting/enrollment requirements, and adhere to Medicaid program participation guidelines.
- Providers may contract directly with the state, Medicaid managed care organizations (MCOs), or other similar benefit management entities.
- Depending on the type of service being rendered, reimbursement may be fee-for-service, capitation, an hourly or daily rate, or other payment method.



- Participate and support Medicaid/MCO quality improvement activities, periodicity schedules, and program initiatives.
- Providers are subject to various federal and state auditing requirements to ensure the operational and fiscal integrity of the program.



- Beneficiaries

- Must provide sufficient documentation to meet Medicaid eligibility requirements (e.g., citizenship and identity, income, other assets, health/disability status, etc.)
- Must also report certain changes in circumstances such as income, household residents, place of residence, etc.
- Comply with Medicaid/MCO participation requirements, including enrollment procedures, coordination of benefits, applicable cost-sharing provisions, program integrity activities, etc.



- Families

- Support and assist beneficiary as appropriate in understanding and complying with Medicaid participation requirements.
- When possible, provide care or other support to allow beneficiary to remain at home rather than receive care in an institutional setting.

- Advocates

- Provide advocacy on a population-wide or individual basis to help beneficiaries navigate Medicaid program.
- May assist beneficiaries in appealing adverse decisions.
- Advocate for improvements in Medicaid benefits, eligibility levels, program administration, etc. with Medicaid agency, Governor's Office and legislature.



Medicaid 101: Overview Of Eligibility & Coverage of Services



Ann Kohler, Director Medicaid Practice, Marwood Group

Medicaid Eligibility

- **Categorical Eligibility** – people must fit into a pre-defined group of individuals:
 - Children;
 - Parents;
 - Pregnant women;
 - Seniors;
 - People with Disabilities; and
 - Childless, non-elderly, adults (ACA expansion)
- **Income Eligibility** – people must also have income below defined limits, usually set by Federal Poverty Level (FPL)
- **Medically Needy Eligibility** – individuals can become Medicaid eligible if they spend their own money on health care expenses (Spend-down)



Medicaid Eligibility: Mandatory And Optional Groups

- **Mandatory Groups:**
 - Categorical Groups that a State must include if they participate in Medicaid;
 - Over 25 mandatory groups, including:
 - Supplemental Security Income (SSI) eligible (except in 209(b) states);
 - Children 0-5 below 133% FPL; and
 - Children aging out of foster care until age 26
 - Low-income Medicare beneficiaries (not full Medicaid services).
- **Optional Groups:**
 - Groups that a State can choose to include;
 - Includes all Medically Needy Groups;
 - Over 25 optional Categorical groups, including:
 - Medicaid Buy-ins;
 - Affordable Care Act (ACA) expansion;
 - Higher income eligibility for Medicaid categories.



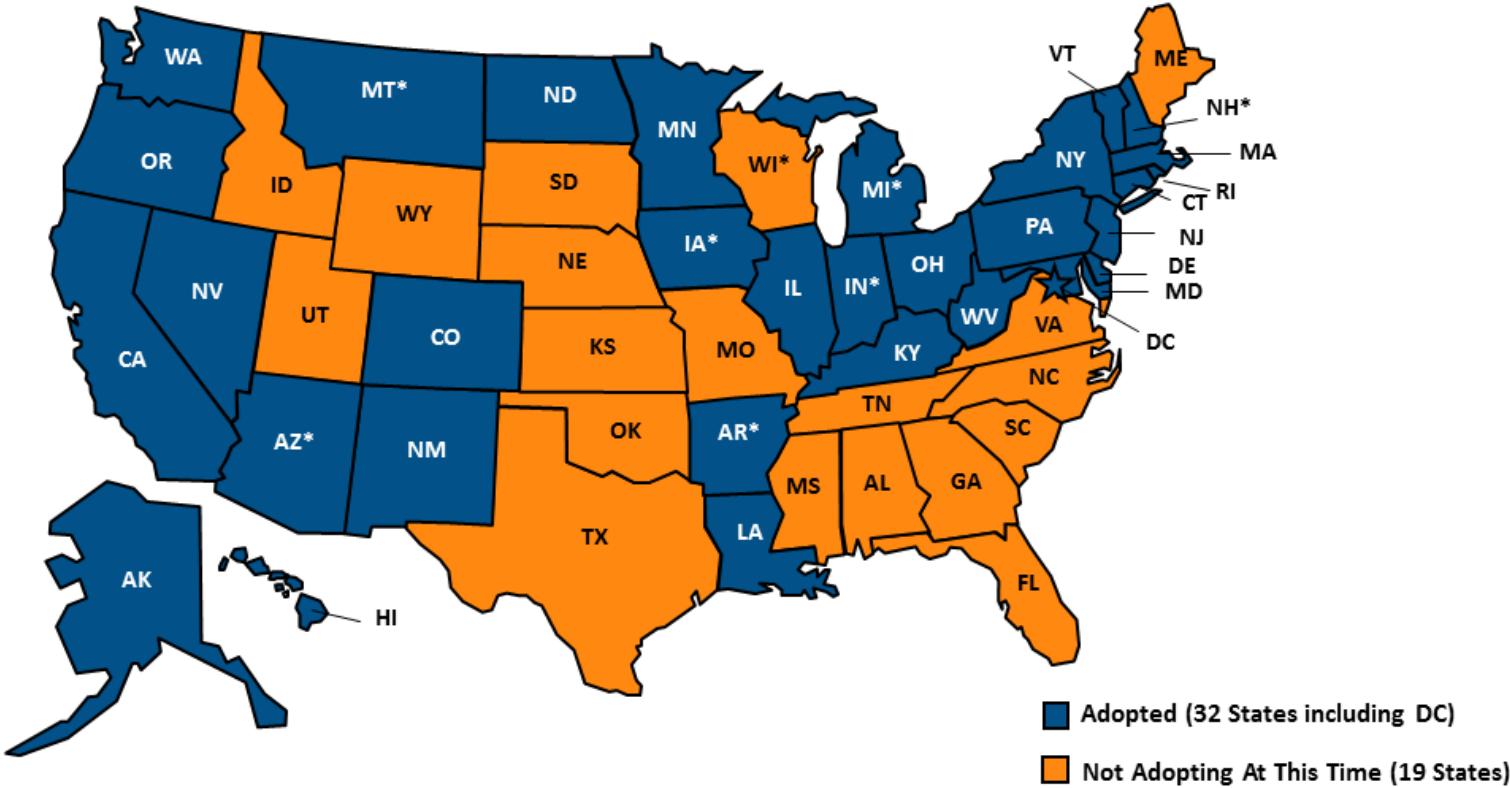
ACA Changes

- ACA expanded Medicaid eligibility to childless adults and raised eligibility to 138% FPL, and eliminated asset tests only for the non-elderly and non-disabled groups
- ACA also changed how income is counted by moving to modified adjusted gross income (MAGI)
 - All States must move to MAGI for non-elderly and non-disabled
- Supreme Court ruled the eligibility expansion could be a state option
- The Senate and House Bills proposed major changes to Medicaid expansion under the ACA during their 2017 repeal efforts; however, no changes have been made at this time
 - The House bill proposed repealing Medicaid expansion as of December 31, 2019, freezing enrollment and churning off beneficiaries that exit the program
 - The Senate bill would have lowered the federal match rate for the Medicaid expansion population starting in 2020, and dropping each year until it reached traditional FMAP levels in 2024
 - States would have the option to impose work requirements on their Medicaid expansion population
- ACA simplified the eligibility process
 - Electronic verification of income
 - No wrong door



Current Status of State Medicaid Expansion

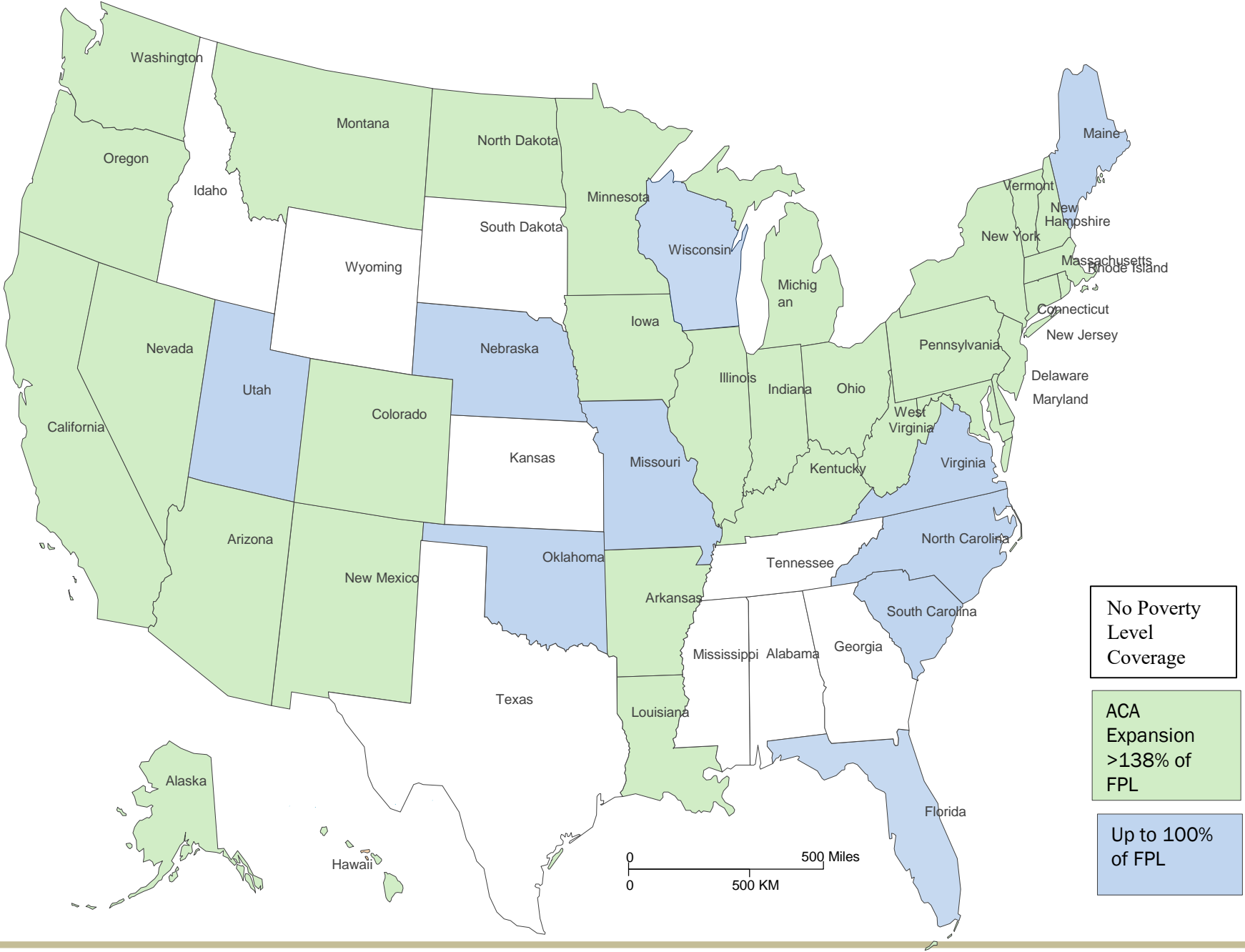
Current Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated January 1, 2017.
<http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>



