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OVERVIEW AND HISTORY OF MEDICAID: HOW MEDICAID IS ADMINISTERED

Jerry Dubberly, Principal

DEDICATED TO GOVERNMENT HEALTH PROGRAMS





■ MEDICAID HISTORY

- Signed into law July 30, 1965 along with Medicare
- Title XIX of the Social Security Act
- State and Federal Partnership
- Entitles certain individuals to health care coverage





■ MEDICAID HISTORY

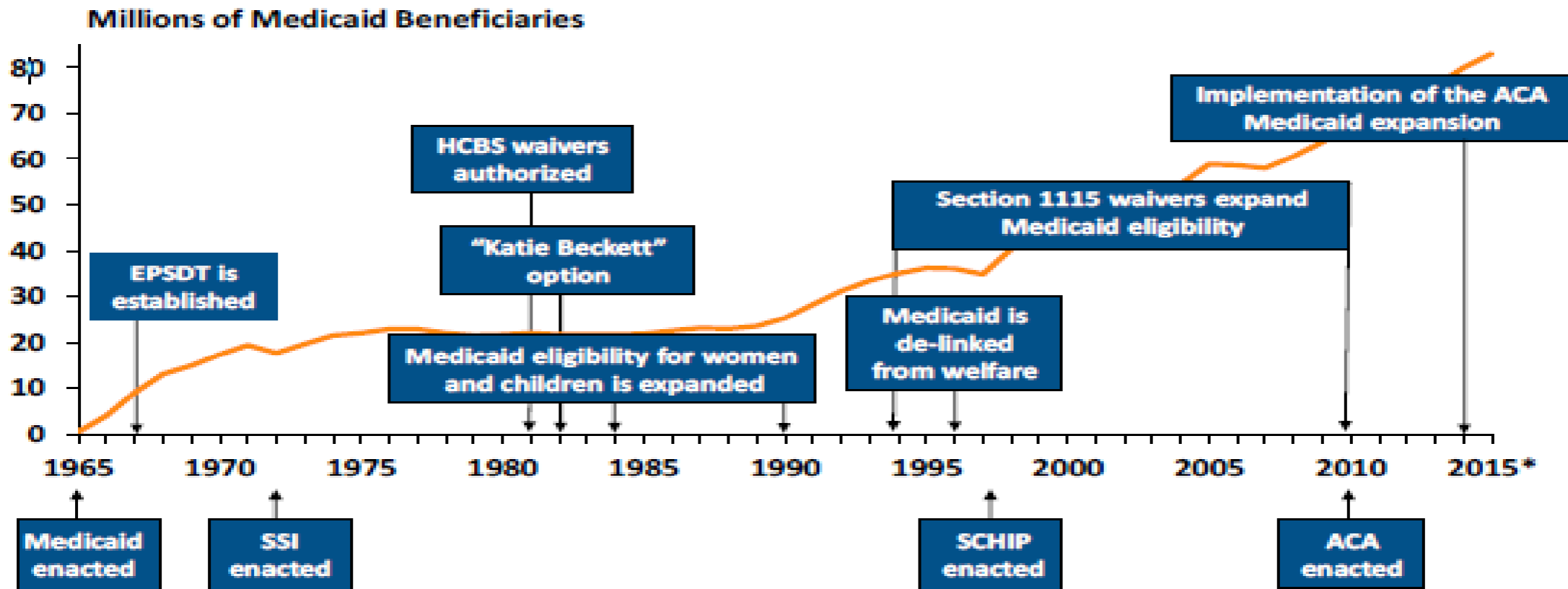
- Originally, health plan for low-income individuals on welfare but delinked from welfare in the 1980's and 1990's.
- Optional program – all states and territories participate today.
- Mandatory and Optional benefits.



■ MEDICAID HISTORY

Figure 2

Medicaid has evolved over time to meet changing needs.



NOTE: *Projection based on CBO March 2015 baseline.

SOURCE: KCMU analysis of data from the Health Care Financing Administration and Centers for Medicare and Medicaid Services, 2011, as well as March 2015 CBO baseline ever-enrolled counts.





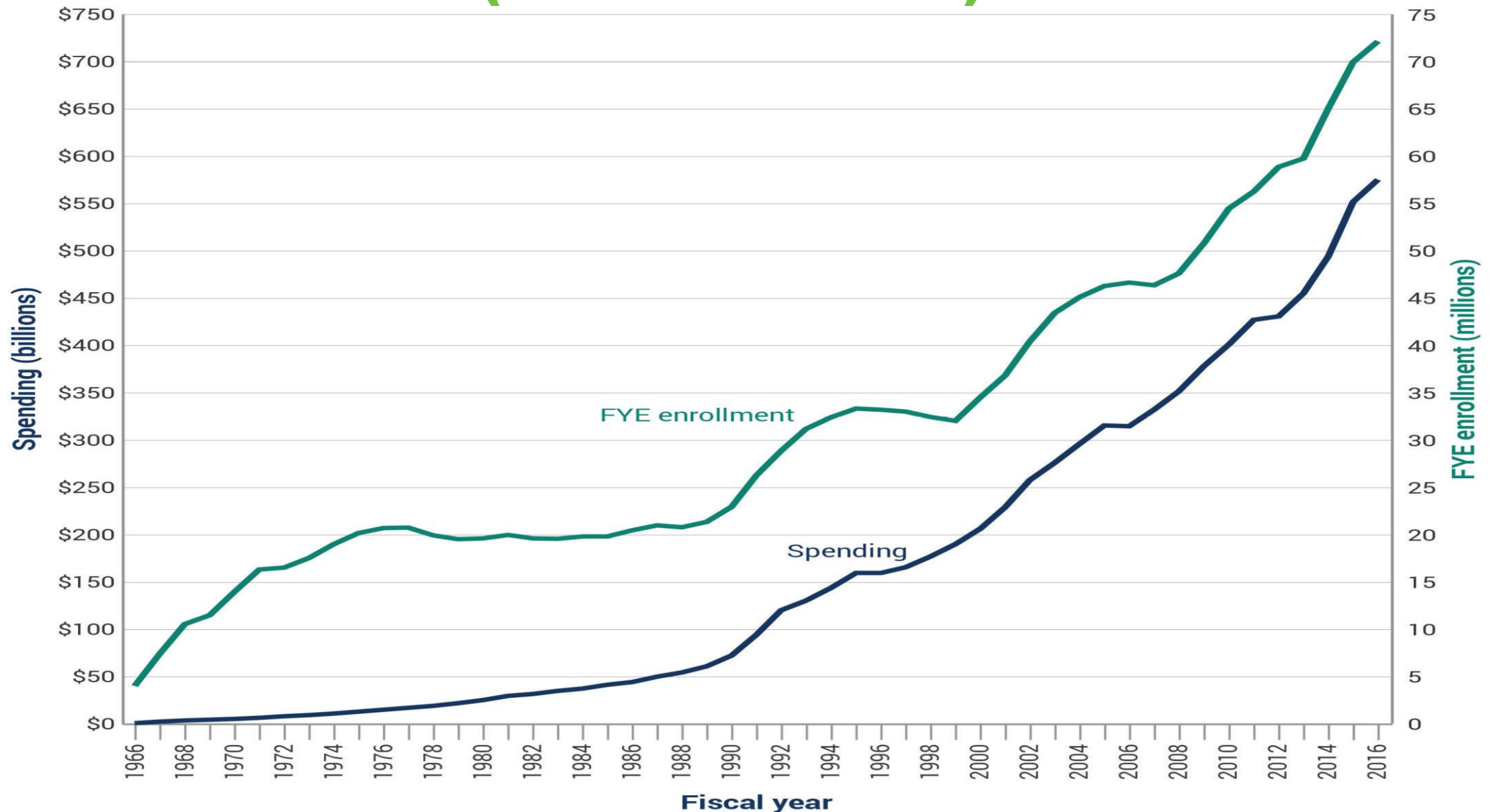
■ MEDICAID TODAY

- Medicaid covers 1 in 5 Americans
- Enrollment: 73,663,050
 - Medicaid: 67,168,933
 - Children's Health Insurance Program: 6,464,117
- 28% increase in enrollment from Pre-ACA
- Medicaid Expenditures \$565.5 Billion in FY2016
 - 17% of total National Health Expenditure
- Medicaid is the primary payer across the nation for long-term care services

Sources: <https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
<https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.htm>