Distribution Of States With Poverty Level Coverage for Aged, Blind, and Disabled



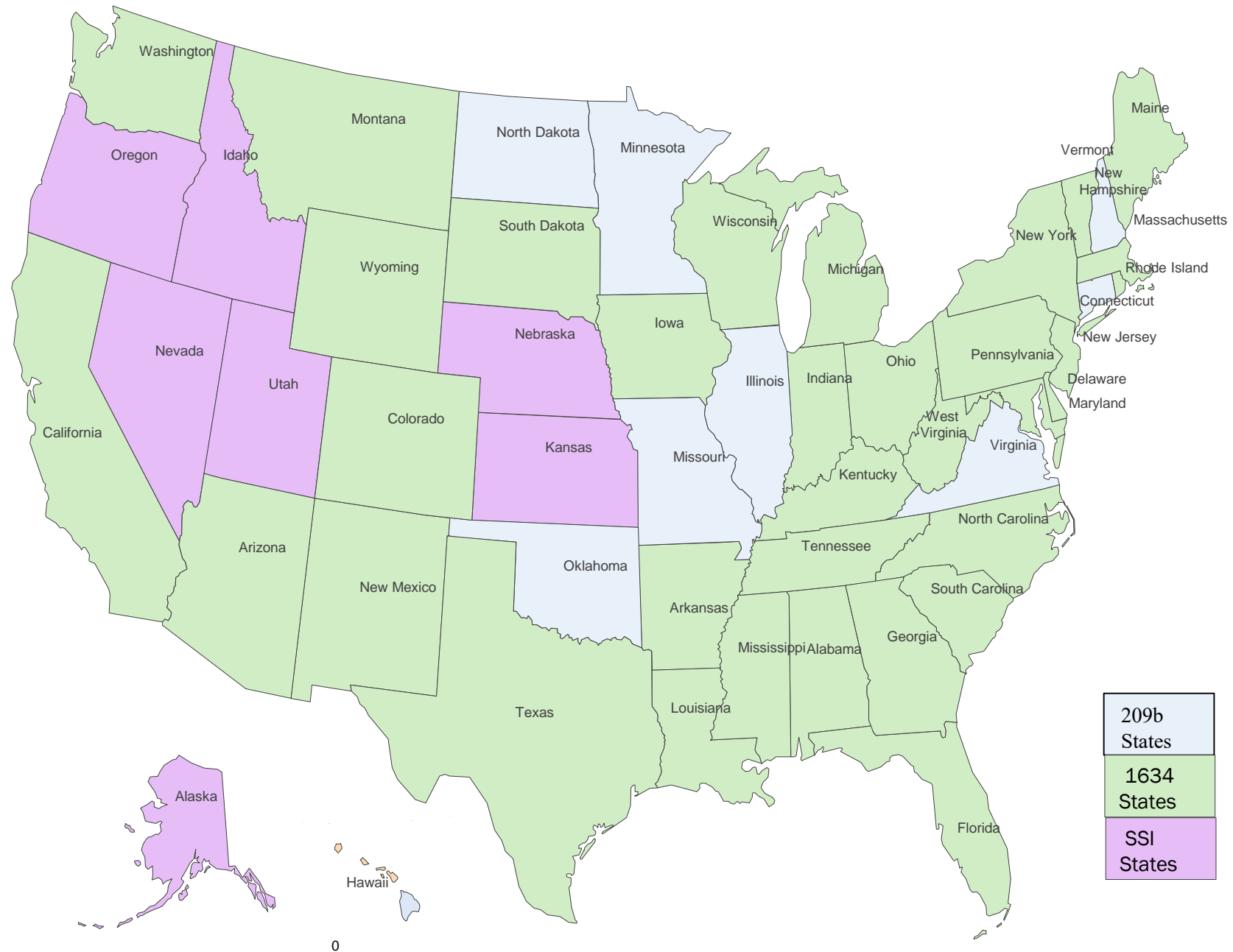
SSI And 209B States

Most states follow Social Security rules for aged and disabled

- States choose between following Federal Rules and having Social Security perform the eligibility determination (1634 states) or developing their own rules (209b states)
 - In 1634 states, an individual's application for SSI is also their application for Medicaid
 - Some states follow the Federal/SSI standard, but are not "1634 states" since they continue to make their own eligibility determinations and participants must apply separately for Medicaid
- ACA changes do not affect the eligibility rules for aged and disabled and asset limits remain
- Federal SSI are set annually, and are approximately 75% of FPL, but states may also add a state supplemental amount which raises eligibility level
- Many states cover aged and disabled up to the federal poverty level



Distribution Of 209b States

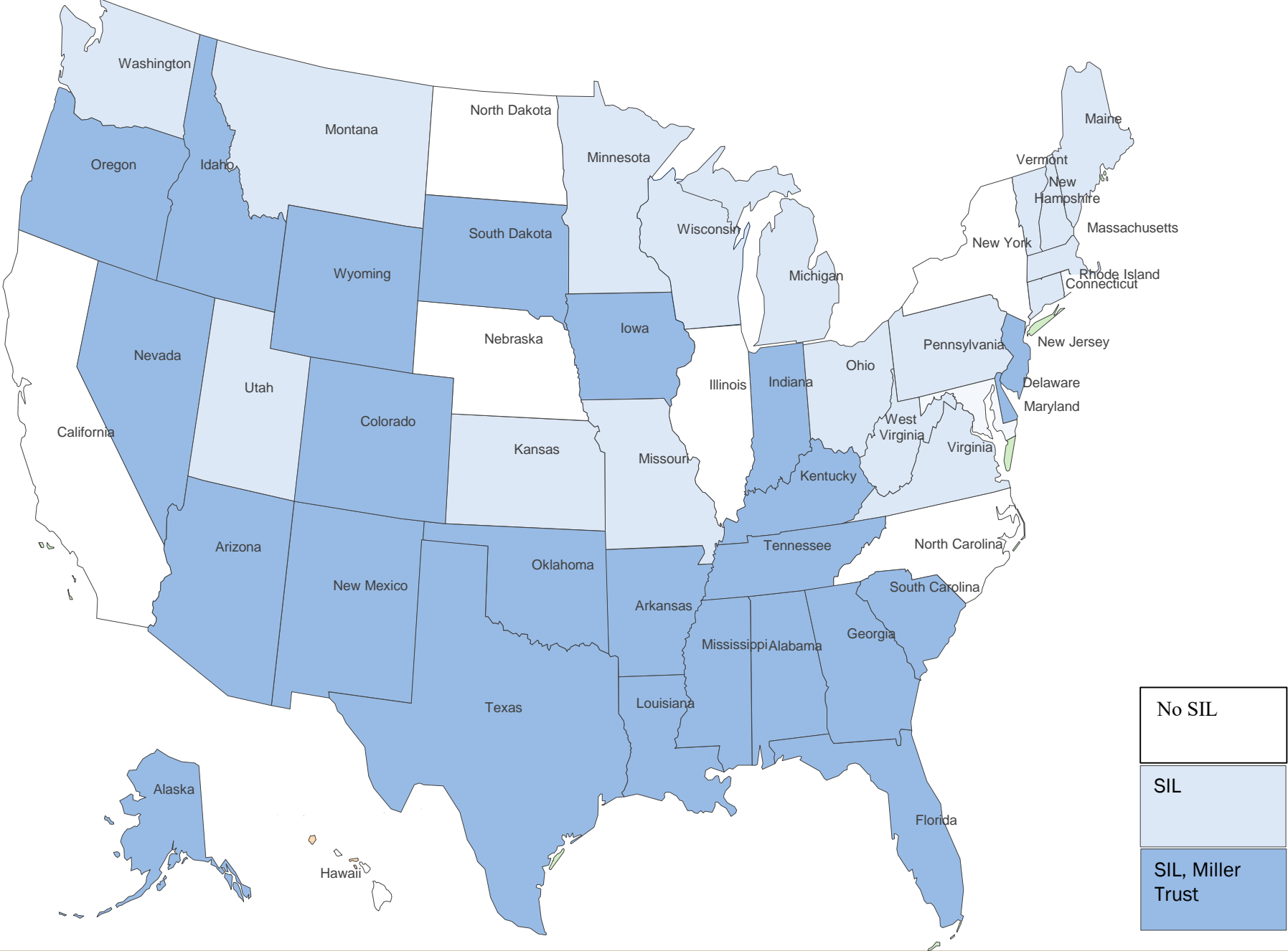


Eligibility Levels for Long Term Care

- **States may have higher eligibility levels for long term care**
 - Many states use 300% of the federal SSI level for long term care eligibility- both institutional and HCBS
 - Some states, which do not have a medically needy program use the Special Income Rule (Miller Trust) to qualify individuals for long term care
- ACA extended spousal impoverishment protections recipients of Home and Community Based Waivers



Distribution of States That Have Special Income Limits Or Miller Trusts



- **Mandatory services include:**
 - Hospital services & Nursing homes;
 - Physician Services, nurse practitioners;
 - X-rays, clinics, lab services
 - Free standing birth centers
 - Tobacco cessation for pregnant women
- **Optional services include:**
 - Prescription Drugs;
 - Dental;
 - Case Management;
 - Rehabilitation;
 - Personal Care.
- **Other considerations:**
 - If a person has other coverage (such as Medicare or private insurance), Medicaid only pays for services not provided through the other coverage;
 - Medicaid often assists with copays/premiums associated with other coverage.



Medicaid Services

- Once a person comes into Medicaid, they have access to all of the services that the state covers and are medically necessary;
- Services must be statewide, comparable, delivered with reasonable promptness, and allow individuals to choose providers;
- States can define the “amount, duration and scope” of services to reasonably achieve their purpose;
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): Children under 21 can get all medically necessary optional and mandatory services, regardless of whether the state covers them for other individuals.



Medicaid Rate-Setting

- Process: Most rates are set by formula or amount in a “state plan amendment,” i.e., a change in the state’s CMS-approved plan governing use of Federal matching payments
- Requirements: Federal law requires rates to be sufficient to generate access on a par with general population (*SSA Section 1902(a)(30)(A)*) [See next page...]
- Fee for service: Traditional approach to payment was to reimburse for each bit or piece of health care used, i.e., a fee for every service.
 - For pregnancy that could include multiple prescriptions (and fills), a hospital stay, and physician’s services for delivery, prenatal and post-natal visits
 - Fee-for-service now also means “not managed care”
- Prescription Drugs: “Rate-setting” for prescription drugs entails setting reimbursement formulas for local pharmacies, federally-mandated manufacturer rebates and sometimes a state-negotiated rebate as well
 - All approved drugs must be covered (so long as manufacturer participates in federal drug rebate program) but NOT all drugs must be “preferred” nor covered without guidelines or conditions, such as prior authorization
 - The potential for establishing preferred or unconditional prescribing helps leverage state-negotiated rebates
- Institutions: There are various payment methods for facility-based care, including “cost-based” reimbursement and “price-based” reimbursement
 - Cost-based usually includes cost reporting, interim payments, and cost reconciliation
 - Price-based methodology is based on payments using a fixed-fee methodology, generally DRGs for hospital inpatient, OPPIs for outpatient services, and RUG-based payments for nursing homes
 - Some hospitals and nursing homes receive lump-sum “supplemental” payments not directly tied to individual services
- Reform: Revisiting the “fee for service” approach has risen to the top of State Medicaid program agendas....

Medicaid Rate-Setting

Medicaid's Minimum Access Requirements

Statutory Requirement

*“SEC. 1902. [42 U.S.C. 1396a] (a) A State plan for medical assistance must—
...(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers **so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area;**”*

(emphasis added)

New Federal Regulations*

- **Requirements:** Federal law requires rates to be sufficient to generate access on a par with general population (*SSA Section 1902(a)(30)(A)*)
 - That same federal law also requires that “payment” secure quality services and provoke efficient use
 - Supreme Court recently determined that providers do NOT have legal standing to challenge state payment rates against this federal standard (*Armstrong v. Exceptional Child Center, Inc.*)
- Following the Supreme Court decision, CMS published regulations establishing the process states must go through to assure sufficient access
- Medicaid services covered under the new regulations include:
 - Primary care and physician services
 - Behavioral health services
 - Obstetric services
 - Home health
 - Other services for which the state or CMS has received unusually high number of complaints, or which is experiencing **a change in payment that could diminish access**
- Beginning July 2016 States are to required create and maintain “access monitoring plans” for each service
 - Stakeholder input and public notice
 - Comparison of Medicaid rates to other payers
 - Measurement of access versus established metrics such as time and distance to participating providers

Value-Based Purchasing

Overview

Overarching objective

One way to express a state's goal might be to **pay for a valued outcome** (e.g., quality of life or survival) independent of the number or type of services provided

Core idea

VBP pays for (or incents) end-to-end or comprehensive care that *should be* managed together, e.g., by a coordinated team, instead of paying each service discretely on a volume basis

Basic approach

Identify a *collection of related services* attached to a distinct health condition or outcome and incentivize or combine all payments for these related services.

These collections of services vary, and each could be thought of as a health-related **product**.

Initial steps

Defining these collections of related services entails answering a number of questions:

- Which services should be grouped together?
- Which providers should be included in the “team”?
- What time frame should be included in each package of services?
- How is quality factored into payment?

Value-Based Purchasing

Terminology

“New Payment Models” v. “Delivery System Redesign”

- Payments go to those who deliver a service – or, increasingly, packages of services
- Payment innovations that redefine a package of services often directly entail a new model of service delivery
- Health care provider markets and delivery systems sometimes reorganize themselves in response to (consolidated) payment for these new packages of service
- These innovations are known *both* as new delivery models *and* new payment models

Value-Based Purchasing

Examples of Common and Emerging Payment Models and Delivery System Redesigns

- **Managed care organizations**
 - Service package: comprehensive care for each enrollee
 - New payment model: single monthly payment for all services for each enrollee
 - Scale: encompasses geographic regions or full states
- **Accountable care organizations**
 - Service package: comprehensive care for each enrollee
 - New payment model: single monthly payment for all medical services for each assigned patient
 - Scale: encompasses patients of a particular health system
- **Patient-centered medical homes**
 - Service package: comprehensive care for each enrollee
 - New payment model: monthly supplemental payment **and/or** periodic incentive payment
 - Scale: incentives encompass total medical spend for all of a doctor's patients
- **Health homes**
 - Service package: variable, but might include all specialized services (e.g., behavioral health care) or both specialized and physical health services
 - New payment model: monthly supplemental payment to a provider or care coordinator
 - Scale: encompasses some combination of care for all of a provider's patients
- **Episode-based payments**
 - Service package: all services associated with an episode of sinusitis, pregnancy and delivery, etc.
 - New payment model: bundled/combined payment or retrospective incentives
 - Scale: encompasses all condition-related care for all of a provider's patients

Medicaid Payment Integrity

Basic concepts

- **General requirements for a proper Medicaid payment**
 - Approved service
 - Approved payment rate and methodology
 - Enrolled provider
 - Eligible beneficiary
 - All sufficiently documented

Core concepts

(not formal definitions)

- *Fraud: intentionally improper claims*
- *Waste: proper but unnecessary claims*
- *Abuse: intentionally wasteful claims*

Medicaid Payment Integrity

Tools and Activities

- **Resources and Requirements**

- Accountability for all payments accrues to the single state Medicaid agency
 - Operating agencies and contractors assist with payment integrity, but CMS ultimately holds the designated single state Agency accountable
- Agency investigators, auditors, compliance and program staff all contribute
- CMS efforts are now consolidated in the Payment Error Rate Measurement (PERM)* program
- All states implement MMIS-related Surveillance and Utilization Review Systems (SURS)

- **External review and audit authorities**

- Medicaid Fraud Control Units (State Attorneys General)
- State auditors (e.g., legislative, agency, State inspectors general)
- CMS
- Federal HHS Office of Inspector General
- Federal Government Accountability Office
- Law enforcement (e.g., prosecutors, FBI)

- **Core activities**

- Reporting and investigation
- Pattern recognition
- Referral and prosecution
- Recovery
- Remediation, avoidance and prevention

*Under final federal regulations published July 5, 2017, PERM will supercede/encompass statewide eligibility accuracy measurement previously conducted by state Medicaid Eligibility Quality Control (MEQC) units, and MEQC would be reshaped to compliment PERM as an off-year state-driven analytic pilot program

Medicaid Payment Integrity

Agency approach

Potential Enablers

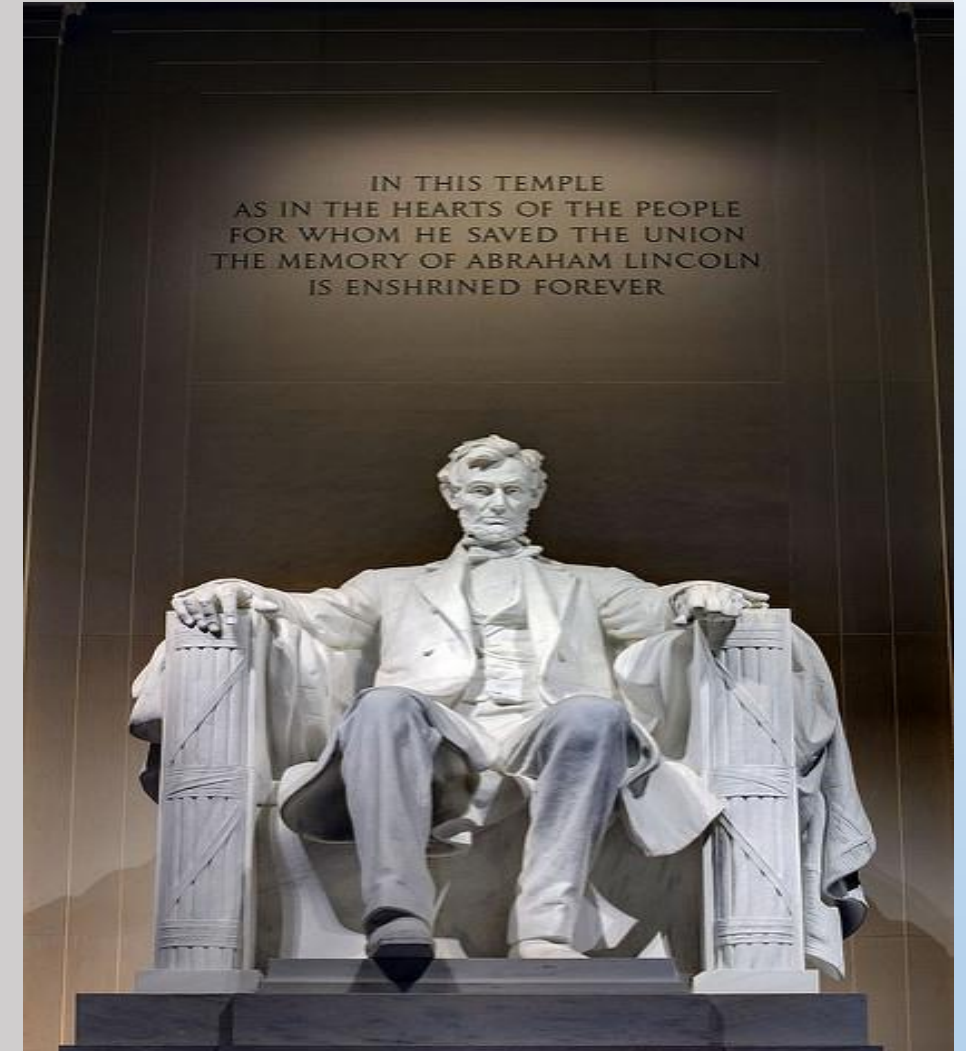
- Robust organizational communications at all levels
- Governance structure (e.g., decision rights, incentives, accountability)
- Talent and skills to support payment integrity goals
- Data and reporting infrastructure

Example objectives

- **relentlessly pursue sources of errors** (both internally and externally)
- sustainably remediate errors through appropriate **prevention and recovery** interventions
- **continually improve** over time

Medicaid Waivers and Health Care Delivery

David Parrella, Last Best Hope Consulting
August 28, 2017



SOME FUNDAMENTAL QUESTIONS

- Is demography destiny? Will the needs of an aging population overwhelm the public financing systems (Medicaid and Medicare)?
 - Are these programs sustainable?
- Are we headed for a long term care financing crisis?
 - Maybe not??