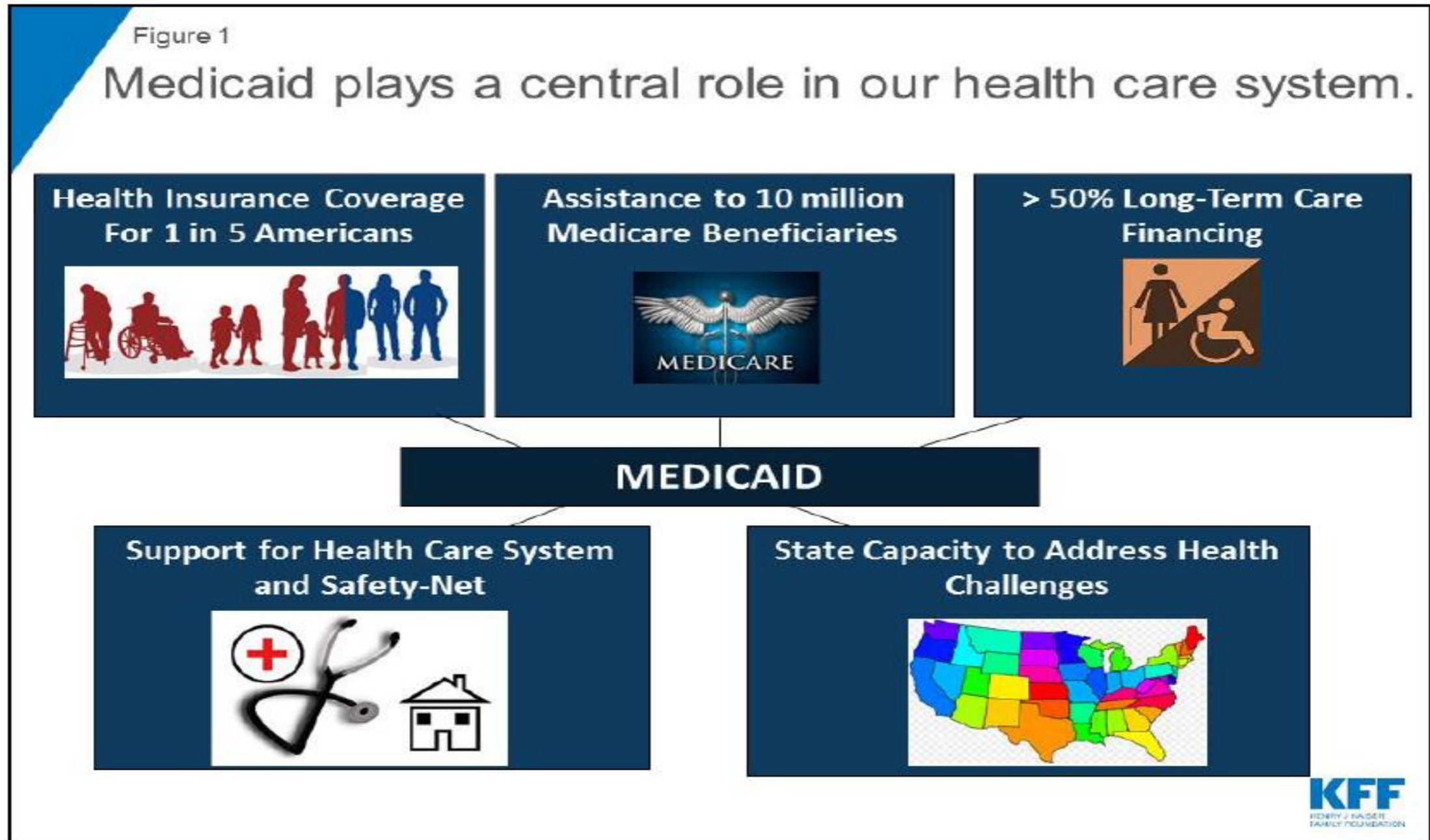
MEDICAID TODAY - ENROLLMENT AND SPENDING (FY1966-2016)



<https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-8.-Medicaid-Enrollment-and-Spending-FYs-1966-2016.pdf>



MEDICAID TODAY



<https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/>



■ MEDICAID ADMINISTRATION

- State and federal partnership
- Federal government establishes rules and parameters for the program and supplies federal funding streams.
- Federal rules of engagement are defined in statute and regulations
 - Social Security Act (Title XIX)
 - Code of Federal Regulations (Title 42)



■ MEDICAID ADMINISTRATION

- 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
 - Frequently Asked Questions (FAQs)



■ MEDICAID ADMINISTRATION – STATE PLAN

- The Medicaid State Plan is the agreement between the state and federal government describing how Medicaid will be administered in a state.
- State Plan includes information such as:
 - Eligible populations
 - Covered benefits
 - Reimbursement methodologies
 - Administrative components
- Can be updated through State Plan Amendments (SPAs)



■ MEDICAID ADMINISTRATION – KEY CONCEPTS

- ***Statewideness*** - States are required to offer the services in their State Plan to all eligible recipients without regard to geographic location.
- ***Comparability*** - Medicaid benefits must also be comparable across the eligible population, meaning that states may not discriminate by providing different services to individuals within specific eligibility groups or limit services based on diagnosis, type of illness, or condition.
- ***Amount, Duration, and Scope*** - Each Medicaid service category must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
- ***Freedom of Choice*** – States must ensure beneficiaries have freedom of choice of providers.



■ **MEDICAID ADMINISTRATION – STATE FLEXIBILITY**

- Subject to review and approval by CMS, states have flexibility regarding eligibility levels, benefits, provider payments, delivery systems and other aspects of their programs.
- Flexibility granted through:
 - State Plan Amendments
 - Waivers



■ **MEDICAID ADMINISTRATION - WAIVERS**

- States may gain additional flexibility through CMS-approved waivers.
- Subject to review and approval by CMS, states have flexibility regarding eligibility levels, benefits, provider payments, delivery systems and other aspects of their programs.
- Various degrees of flexibility and levels of reporting and accountability to CMS based on the waiver type.



■ MEDICAID ADMINISTRATION - WAIVERS

- Types of Medicaid Waivers
 - **1915(b)**: Waives “freedom of choice” and used to implement delivery models, such as mandatory enrollment in managed care, that require eligible beneficiaries to use certain providers to receive services.
 - **1915(c)**: Waives comparability and statewideness and authorizes states to provide home and community-based services (HCBS) as an alternative to institutional care.
 - **1115 Demonstration**: Allows the Secretary of HHS to authorize any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of the program.



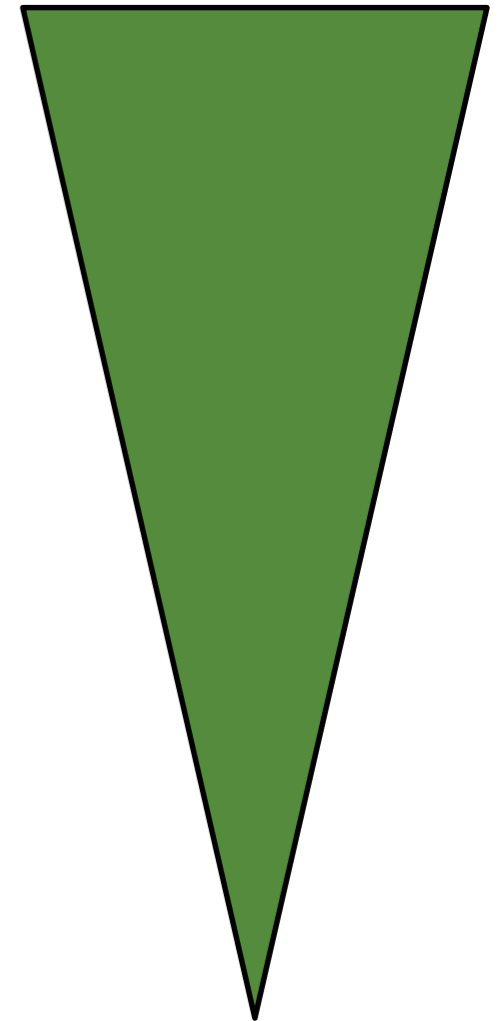
■ MEDICAID ADMINISTRATION - WAIVERS

- **1915(b)** waivers must demonstrate **Cost Effectiveness**.
 - Waiver will not cause expenditures to be higher than they would have been without the waiver.
- **1915(c)** waivers must demonstrate **Cost Neutrality**.
 - The average per capita expenditure under the waiver during each waiver year not exceed 100 percent of the average per capita expenditures that would have been made during the same year for the level of care provided in an institution had the waiver **not** been granted.
- **1115** demonstrations must demonstrate **Budget Neutrality**.
 - Federal spending will not be more than what it would have been in the absence of the waiver.



■ **MEDICAID ADMINISTRATION – WHERE DO I START?**

- Social Security Act (Title XIX)
- Code of Federal Regulations (Title 42)
- CMS Guidance
- State Plan or Waiver(s)
- State statute and regulations
- State policy manuals and guidance





■ **MEDICAID ADMINISTRATION – PRIMARY ROLE OF CMS**

- The Centers for Medicaid and Medicare Services (CMS) has federal responsibility for Medicaid administration.
- Ensures appropriate federal matching payments to states.
- Evaluates State Plan Amendments and waiver requests.
- Interprets federal statutory requirements.
- Collects data on expenditure of federal funds.



■ **MEDICAID ADMINISTRATION – PRIMARY ROLE OF CMS**

- Monitors and enforces state compliance with federal requirements as well as State Plan or waivers.
- Ensures the efficient administration of the program by the state.
- Ensures federal matching funds are not spent improperly or fraudulently.



■ **MEDICAID ADMINISTRATION – PRIMARY ROLE OF THE STATE**

- Must identify a single-state agency.
- Day-to-day administration of the Medicaid program.
- Define eligible populations and enrollment.
- Determine covered benefits, service settings, and provider types.
- Set reimbursement and pay providers.
- Identify delivery system(s).



■ **MEDICAID ADMINISTRATION – PRIMARY ROLE OF THE STATE**

- Ensuring state and federal health care funds are not spent improperly or fraudulently.
- Collecting and reporting information necessary for effective program administration and accountability.
- Resolving grievances by applicants, enrollees, providers and plans.



■ MEDICAID ADMINISTRATION - FUNDING

- 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
 - Inversely proportional to a state’s average personal income relative to the national average
 - FFY 2019 Minimum of 50% & Maximum of 79.39% (not including ACA enhanced match rate)
 - Adjusted on a 3-year cycle, and published annually
- All states receive a 50% match for administrative costs.
- FMAP exceptions for certain populations and services (e.g., Native Americans and Alaska Natives, information systems, family planning, Medicaid expansion population, etc.).



■ MEDICAID ADMINISTRATION - FUNDING

- 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
 - Certified Public Expenditures
- Federal law does require that at least 40 percent of the non-federal share comes from state funds.
- CMS verifies that state funding sources meet statutory and regulatory requirements prior to authorizing FMAP payments.



■ MEDICAID ADMINISTRATION - FUNDING

- Federal funding flow overview:
 - States file a CMS-37 form identifying anticipated quarterly budgeted costs.
 - CMS issues a grant award to the state authorizing federal Medicaid funds for the quarter based on the CMS-37.
 - States file a CMS-64 form identifying actual quarterly expenses.
 - Actual expenses are reconciled to the advance.



■ **MEDICAID ADMINISTRATION – DELIVERY SYSTEM**

- Fee-for-Service (FFS)
- Managed Care
 - Covers nearly two-thirds of Medicaid beneficiaries
 - Responsible for ensuring access and improving quality
 - Additional flexibility over FFS



■ SUMMARY

- Medicaid created in 1965 through Amendments to the Social Security Act.
- Tremendous growth in the program over the years.
- Joint federal and state partnership.
- State Plan is the operational agreement between CMS and the state.
- Majority of funding through CMS with a number of elaborate and complex funding mechanisms.
- State flexibility available through various waivers.
- Medicaid Managed Care has become the predominant delivery system model.

MEDICAID 101: OVERVIEW OF MEDICAID ELIGIBILITY

Ruth Kennedy
Health Policy Director
Southern Strategy Group-LA





THE
GATE KEEPERS

“Origins” of Medicaid Eligibility

Deeply rooted in two federally financed cash-assistance programs for the very poor: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) for “Aged Blind, and Disabled”

AFDC-Related “Categories”	SSI-Related “Categories”
Children and Their Parents	Age 65 and Above
Pregnant Women	Blind and (Majorly) Disabled

Categorical Eligibility Factors

- Person fits within a Medicaid “**category**” (based on factors such as age, relationship, meeting definition of disabled or blind)
- Meets **non**-financial factors such as state residency, citizen or appropriate immigration status, assignment of rights

Financial Eligibility Factors

- Countable monthly income
- Countable resources (assets)



53+ Years of Medicaid Eligibility “Evolution” (1965-2018)

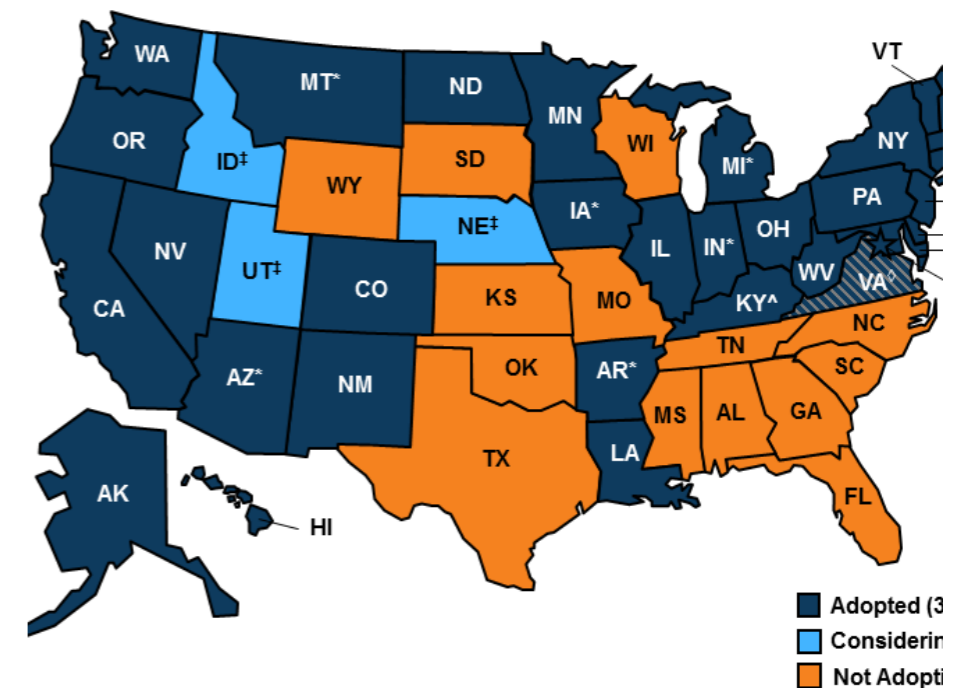
- New **mandatory** Medicaid categories/programs added
- New **optional** Medicaid categories/programs/services added
- **Optional** higher income limit than SSI for persons needing long term services and support (Special Income Level (SIL))
- **Mandatory** higher income limits for pregnant women and minor children
- Spousal impoverishment income and resource protections
- Option to use **more lenient methods** of calculating income and resource eligibility than used for cash program (1902(r) (2))
- Standardizing method for determining net countable income (MAGI); eliminating any assets test for children and parents

Mandatory vs Optional Eligibility Groups

- **Mandatory** Groups (> 25 Groups States Must Cover)
 - People age 65 and > **or** who meet the disability standard below ~75% FPL
 - Children 0-5 below 133% FPL or 6-18 below 100% FPL
 - Pregnant women below 133% FPL
 - Children aging out of foster care until age 26
 - Medicare beneficiaries with limited income and resources (not full Medicaid)
- **Optional** Groups (> 25 Groups States Can Elect to Cover)
 - Medically Needy groups
 - Special Income Level (SIL) with higher income limits for persons needing Long Term Services & Supports
 - Medicaid Buy-in such as “Ticket to Work”
 - Breast and Cervical Cancer (BCC) Program
 - Family Opportunity Act
 - Affordable Care Act (ACA) expansion

Affordable Care Act (ACA) Changes to Medicaid Eligibility (Effective 1/1/14)

- Expansion to Adults age 19-64 for whom there was no previous “category”
 - Adults without a minor child in home at 138% FPL and below
 - Parents who are not otherwise eligible for Medicaid (income > the State’s TANF maximum) and 138% FPL
 - **Cannot have other health insurance or be eligible for Medicare**
 - Higher federal match rate for expansion adults (currently 93%)
 - Supreme Court ruled in June 2012 that expansion of eligibility is **optional** for states



ACA Medicaid Eligibility Changes that Impacted ALL States

- Standardized certain aspects of eligibility for children, parents, pregnant women, expansion adults (think AFDC-related categories)
 - Countable income calculated using federal income tax methods—Modified Adjusted Gross Income (MAGI)
 - Electronic verification of income
 - No wrong door—coordination and sharing of application and information with federal and state insurance marketplaces
 - No assets test allowed
 - **Important to note that these ACA changes do not apply to the SSI-related eligibility groups (seniors, people with disabilities, blind)**
 - Still significant variation among states in determining countable income and resources for SSI-related groups

Establishing **Disability** for Medicaid Eligibility Purposes

- SSA definition of disability is used in 1634 and SSI criteria states
- Sets a very high bar of major and long-term disability :
- Medically determinable mental or physical disability that-
 - Renders person “unable to work engage in any ‘substantial’ gainful activity” (SGA)
 - for 12 months or longer , or
 - Can be expected to result in death
- 2018 SGA = \$1180 (\$1970 if blind)
- Social Security *Blue Book* contains the minutia
 - Part A (Adults)
 - Part B (Children < 18 Years Old)
 - Some conditions “automatically” meet the criteria
- Some 209(b) states use more stringent criteria for determining disability and/or blindness