Deinstitutionalization can be tough!

- Older bricks and mortar nursing facilities may be forced to close
- While that is part of the long term goal, in the short term closings can cause disruptions for clients and their families
- Job losses can be significant issues for workers, collective bargaining, and state legislators
- As you implement the new community LTSS, you will be forced to double-fund some portion of your LTC system (nursing home and HCB) as you wind one system down in favor of the other
 - It's hard to shut down the facilities on the day that funding begins for the new alternatives

Medicaid Waivers

Description

- Waivers consist of Federal statutory authority given to CMS to exempt states from certain Medicaid requirements, including state-wideness, freedom of choice, comparability, and the definition of a federally “matchable” state health-related expense

Differentiators

- Waivers differ from Medicaid state plan amendments in key ways:
 - Not an “entitlement” – can have enrollment limits or waiting lists
 - Cost-neutrality requirements
 - Include evaluation requirements and other “terms and conditions”
 - Must be renewed, e.g., every 3-5 years
- Most common waivers
 - 1115 demonstrations: Waiver of variety of Medicaid policies for “research and evaluation”
 - 1915(b): Waiver of “freedom of choice”
 - 1915(c): Waiver of comparability allows states to target diagnoses, and option to waive state-wideness

Medicaid Waivers

- 1115 Waivers provide broad flexibility
 - Can expand coverage to “non-categorical” groups;
 - Can implement managed care;
 - Can obtain federal matching funds for otherwise non-Medicaid state expenses;
 - Can test new service-delivery methods.
- 1915(b) Waivers
 - Can limit which providers individuals can choose from;
 - Allows states to enroll people in managed care.
- 1915(c) Waivers
 - Provide Home and Community-Based Services (HCBS), including:
 - Habilitation;
 - Transportation;
 - Personal Care.
 - Allows states to create a robust service package for individuals with an institutional level of care.

WHAT'S THE HEADLINE HERE?

- Medicaid spending on Home Health and Personal Care services exceeds spending on Institutional Care
- Waiver authorities will become **more important** in the years to come as a way of delivering care to an aging population
- Will we have the labor force to sustain the momentum for community care?
- Will the potential for future caps on Medicaid spending allow the momentum towards Community-Based care to continue?

LTSS AUTHORITY OPTIONS

- Waivers
 - 1115 - Research and Demonstration
 - 1915(b) - Waiver of Freedom of Choice (Managed Care)
 - 1915(c) - Waiver of Comparability and Statewidedness (Home and Community Based Services)
 - 1332 or successor - Waiver to reform Medicaid or a waiver of Essential benefits
- State Plan
 - 1915 (i) - HCBS
 - 1915 (j) - Self-Directed PCA
 - 1915(k) - Community First Choice
 - MFP - Money Follows the Person

1915(c) Waivers

- Introduced by the Omnibus Reconciliation Act of 1981
- What does “waive” mean?
 - “Waive” means that CMS agrees not to abide by certain statutory requirements
- May waive
 - Statewide (service can be provided in limited geographic areas)
 - Comparability (service can be provided to limited populations)
 - Income and Resource Rules (client eligibility can be determined outside of standard rules for categorically or medically needy populations)
- Provide services in a home and community based environment that assist in diverting and/or transitioning individuals from institutional settings

1915 (c) Waivers

- State HCBS Waiver programs must
 - Demonstrate cost-effectiveness (comparing the cost of the intervention against “do nothing” over a period of time, 3-5 years)
 - States can use “waiver math” – “If I don’t get this waiver I’ll have build x number of nursing home beds over the next 5 years which would cost me \$\$\$ million...”
 - Protect people’s health and welfare (through a quality assurance plan)
 - Provide adequate and reasonable provider standards to meet the needs of the target population (spelled out in the waiver application and state regulations)
 - Ensure that services follow an individualized and person-centered plan of care

1915 (c) Waiver

- Can be combined with a 1915(b) waiver – Freedom of Choice – to implement managed care
- Historically, 1915 (c) waivers were required to be unique for each condition/population to be served
 - Often administered by different state agencies outside of the Medicaid agency
 - However, Medicaid retains the federal accountability
 - Resulted in service silos

Recent Federal 1915 (c) Waiver Changes

- You are now allowed to combine multiple conditions and populations under a single 1915 (c) waiver
- Reduces the administrative burden in terms of federal reporting
- States/Advocates may still resist combining populations because of the state appropriation process
 - May want to preserve line item funding for unique populations and needs

1115 Waivers

- 1115 waivers are statutorily designed to be research and demonstration programs to test new ways of delivering services, providing alternate benefits, or expanding eligibility and coverage
 - Practically/operationally speaking – their scope is much broader and long-term
- 1115s can be used for a modifications of wide range of supports/services:
 - Family planning waivers
 - Eligibility Expansion
 - Managed Care
 - Hospital financing

LTSS within 1115 Waivers

- States can offer LTSS as part of a research and demonstration waiver
- Some states have used 1115 plus 1915(b/c) waivers to deliver HCBS
- 1115 waivers allow the states the maximum flexibility to test innovative policy and delivery approaches that promote the overall objectives of the Medicaid program,** including:
 - Managed Care for LTSS Services
 - Services to caregivers (Washington state)
 - “Preventive LTSS” to those not yet eligible (Minnesota, Delaware, Washington State, etc)

**The “overall objectives” of the program is subject to interpretation and can change based upon the views of the current administration

Current Issues in 1115s

- What is the role of the Medicaid program?
- Where does Medicaid overlap with private insurance? Where does it have different objectives, goals, and desired outcomes?
- Key policy debates & 1115 proposals testing these philosophical propositions:
 - Work requirements
 - Time-limits on enrollment for adults without disabilities
 - Mandatory copayments
 - Retroactive eligibility waivers
 - Non-emergency Medical Transportation
 - Exchange-based Medicaid delivery
 - Essential Health Benefits
- Important states to watch:
 - Indiana
 - Wisconsin
 - Arizona
 - Arkansas
 - Kentucky
 - Others!

New Class of Federal Waivers: 1332s

	SSA Section 1115 Waivers	ACA Section 1332 Waivers
Scope	<ul style="list-style-type: none"> Medicaid CHIP 	<ul style="list-style-type: none"> Health Insurance Marketplace structure Essential benefits Marketplace subsidies, insurance risk mitigation approaches, benefit design, mandates and penalties <i>Other federal health care laws*</i>
Key Requirements	<ul style="list-style-type: none"> Federal budget neutrality -- <i>within</i> Medicaid and CHIP CMS policy, e.g., beneficiary protections, source of state matching funds, etc. 	<ul style="list-style-type: none"> Federal budget neutrality for all Federal costs, but calculated as if Medicaid policy remained unchanged Budget neutrality must be calculated separately for any associated changes to Medicaid No loss in benefits (services, affordability) for consumers No loss in aggregate number covered in the state, nor for losses among number of vulnerable populations covered HHS and US Treasury Departments will “continue to examine the types of changes that will be considered in assessing State Innovation Waivers.” **
Common Uses	<ul style="list-style-type: none"> Financing alternatives Delivery system transformation 	<ul style="list-style-type: none"> TBD
Effective Date	<ul style="list-style-type: none"> 1965 	<ul style="list-style-type: none"> January 2017

*Coordinated Waiver Process: Section 1332 allows the HHS Secretary to consolidate 1332s, 1115s and “any other Federal law relating to the provision of health care items or services.” The current administration has published regulations enabling coordinated waiver submissions and review, but disallowing consolidation of ACA State Innovation (1332) and non-ACA waivers like Medicaid’s 1115s. See Federal Register 80:241 December 16, 2015 pps. 78133-78134.
 **ibid, p. 78134

What' in Jeopardy with the ACA repeal?

- 1915 (c) waivers stay the same
- Community First Choice Option is Removed
- What is the overall impact of the projected \$800 million reduction in Medicaid spending over the next decade on long term care services?
 - States could be forced to:
 - Restrict Medicaid eligibility (increase the level of care requirements for skilled nursing)
 - Limit the number of slots available in HCBS waivers
 - Reduce coverage of optional services
 - Reduce client protections under managed care
 - Can Long Term Care managed care survive a cut in federal funding?
 - What about “actuarial soundness”?

Medicaid “Reform” Includes the Potential to Waive “Essential Benefits”

10 services which include:

- 1) Ambulatory care (physician, outpatient, etc.)
- 2) Emergency care
- 3) Inpatient Hospital
- 4) Maternity care and birth control
- 5) Mental health and substance abuse
- 6) Prescription drugs
- 7) Rehabilitative and habilitative services (LTSS)
- 8) Laboratory
- 9) Preventive and wellness (includes chronic disease management)
- 10) Pediatric

A Mad Men Health Care Dinner Party

- Don- I'll have the Heart Bypass for \$95,000
- Duck – Severe treatment for Depression for \$35,000
- Betty – I'm pregnant! \$25,000 for global OB care
- Elizabeth – I'm healthy! \$1,000 for primary care
- Karen – I've got HEP C - \$145,000
- John – I'm an alcoholic with cancer - \$500,000
- Total Bill - \$801,000



With Essential Benefits

Lets split the bill. That means:

- We cover Betty's maternity
- We cover John's substance abuse treatment
- We cover Duck's mental health treatment
- We cover Karen's HEP C pre-existing condition
- Liz gets stuck with the bill (\$100k) because she is healthy, has no pre-existing conditions, and is not pregnant



What happens when these people age?