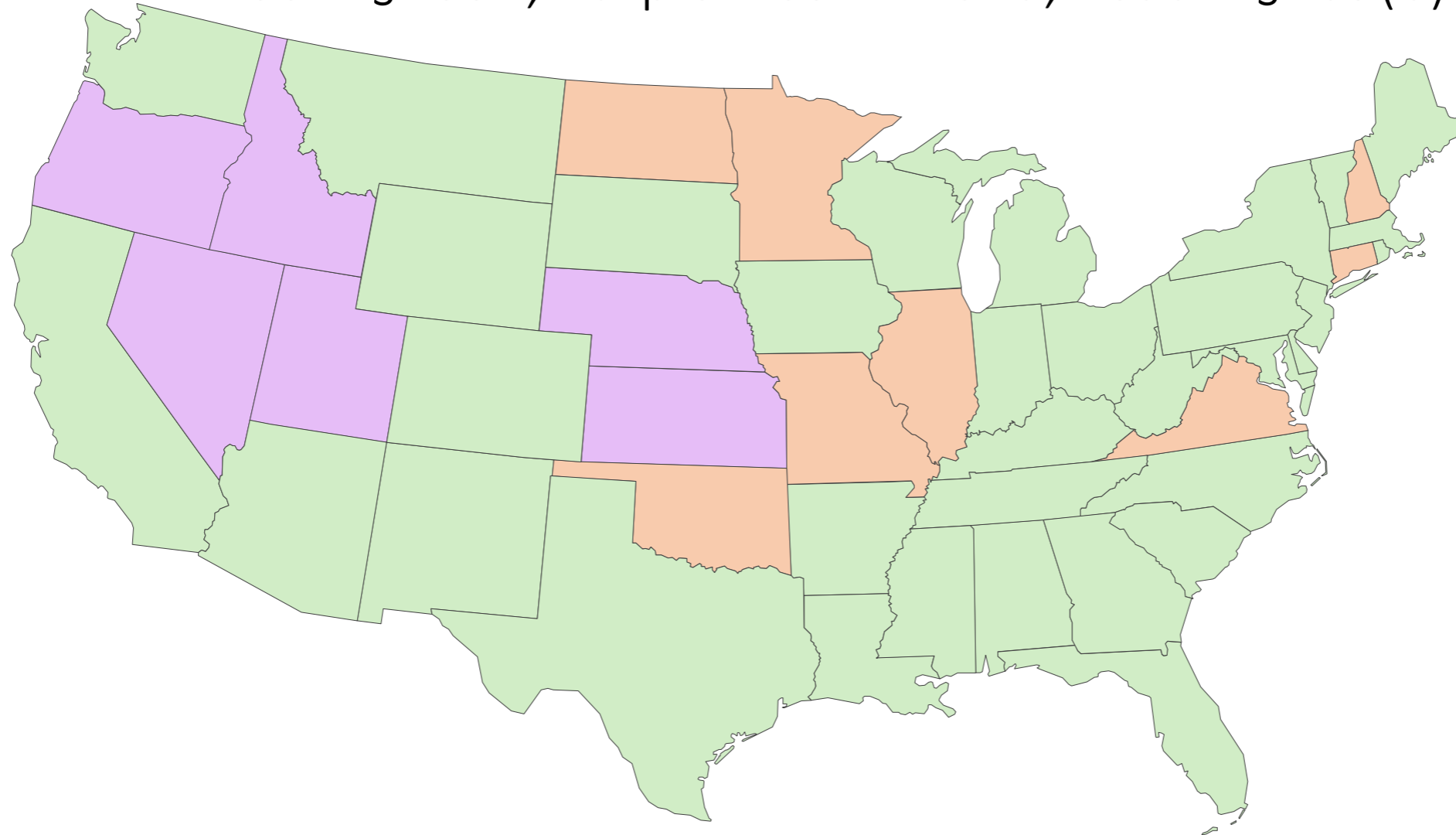


Three Options States Have for Determining Medicaid Eligibility of SSI Beneficiaries

- **Section §1634 States—SSA Administration (33 states and DC)**
 - Same eligibility criteria as SSI
 - Contract with SSA via a “1634 agreement” to also determine **Medicaid** eligibility for SSI
 - **No separate application required**—eligibility files transmitted to state
 - Referral to state for final determination in rare cases (Medicaid qualifying trusts, transfer of resources, TPL, refusal to assign rights)
- **SSI Criteria States—State Administration (7 states and Northern Mariana Islands)**
 - Same eligibility criteria as SSI for income, resources and disability
 - Categorically eligible for Medicaid but **separate application is required**
- **Section § 209(b) States (10 states)**
 - Can have own rules; use at least one eligibility criterion more restrictive than SSI
 - **Separate application is required**
 - Criteria cannot be **more** restrictive than standards in effect 1 July 1972
 - **All but HI have income limit close to SSI limit; asset limit** can be lower (or higher)
 - Must provide for deducting incurred medical expenses (Spend-down)

Medicaid Eligibility Administration for SSI Beneficiaries 2018

Green=§1634; Purple = SSI Criteria; Peach=§209(b)



“Eligibility” Factors for Medicaid Home and Community-Based Waivers

- **Meet Medicaid Categorical and Financial Eligibility**
 - For group included in Medicaid State Plan and specified in Waiver
- **Meet Institution-Equivalent Level of Care (LOC)**
 - In absence of waiver services, would require Medicaid payable services provided by nursing facility, ICF/DD facility, or hospital
 - Clinical determination that looks at functional ability/need for assistance with personal every day activities like bathing, dressing, eating and transferring
- **Be a Member of the Waiver Target Group**
 - Three broad target group are 1) Aged and/or Disabled, 2)I/DD, and 3) Persons with Mental Illness (may be called Serious Emotion Disturbance {SED) for age 21 and <)
 - May be much more narrowly targeted e.g., (autism, HIV)
 - Cost **can** be a factor, depending on if waiver cost limit is individual or aggregate



Can Be “a **Lot** of Spoons in This Gumbo” to Determine Eligibility !

- Medicaid Eligibility Worker
- Team Determining if Disability Factor Met (if not already SSI or RSDI)
- Person(s) Tasked with Determining Medical Need/Level of Care
- “Target Group” State Agency Personnel
 - I/DD Agency
 - Office of Aging
 - Behavioral Health Agency
- Case Manager
- Person Completing Assessment and Service Plan



State Residency Requirement

- States cannot require a durational residency requirement
- State of residency is state in which person is currently living and intends to reside
- Medicaid eligibility cannot be terminated because of a person's temporary absence from the state if they "intend to return" (and have not enrolled in Medicaid in the other state)
- Persons considered incapable of indicating intent to reside—
 - of 49 or less, or mental age 7 or less
 - Judged legally incompetent or
 - Found incapable of indicating intent based on medical documentation
- If unable to indicate intent, State of residence is where person is currently living
- *Cannot have out-of-state property excluded as "home property" (as exclusion is based on "intent to return")*

Where do you live?

Special Financial Eligibility Considerations for Long Term Services and Supports (LTSS)

- States may have higher income eligibility levels for people needing care in institution or HCBS
- Special Income Level (SIL)
 - 300% of Federal Benefit Rate (FBR) which is maximum monthly SSI payment amount
 - Calendar year 2018 FBR is \$750 for individual; \$1125 for couple
- “Spend-down” of income above Special Income Level to qualify for long term care
 - Medically Needy (MN) optional program and in 209(b) states even if no MN Program
 - Medicaid Qualifying Trusts
- Post eligibility treatment of income
 - Income is considered to determine amount of income (if any) person must pay toward cost of care
 - Allowance for maintenance needs, medical expenses, family, housing
- Spousal Impoverishment (ACA extended option to apply HCBS)

Qualified Income (“Miller”) Trust (QIT) Allows Person with Income > Limit to Qualify for Medicaid

- Also called “Utah Gap” trust, referring to the gap between a person’s monthly income and their medical bills/cost of care
- “Income only” trust, result of 1990 Colorado litigation *Miller v Ibarra*
- Addresses problem of too much income to get Medicaid but **not** enough to pay high long term medical bills
- All income goes into the trust (effectively “impoverishing” person); funds from trust pay medical bills; Medicaid pays the balance.
- Includes payback (to Medicaid) provision on death of beneficiary
- Helps with **income** over the limit but not excess **resources**
- Good practical resource on Miller Trusts in.gov/fssa/ddrs/4860.htm

“Income Cap” States Where Miller Trust May Be Needed

Alabama	Indiana	Oregon
Alaska	Iowa	South Carolina
Arizona	Kentucky	South Dakota
Arkansas	Louisiana	Tennessee
Colorado	Mississippi	Texas
Delaware	Nevada	Wyoming
Florida	New Mexico	South Carolina
Georgia	New Jersey	
Idaho	Oklahoma	

It's Not Just About the Income and Resource Limits, But How They Are Calculated

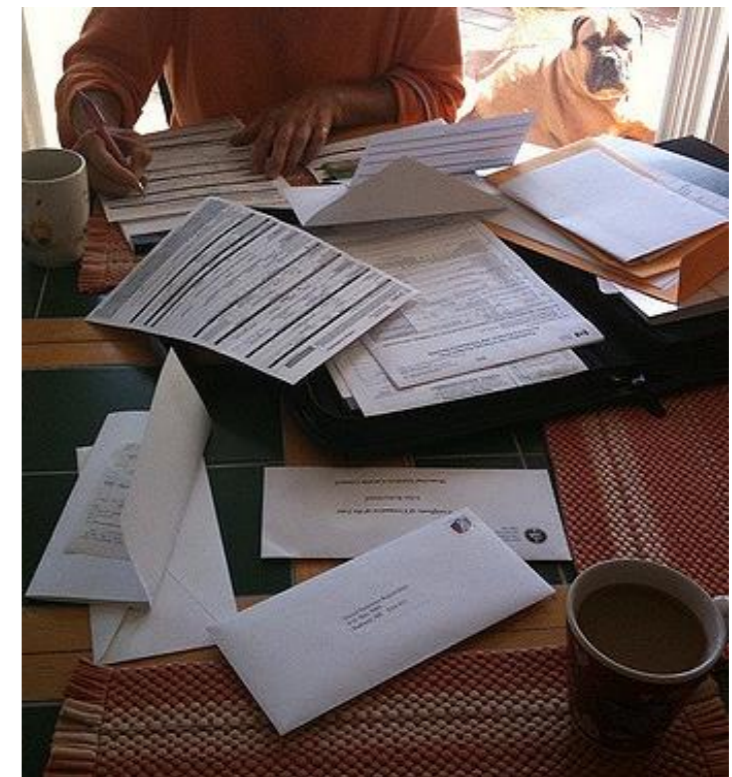


- States can have **less** restrictive income and or resource “methodology” than SSI under Section 1902(r)(2)
- Income and resource exclusions, *i.e.*
 - For institutional level of care, income of parent or spouse
 - Cash surrender value of life insurance policies with total face value at or below \$ XX
 - Value of “in kind support and maintenance”
- States have flexibility in establishing **maximum home equity value** that can be exempt
- Details can be found in Medicaid State Plan

Some Important “Logistical” Considerations for Medicaid and HCBS Eligibility

Paperwork and required documentation can be exhaustive

- Lengthy application forms
- Verification and proofs of income, assets, comparable to applying for a home mortgage
- May require completion of forms by physician
- Face-to-face interview both inside home and outside of home
- Eligibility must be **re-established** at least annually for factors subject to change
 - Medicaid categorical eligibility
 - Institutional level of care
 - Target Population for Waiver
- Critically important to report changes in circumstances within 10
 - Changes can adversely impact continued Medicaid or HCBS waiver eligibility
 - Mail returned from post office is grounds for immediate closure of Medicaid eligibility without advance notice



Key Resources for “Digging Deeper”

- A state’s approved **Medicaid State Plan**
 - Any less restrictive methodologies under Section 1902(r) (2) must be spelled out
 - CMS has developed templates to standardize documentation
 - Search for Supplement 8a to ATTACHMENT 2.6-A for (income) and Supplement 8b to ATTACHMENT 2.6.2 (for resources)
- A state’s approved **HCBS Waiver Application**
 - *Appendix B-1: Participant Access and Eligibility*
 - *Appendix B-2: Individual Cost Limit if applicable*
 - *Appendix B-4- Medicaid Eligibility Groups Served in Waiver*
 - *Appendix B-5: Post-Eligibility Treatment of Income*
 - *Appendix B-6: Evaluation/Reevaluation of Need for Care*
- Be careful about relying on fact sheets and summaries as they may be incomplete

Questions?





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Outpatient Hospital
Tobacco Cessation **Physician Services** *Family Planning Services*
Rural Health Clinic Services **Nursing Facility Services**
Federally Qualified Health Center Services
EPSTD: Early and Periodic Screening, Diagnostic, and Treatment Services *Freestanding Birth Center Services*
Laboratory and X-ray Services Certified Pediatric and Family Nurse Practitioner
Home Health Services
Transportation **Inpatient Hospital**

States Required to provide Certain Mandatory Services

- Inpatient Hospital
- Outpatient Hospital
- Physician Services
- Laboratory & X-rays
- Home Health
- Nursing Facility
- EPSDT
- Rural Health Clinics
- Federally Qualified Health Centers
- Transportation
- Family Planning



States Have Choice to Provide Certain Optional Services

- Prescription Drugs
- Clinic Services
- Physical Therapy
- Occupational Therapy
- Speech, hearing & language disorder
- Podiatry
- Optometry
- Dental
- Chiropractic
- Dentures
- Prosthetics
- Eyeglasses
- Other practitioner services



Most Long Term Services and Supports in the Community are Optional

- Personal Care
- Private Duty Nursing
- Hospice
- Case Management
- Home & Community Based Services (1915 i, j, k)
- PACE
- Community Mental Health
- Health Homes for Chronic Conditions
- Institutes for Mental Disease (65+)
- Inpatient psychiatric services (<21 yrs)
- TB related services



CMS Must Review State Plan Amendments & Waivers for Consistency with SSA

	SPA	Waivers
Submission to CMS	Proposed changes to Medicaid plan	Formal request to have certain federal Medicaid requirements waived
What States Can Ask For	Any aspect of Medicaid program administration (eligibility, benefits, services, provider payments, etc); must comply with federal Medicaid	Must relate to an area specified in Medicaid statute. Main waiver types: <ul style="list-style-type: none">• 1915 (b) Managed Care• 1915 (c) HCBC• Combined 1915

SPAs and Waivers continued

	SPAs	Waivers
Budget Requirements	No cost or budget requirement	Must be cost effective or cost neutral; calculations depend on waiver type
Approval Process	90-day clock that can be suspended if CMS submits information requests to the State	Process for 1115 waivers must be transparent; other waivers posted to Medicaid.gov but not subject to transparency



CMS and Medicaid Directors Have Worked To Improve the SPA and Waiver Processes

Transforming Medicaid: Improving Program Efficiency

SPAs or 1915 waivers are tools that are available to states when they are planning to make programmatic or operational changes to their Medicaid program to better meet the needs of their beneficiaries.



Data collected between calendar year 2016 and the first quarter of 2018



Total of 84%
approved within the first
90 day review period in
the first quarter of 2018



Medicaid SPAs and 1115 Waivers Cover a Variety of Administrative and Service Topics

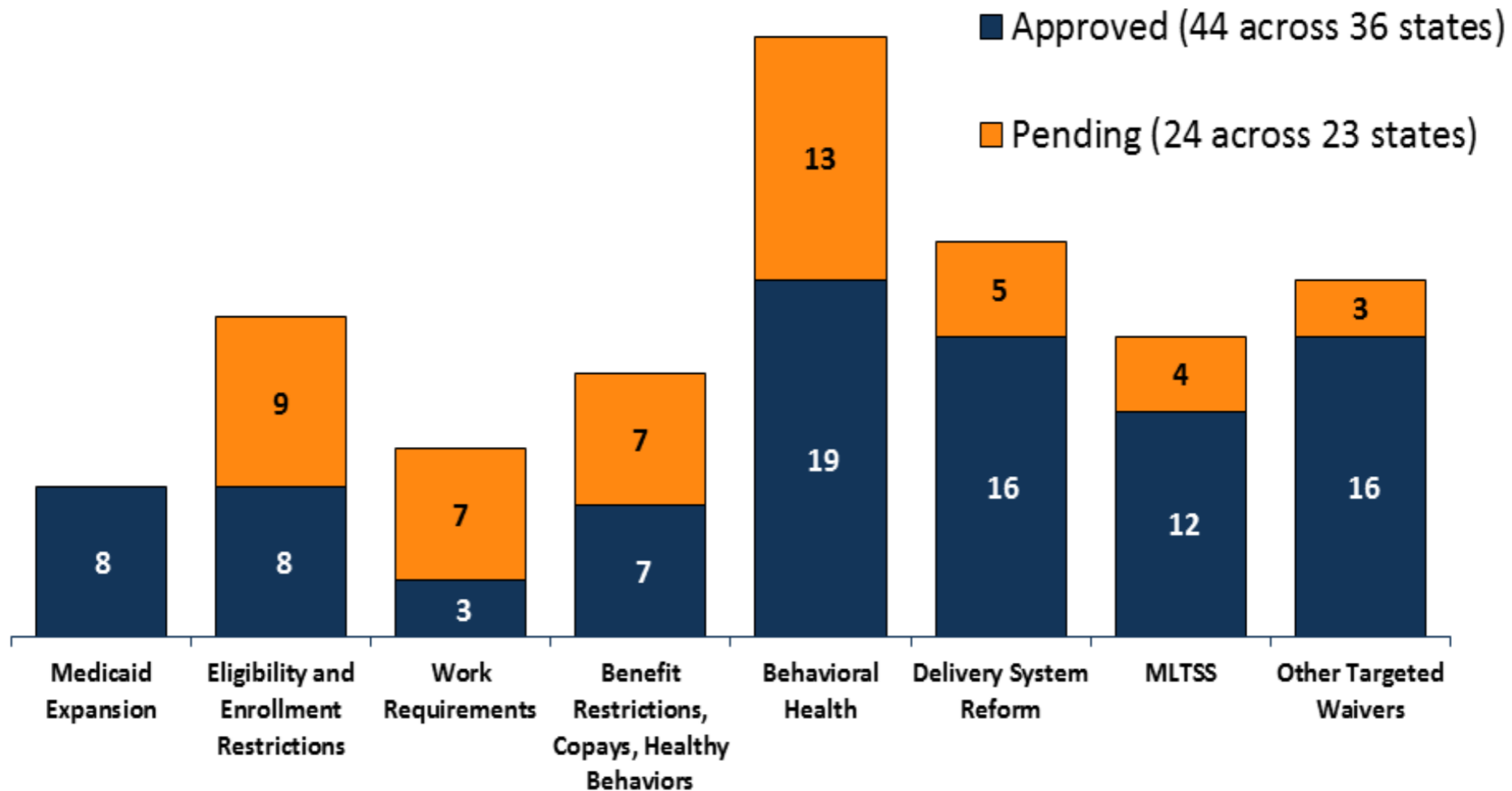
- Eligibility and Enrollment Enhancements
- Medicaid Expansion
- Work Requirements, Co-Pays, Healthy Behaviors
- Benefit Changes
- Pharmacy
- Behavioral Health and Opioids
- Managed Long Term Services and Supports
- Delivery System Reforms