- If Essential benefits are waived, more of them will incur out of pocket costs that will cause them to spend down, perhaps to bankruptcy
- Is Medicaid going to be there for them?





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MEDICAID LONG TERM SERVICES AND SUPPORTS (LTSS)

JERRY DUBBERLY, PHARMD, MBA

DEDICATED TO GOVERNMENT HEALTH PROGRAMS





■ TOPICS

- Overview of Medicaid Long Term Services and Supports
- LTSS Authority Options
 - State Plan
 - Waivers
- Deinstitutionalization



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■ OVERVIEW OF MEDICAID LTSS

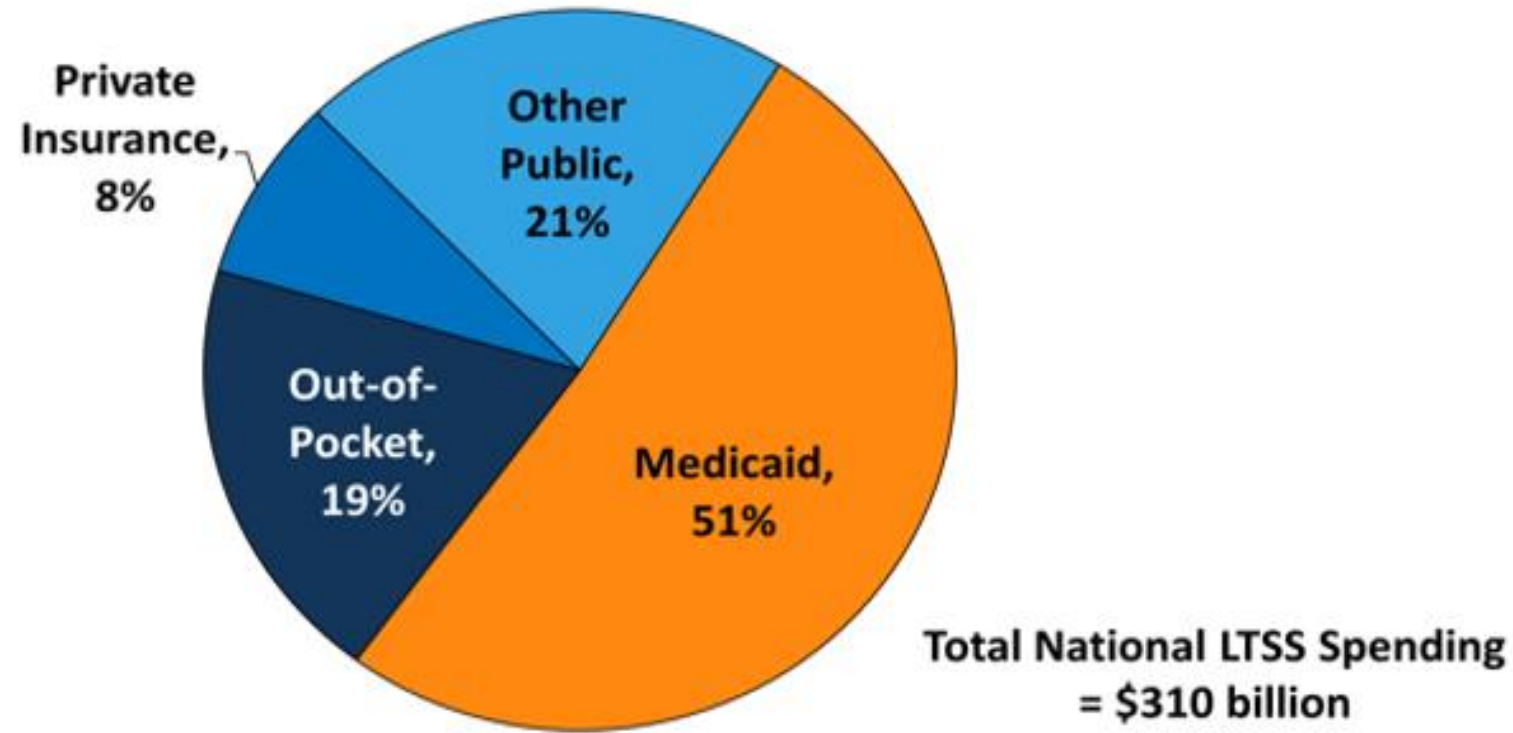


■ MEDICAID LTSS

- Includes *Institutional Care* and *Home and Community Based Long Term Services and Supports*
- Services may be defined through state plan authority, waiver authority, or a combination
- Medicaid is the primary payer of LTSS



■ MEDICAID: PRIMARY PAYER LTSS, 2013



NOTE: Total LTSS expenditures include spending on residential care facilities, nursing homes, home health services, and home and community-based waiver services. Expenditures also include spending on ambulance providers and some post-acute care. This chart does not include Medicare spending on post-acute care (\$74.1 billion in 2013). All home and community-based waiver services are attributed to Medicaid.

SOURCE: KCMU estimates based on CMS National Health Expenditure Accounts data for 2013.





■ INSTITUTIONAL BENEFITS

- Mandatory Benefit
 - Nursing Facility
 - Hospital

- Optional Benefit
 - Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/ID)
 - Inpatient psychiatric services <21 or ≥65 yrs

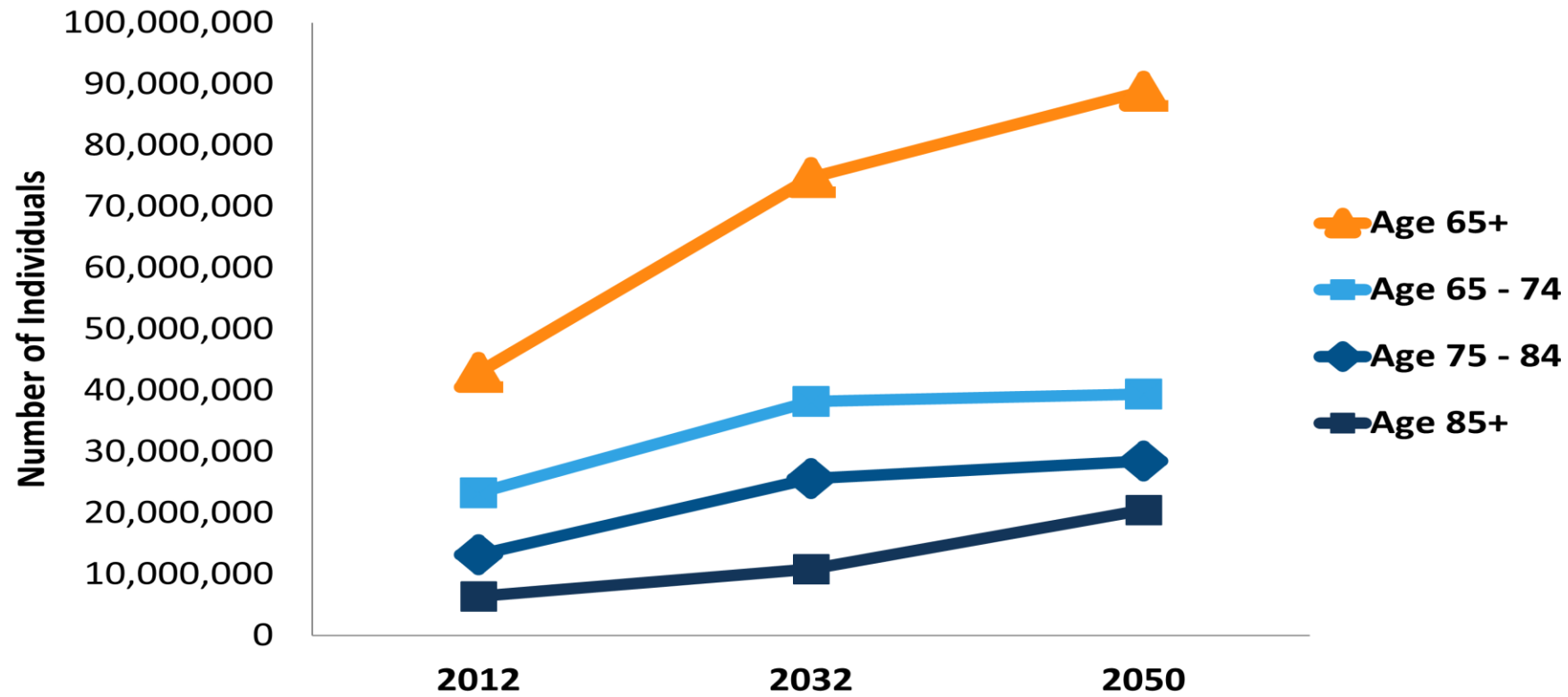
- Excluded Benefit
 - Institutions for Mental Disease (IMD) if 21-64 yrs of age



AGING POPULATION

Figure 1

The 65 and Over Population Will More Than Double and the 85 and Over Population Will More Than Triple by 2050



SOURCE: A. Houser, W. Fox-Grage, and K. Ujvari. *Across the States 2013: Profiles of Long-Term Services and Supports* (Washington, DC: AARP Public Policy Institute, September 2012), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf.