1115 Waiver Activity

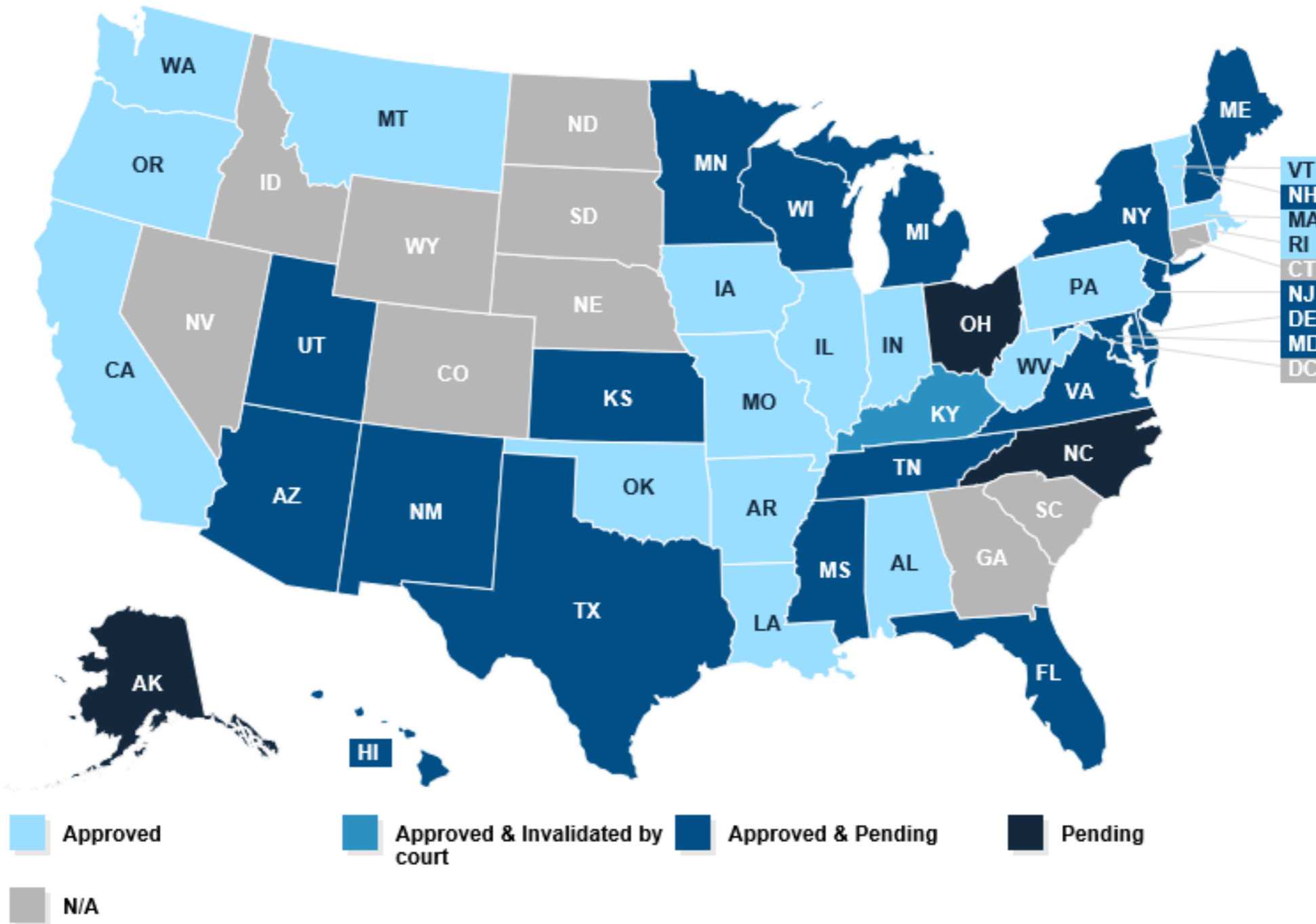
Figure 1

Landscape of Approved vs. Pending Section 1115 Medicaid Demonstration Waivers, March 5, 2018



Notes: Some states have multiple approved and/or multiple pending waivers, and many waivers are comprehensive and may fall into a few different areas. Therefore, the total number of pending or approved waivers across states cannot be calculated by summing counts of waivers in each category. Pending waiver applications are not included here until they are officially accepted by CMS and posted on Medicaid.gov. For more detailed information on each Section 1115 waiver, download the detailed approved and pending waiver tables posted on the tracker page. "MLTSS" = Managed long-term services and supports.

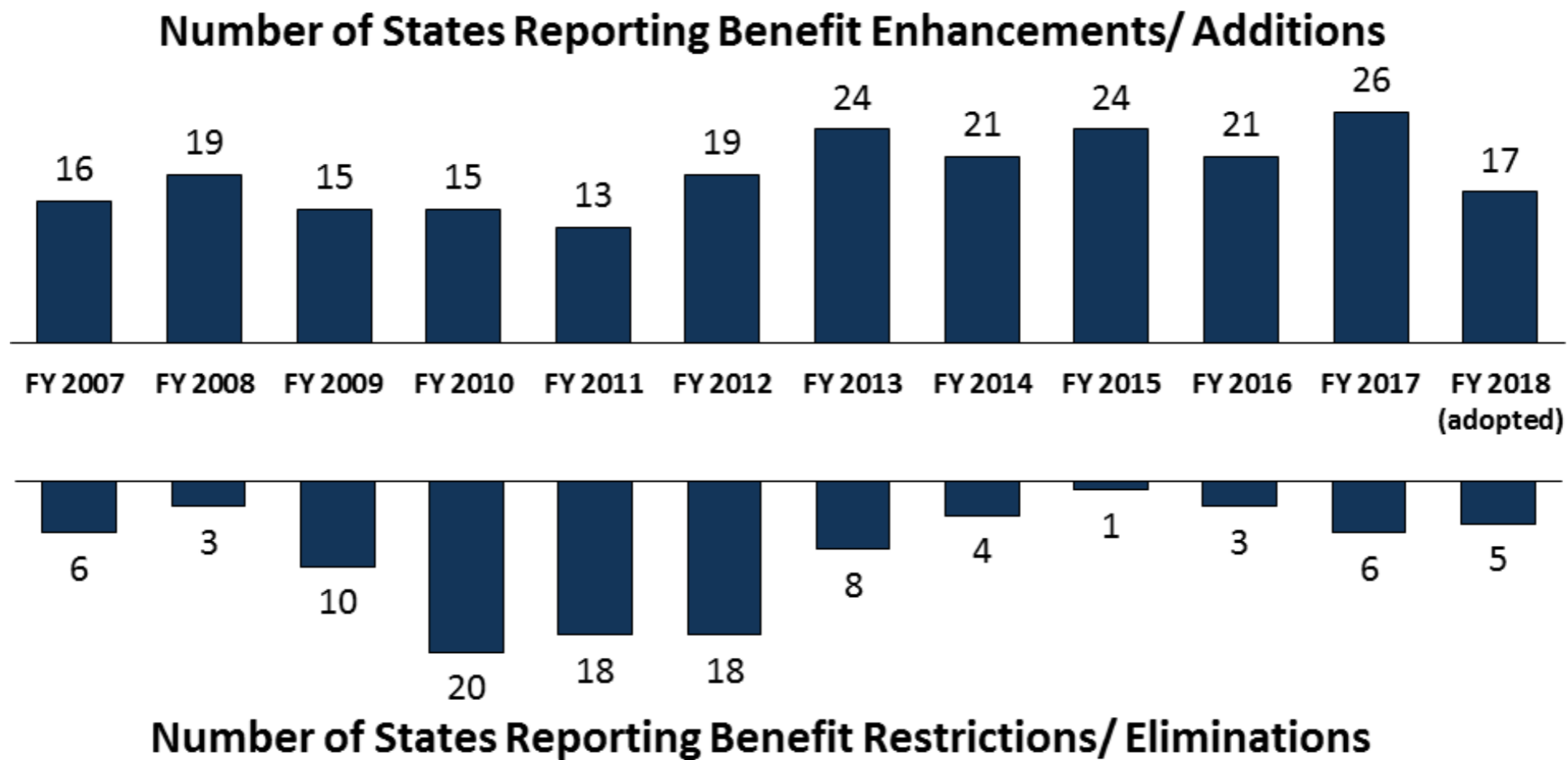
1115 Waiver Activity By State as of August 2018