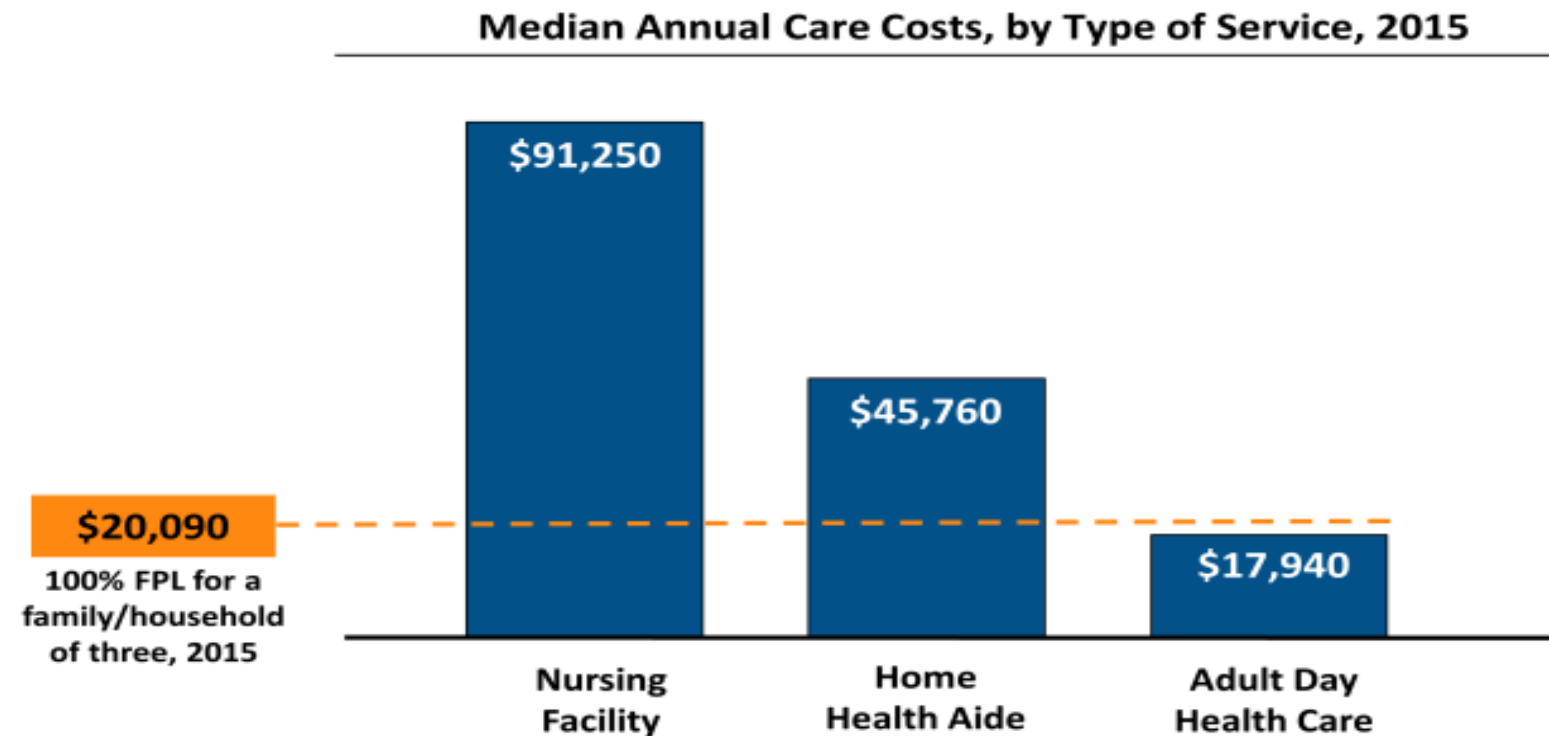




■ WHAT DOES IT COST?

Figure 2

Long-Term Services and Supports Are Expensive, Often Exceeding What Beneficiaries and Their Families Can Afford



SOURCES: Genworth, *Genworth 2015 Cost of Care Survey* (Richmond, VA: Genworth Financial, Inc., April 2015), https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_040115_gnw.pdf; U.S. Department of Health and Human Services, 2015 Poverty Guidelines, <https://aspe.hhs.gov/2015-poverty-guidelines>.





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■ **LTSS AUTHORITY OPTIONS**



■ REMINDER

- State Plan
 - Operational agreement between state and federal government regarding how Medicaid program will be structured and administered
- Waivers
 - 1115 – Research and Demonstration
 - 1915(b) – Waives Freedom of Choice
 - 1915(c) – Home and Community Based Services



■ **1915(c) WAIVERS**

- Introduced by Omnibus Reconciliation Act of 1981
- May waive:
 - Statewideness
 - Comparability
 - Income and resource rules
- Provide services in a home or community based environment that assist in diverting and/or transitioning individuals from institutional settings



■ 2014 CMS HCBS REGULATIONS

- Defined HCB Setting as:
 - Integrated and supports access to the greater community
 - Providing opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources
 - Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services



■ 2014 CMS HCBS REGULATIONS

- Defined HCB Setting as: (cont.)
 - Selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting
 - Person-centered service plans document the options based on the individual's needs, preferences; and for residential settings, the individual's resources



■ 2014 CMS HCBS REGULATIONS

- Defined HCB Setting as: (cont.)
 - Ensuring an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint
 - Optimizing individual initiative, autonomy, and independence in making life choices
 - Facilitating individual choice regarding services and supports, and who provides them



■ **1915(c) WAIVERS**

- Can be combined with a 1915 (b) Freedom of Choice waiver to implement managed care
 - 1915(b)/(c) Waiver
- Multiple 1915(c) Waivers
 - Condition/population specific
 - Administered by multiple agencies
 - Medicaid accountability
 - Service silos



■ 1915(i) HCBS STATE PLAN OPTION

- Does not require an institutional level of care (LOC)
 - Less stringent needs-based criteria than institutional LOC
 - Proactive approach to institutionalization
- Targets one or more specific populations
- Allows use of self-direction
- Permits “other” services provides flexibility



■ **1915(i) HCBS STATE PLAN OPTION**

- Restricted to those <150% FPL under DRA but expanded to 300% of Supplemental Security Income under ACA
- ACA removed ability to cap enrollment or maintain waiting list



■ **1915(j) SELF DIRECTED PERSONAL ATTENDANT SERVICES**

- Permitted Self-Direction for personal attendant services through State Plan
- States may limit self-direction to geographic areas and limit the number of people eligible to self-direct
- Can target people already getting 1915(c) waiver services
- State can permit:
 - Hiring of relatives
 - Purchasing of goods, supports, services or supplies that increase independence



■ **1915(k) COMMUNITY FIRST CHOICE OPTION**

- Established under the ACA
- Provide certain HCB services and supports through a State Plan option
 - Personal Care Attendant services
 - Acquire, enhance, maintain skills to perform ADLs or IADL
 - Respite/backup system to ensure continuity of care
 - Offer voluntary training on hiring, managing, and firing of attendants



■ **1915(k) COMMUNITY FIRST CHOICE OPTION**

- Optional Community First Choice Option Services
 - Transition costs associated with moving from an institutional to home/community settings
 - Other services in care plan to increase independence
- 6% increase in federal match for these services
- No waiting list or limit on number served allowed



■ **1915(k) COMMUNITIES FIRST CHOICE OPTION**

- Must meet statewideness, comparability, and freedom of choice of provider
- Cannot target specific populations
- Can limit amount, duration and scope
- Must meet institutional level of care
- Income up to 150% FPL
- Maintenance of effort requirement



■ **LTSS WITHIN 1115 WAIVERS**

- States can offer LTSS as part of a research and demonstration waiver
- 1115 demonstration waivers allow states to test innovative policy and delivery approaches that promote the objectives of the Medicaid program
- Managed LTSS service can be provided through an 1115
- Some states have used 1115 plus 1915(b)/(c) waivers to delivery HCBS



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■ DEINSTITUTIONALIZATION



■ PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

- Created under OBRA 1987
- Mandatory part of the State Plan
- Level I PASRR
 - Screen for evidence of a mental illness, intellectual disability, or related condition
- Level II PASRR
 - If screen positive in Level I PASRR
 - Appropriateness of nursing facility placement
 - Determine need
 - Inform the plan of care



■ AMERICANS WITH DISABILITIES ACT (ADA)

- Title II of ADA
 - People with disabilities may not be excluded from participating in, or denied the benefits of, governmental services, programs, or activities



■ AMERICANS WITH DISABILITIES ACT

- Integration Mandate implementing regulations requires:
 - Administration of services, programs, and activities in the most integrated setting appropriate to the needs of people with disabilities
 - Reasonable modifications to policies, practices, and procedures to avoid disability-based discrimination, unless such modifications would fundamentally alter the nature of the service, program or activity
 - Provision of services in the most integrated setting, which enables individuals with disabilities to interact with non-disabled peers to the fullest extent possible



■ OLMSTEAD

- 1999 Supreme Court decision
- Unjustified institutionalization of people with disabilities is illegal and discriminatory
- Requires states to serve individuals in the least restrictive and integrated setting when:
 - Appropriate for individual
 - Not opposed by affected person
 - Can be reasonably accommodated



■ OLMSTEAD

- Olmstead Plan recommended to demonstrate compliance
- U.S. Department of Justice role to enforce integration mandate
- Olmstead complaints are investigated by the Office of Civil Rights



■ MONEY FOLLOWS THE PERSON INITIATIVE

Centers for Medicare and Medicaid Services (CMS):

“...system of flexible financing for long-term services and supports that enables available funds to move with the individual to the most appropriate and preferred setting as the individual’s needs and preferences change.”