Benefit Enhancements Outpace Cuts

Figure 10

Benefit Changes Reported by States, FYs 2007 - 2018

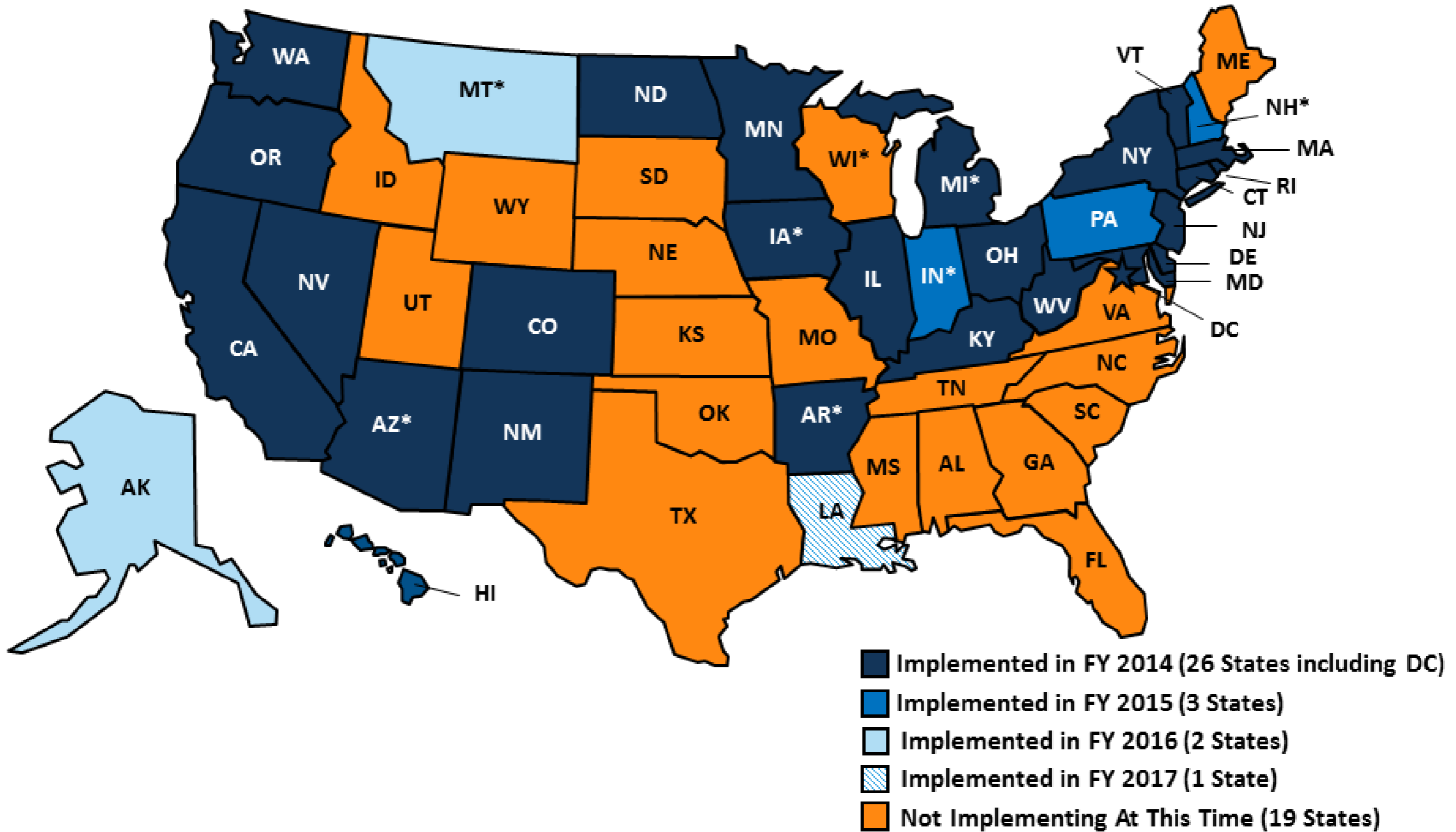


NOTES: States were asked to report benefit restrictions, eliminations, enhancements, and additions in FY 2017 and FY 2018. Excluded from these changes are home and community-based services (HCBS).
 SOURCE: KFF Survey of Medicaid Officials in 50 states and DC conducted by HMA, October 2017.



Figure 1

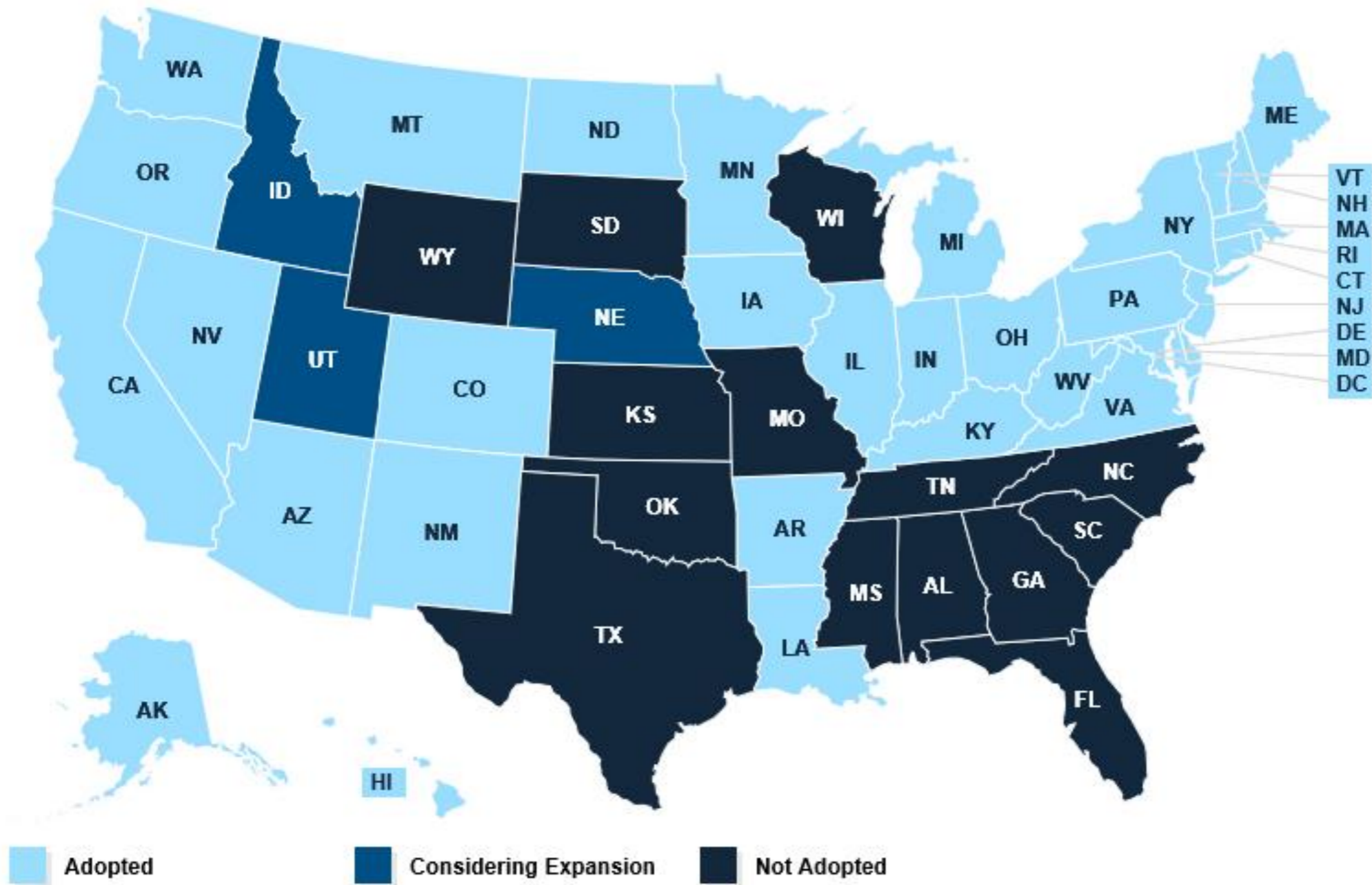
Medicaid Expansion Decisions by Year of Implementation



NOTES: *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 Medicaid expansion waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2017.