Source: <http://www.ncsl.org/print/health/moneyfollowspersonltc.pdf>



■ **MONEY FOLLOW THE PERSON**

- DRA of 2005 created the demonstration opportunity
- Encourages transition of Medicaid enrolled individuals from nursing home to HCB settings
- Enhanced federal matching funds for 12 months for each transitioned Medicaid beneficiary
- Allows Medicaid funding to ‘follow the person’ into the community
- ACA extended through 2016 and reduced time must be in institution to 90 days (vs 6 months)



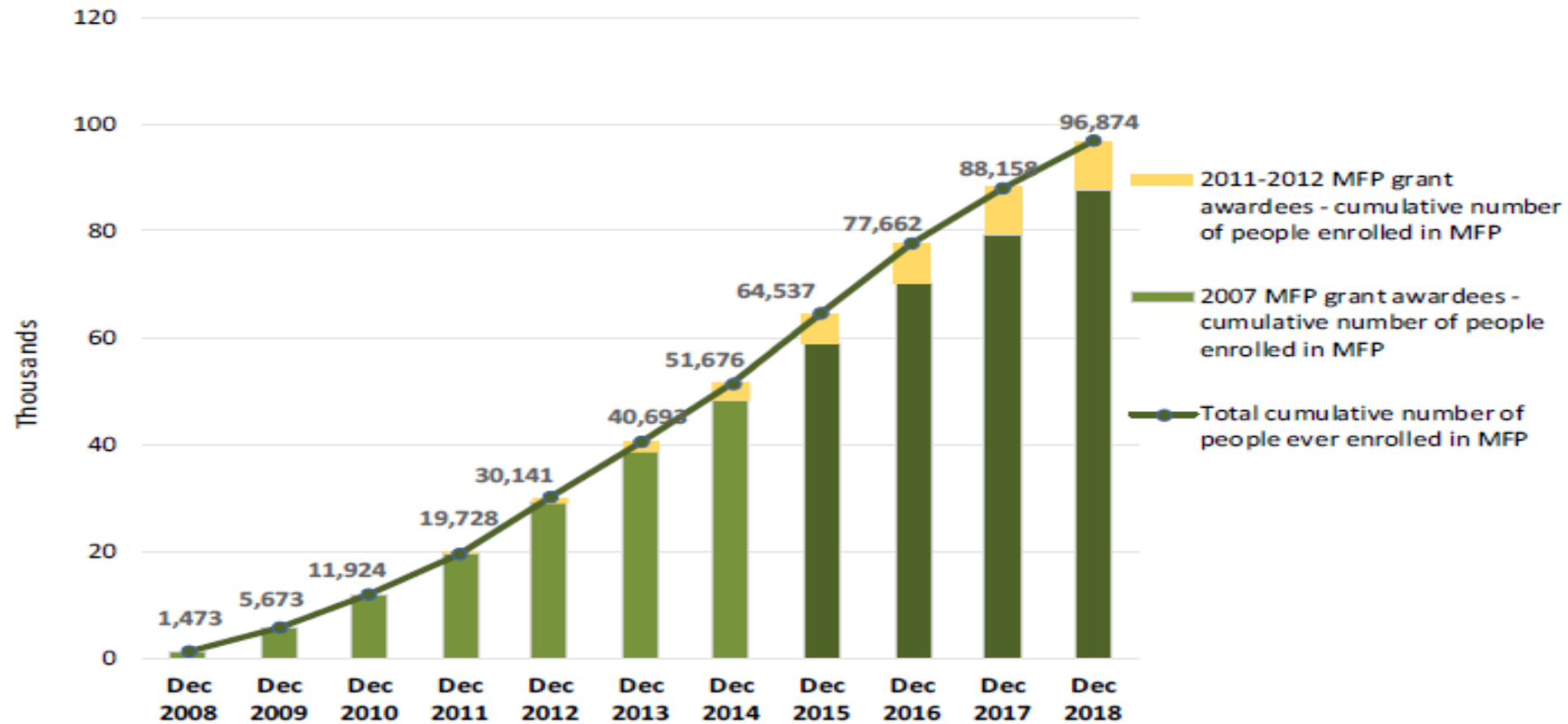
■ MONEY FOLLOWS THE PERSON

- MFP provides funds to:
 - Identify nursing home residents interested in making a transition to the community
 - Provides financial resources to cover costs of transitioning back to the community that are not typically allowed in regular LTSS waivers
 - Funds transition coordination services



MFP TRANSITIONS

Figure II.2. Cumulative total number of MFP transitions, actual (2008–2014) and projected (2015–2018)



Source: Mathematica’s analysis of State MFP Grantee Semiannual Progress Reports, 2008–2014 and 2014 and 2015 supplemental budget worksheets submitted by MFP grantees.



■ MFP BENEFICIARY SPENDING

Table ES.1. Per-beneficiary, per-month total Medicaid and Medicare expenditures pre- and post-transition to community services, by target population

Period	Older adults	Younger adults with physical disabilities	Individuals with intellectual disabilities
Pre-transition expenditures	\$8,079	\$7,759	\$13,469
Post-transition expenditures	\$6,239	\$5,976	\$9,456
Change in expenditures	\$1,840	\$1,783	\$4,013

NOTE: Cost estimates were not created for individuals who transitioned from psychiatric facilities because of small sample size issues.

Source: <https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-2015-annual-report.pdf>



■ **BALANCING INCENTIVES PAYMENT PROGRAM**

- Established under ACA Section 10202
- Goal: Increase access to non-institutional LTSS
- Structural Changes
 - Single Point of Entry/No Wrong Door
 - Conflict-Free Case Management
 - Single State Assessment for determining eligibility



■ **BALANCING INCENTIVE PAYMENT PROGRAM**

- Ran through September 30, 2015
- States received additional Medicaid matching funds when they meet certain requirements for expanding the percentage of long-term care spending for home- and community-based services



■ BALANCING INCENTIVE PAYMENT PROGRAM

Current Non-institutional Medicaid Expenditures (% of total LTSS Spend)	Eligible?	Goal	% FMAP Increase
>50%	No	--	--
25-50%	Yes	50%	2%
<25%	Yes	25%	5%



■ **LTSS: WHAT TO EXPECT GOING FORWARD**

- Expansion of Medicaid LTSS
- Increasing movement of Medicaid LTSS to managed care
- Better coordination across physical health, behavioral health, and HCB services
- Greater CMS focus on quality and oversight
- Use of 1115 authority to reach greater flexibility in delivering HCBS services



MEDICAID MANAGED LTSS

Barbara Coulter Edwards, Principal
August 28, 2017

HEALTH MANAGEMENT ASSOCIATES

Topics We Will Cover

- Current Trends in MLTSS
- Goals for MLTSS
- Role of the State in MLTSS
- Role of the MCO
- Dual Eligible Programs
- New Medicaid Managed Care Rules

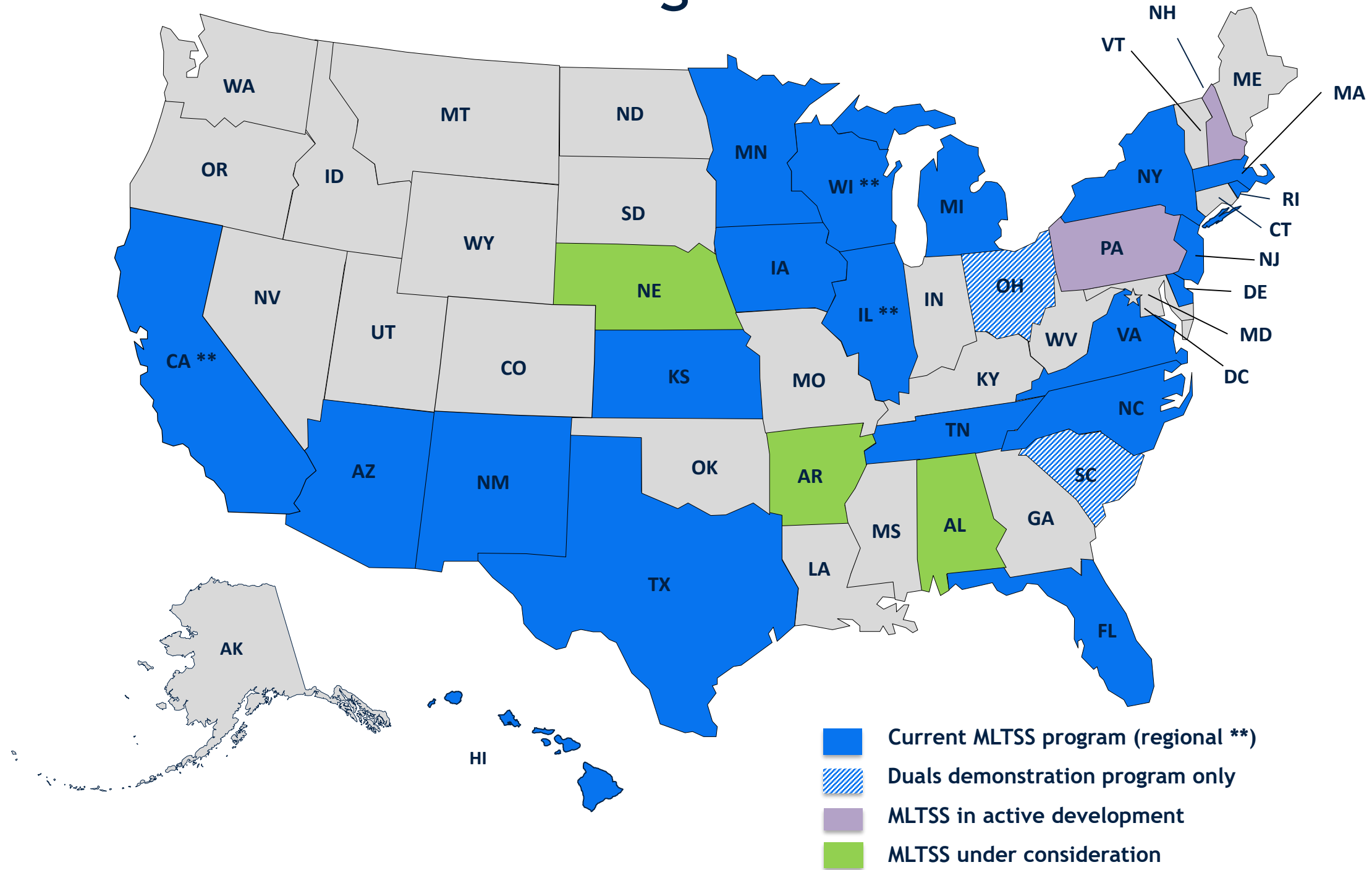
Movement to Managed Long Term Services and Supports

- Currently 22 states have implemented MLTSS and 5 more are actively planning or considering a program
- MLTSS includes institutional and community based services and supports
- Goal is to integrate physical, behavioral, and LTSS in a person centered plan of care
- Requirements for service coordination
- Assessment of all members to determine unmet needs
- Flexibility in services

MLTSS Can Include all Populations and HCBS Waivers

- Medicare/Medicaid dual eligible population
- Adults with disabilities
- Children with Special Health Care Needs
- Persons with Intellectual and Developmental Disabilities
- Foster Care Children

MLTSS Programs - 2017



Source: NASUAD survey; CMS data

State Goals for MLTSS

- Expand community LTSS options, and streamline and standardize the way people access them;
- Develop new models of care that integrate financing, care coordination and service delivery;
- Innovate in the LTSS sector with creative housing and other supports, greater use of technology, and new strategies to recruit and retain direct care workers;
- Strengthen the focus on quality measurement, including both quality of life and quality of care, in order to achieve better outcomes; and
- Ensure long-term sustainability of the system as demand for LTSS grows.

State Initiatives and Innovations

- Use of data to support continuous quality improvement
- Use of technology
 - ✓ Electronic visit verification (EVV)
 - ✓ Remote monitoring and support
- Enhancing risk management
 - ✓ Back-up plans and mitigation strategies
- Integrated provider networks (ACOs)
- Value-based purchasing
- Reduction of Waiting Lists for HCBS

How States Promote Rebalancing in MLTSS

- Blended rate for nursing facility and HCBS
- No waiting lists for HCBS
- Higher capitation rates for HCBS
- Replacing 1915(c) waiver “slots” with 1115-authorized LTSS for plans to administer based on need, cost-effectiveness
- Transition allowances
- Service Coordinators required to help members with diversion, transition and relocation
- Performance measures that penalize any increased NF utilization

What do MCOs Know About LTSS?

- Steep learning curve – particularly for concepts like self-direction
- Many MCOs look to hire state LTSS staff
- Need to have good training on the provider community and how they have been doing business with the state
- Need a strong approach to assuring cash flow to providers
- Need to develop new care management systems
- National MCOs bring staff from one state to start programs in other states
- If they try to inappropriately cut LTSS services – word spreads fast.

MCOs Innovations and Initiatives for MLTSS

- Reaching hard to locate persons
- Building relationships with Members
- Electronic care management systems
- Value based purchasing
- Diversion, transition and relocations
- Person centered service plans that offer increased options

Examples of MCO MLTSS Innovations

- When national disaster hits the community...
- Finding housing solutions
- Bringing the services to persons where they live
- Person-centered service substitutions
- Shared savings with Providers
- Telemedicine and telehealth
- Value added services

Focus on Quality Improvement and Performance

- Begins with the contract - Value based purchasing concepts
- Performance incentives and disincentive
- Shared savings models
- New quality measures for MLTSS are under development
- Evidence-based, best practices to detect both under and overutilization of LTSS
- Member and Provider Complaints and Grievances analyses
- Member Satisfaction Survey
- MLTSS-oriented Performance Improvement Projects

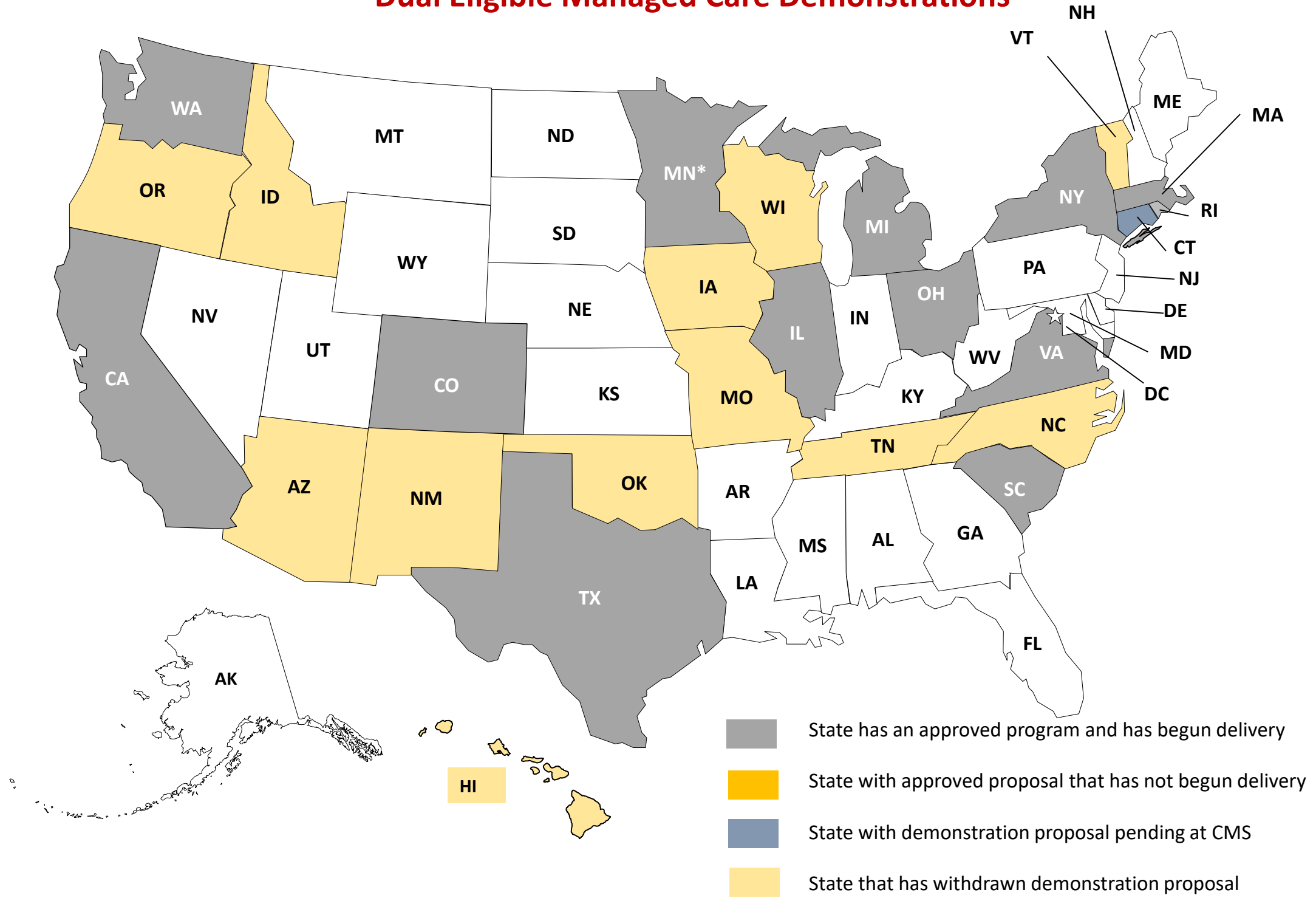
What does MLTSS Mean to HCBS Providers?

- Consolidation and acquisition
- Survival of the fittest
- Competition for members
- Any willing provider no more
- Changing roles for ADRC and AAAs
- This is a game changer

Options for States to Integrate Care for Duals

- Financial Alignment Demos: Capitated or FFS
 - ✓ Allows for shared savings of Medicare dollars
 - ✓ State must agree to MOU requirements
 - ✓ CMS sets rates for Medicare services – sometimes lower than current D-SNP rates
 - ✓ 12 states participating out of original 26
- D-SNPs
 - ✓ State contracts with Dual Eligible-SNP plan for coordination/specific services
 - ✓ State may require MLTSS plans to offer D-SNP (e.g. TX, NM)
 - ✓ Funding is not integrated and there is no shared savings agreement with CMS
 - ✓ Enrollment, appeals/grievances, and other procedures not integrated
- State Specific Waivers/MOUs
 - ✓ MN, MA, and WI have other demo prior agreements and are seeking separate MOUs to maintain these arrangements (MN received MOU)
 - ✓ Other states that pulled out of FADs (TN, HI, NM, OR and AZ) are seeking alternative to the FADS demo
- Program for All-Inclusive Care (PACE)
 - ✓ As of 2015 – 114 PACE programs in 32 states and more on the way.

Dual Eligible Managed Care Demonstrations



*The Minnesota demonstration involves administrative alignment but does not include payment or service delivery innovations

Federal Programmatic Requirements

- MLTSS-specific provisions are based on May 2013 published guidance for States implementing Medicaid-only MLTSS and are woven throughout rule in sections dealing with care coordination, stakeholder engagement, and beneficiary supports
- The regulations address these elements:

1. Adequate planning and transition strategies	6. Support for beneficiaries
2. Stakeholder engagement	7. Person-centered processes
3. Enhanced provision of HCBS	8. Qualified providers
4. Alignment of payment structures with MLTSS programmatic goals	9. Participant protections
5. Comprehensive and integrated service package	10. Quality

Federal Programmatic Requirements

- Application of HCBS regulations to all managed care programs
 - ✓ Settings (with appropriate transition period)
 - ✓ Conflict of interest
- Allow MCO change if NF/residential/employment provider leaves network
- Network time and distance standards required (or other standards for LTSS providers that travel to beneficiaries)



eff. 7/4/16



eff. 7/1/17



eff. 7/1/18

Federal Programmatic Requirements

Person-Centered Processes

- Service plan must be developed by individuals who are trained in person-centered planning and who meet State's LTSS service coordination requirements
- HCBS characteristics in the HCBS final rule apply to managed care networks
- State must permit, as part of time-limited transition of care policy, consumer to continue services they had prior to MCO enrollment with current providers (if not in MCO network)



eff. 7/1/17



eff. 7/1/18

Federal Programmatic Requirements

Beneficiary Supports

- States must assure choice counseling, an ombudsman-like function, other supports
- States must assure that prior authorization and performance expectations reflect LTSS goals (community integration)
- States and plans must establish stakeholder advisory groups
- Clarified that services continue during appeal of denial
- Members must complete internal appeals before State Fair Hearing (standardized timeframes for internal processes)

The Future of MLTSS

- MLTSS is quickly replacing FFS as state programs look for better ways to deliver LTSS
- More states will explore dual eligible integration programs with the support of CMS
- CMS will focus more sharply on areas of risk in managed care (e.g. DME, personal care, lack of access) leading to...
- States will provide more direct oversight and monitoring of MCO performance
- New LTSS performance measures will be implemented and MCO's payment will be more and more based on performance.

Just When You've Figured it Out... The Mega Reg!

42 CFR Parts 431, 433, 438, et al, Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability; Proposed Rules. A/K/A Medicaid Managed Care Mega Rule

- Modernization
- Alignment with Marketplaces and Medicare Advantage programs
- Managed Long Term Supports and Services
- Prepaid Inpatient Health Plans (PIHP), Prepaid Ambulatory Health Plans (PAHPs) and PCCMs and PCCM-entities
- MLR
- Rate Setting Transparency
- State Comprehensive Quality Strategy – Medicaid STARS
- Encounter Data Penalties (July 1, 2017 look back)

Just When You've Figured it Out... Part Deux... Repeal & Replace!

- Medicaid Reform
- Per Capita Caps
- Block Grants
- Flexibility
- Mandates
- Essential Benefits

Thank you!

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