Medicaid Expansion Status as of August 2018



Virginia uses two methods to pay Medicaid providers

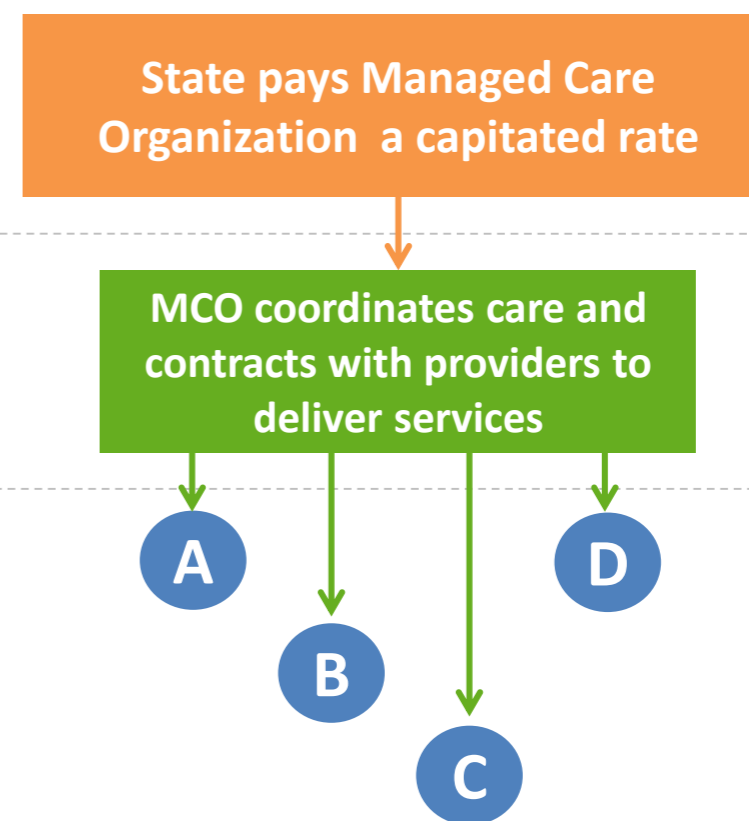
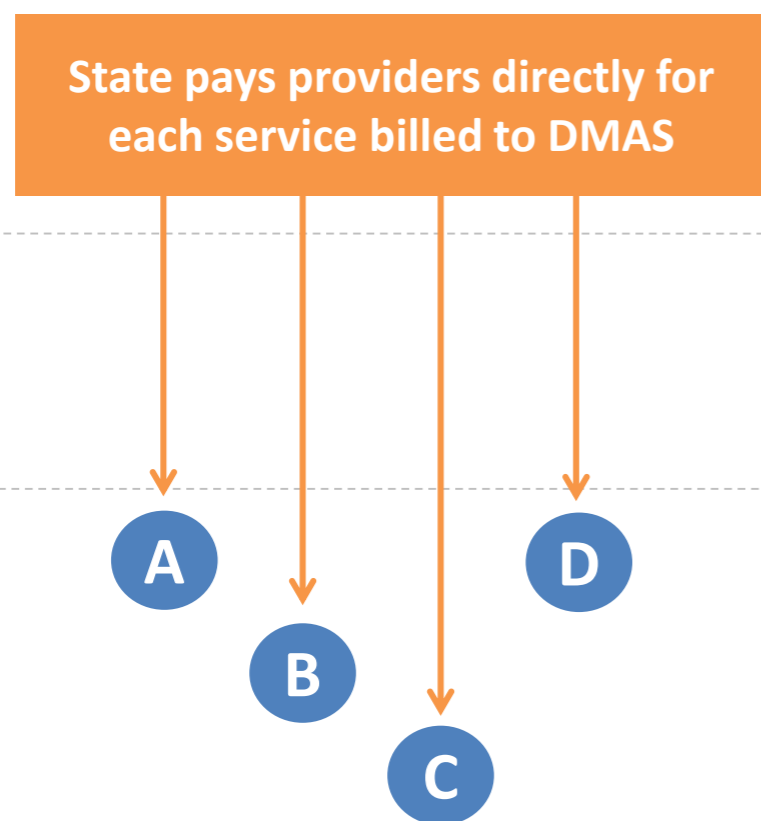
Fee-For-Service (FFS)

Virginia Medicaid pays providers directly for every Medicaid eligible service rendered to Medicaid recipients

Managed Care

Virginia Medicaid pays managed care organizations (MCOs) a set payment for each enrolled member every month. The MCO is responsible for delivering Medicaid health benefits to their enrolled Medicaid recipients

State
Payers
Providers

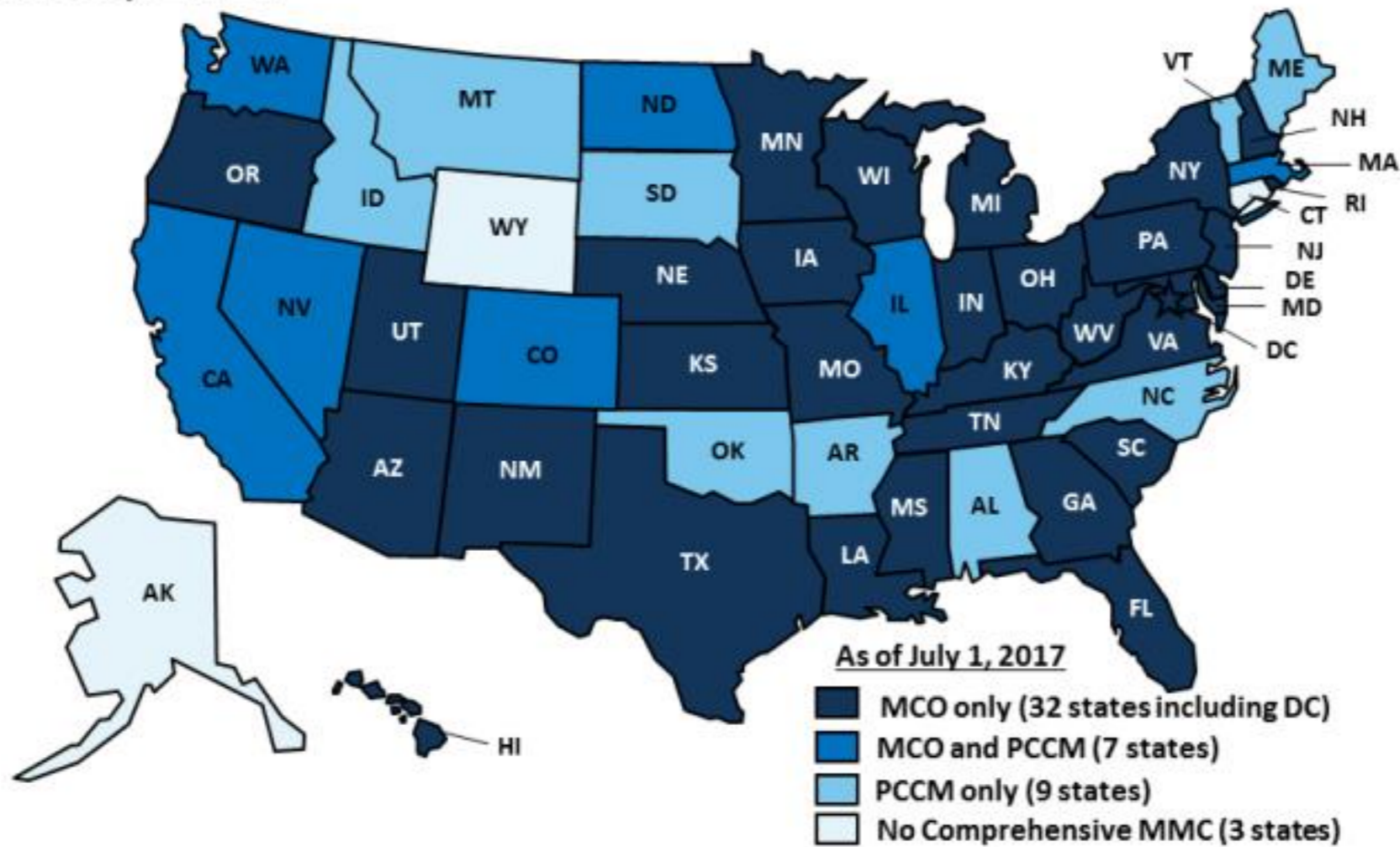


Currently, 95% of full-benefit Medicaid coverage is paid through Medicaid Managed Care

Medicaid Managed Care Continues to Increase

Figure 2

Comprehensive Medicaid Managed Care Models in the States, 2017



NOTES: CA has a small PCCM program operating in LA County for those with HIV. Three states (SC, TX and WY) use PCCM authority to operate specialized care management programs or to make PMPM payments in a Patient Centered Medical Home program; these three are not counted here as a PCCM.

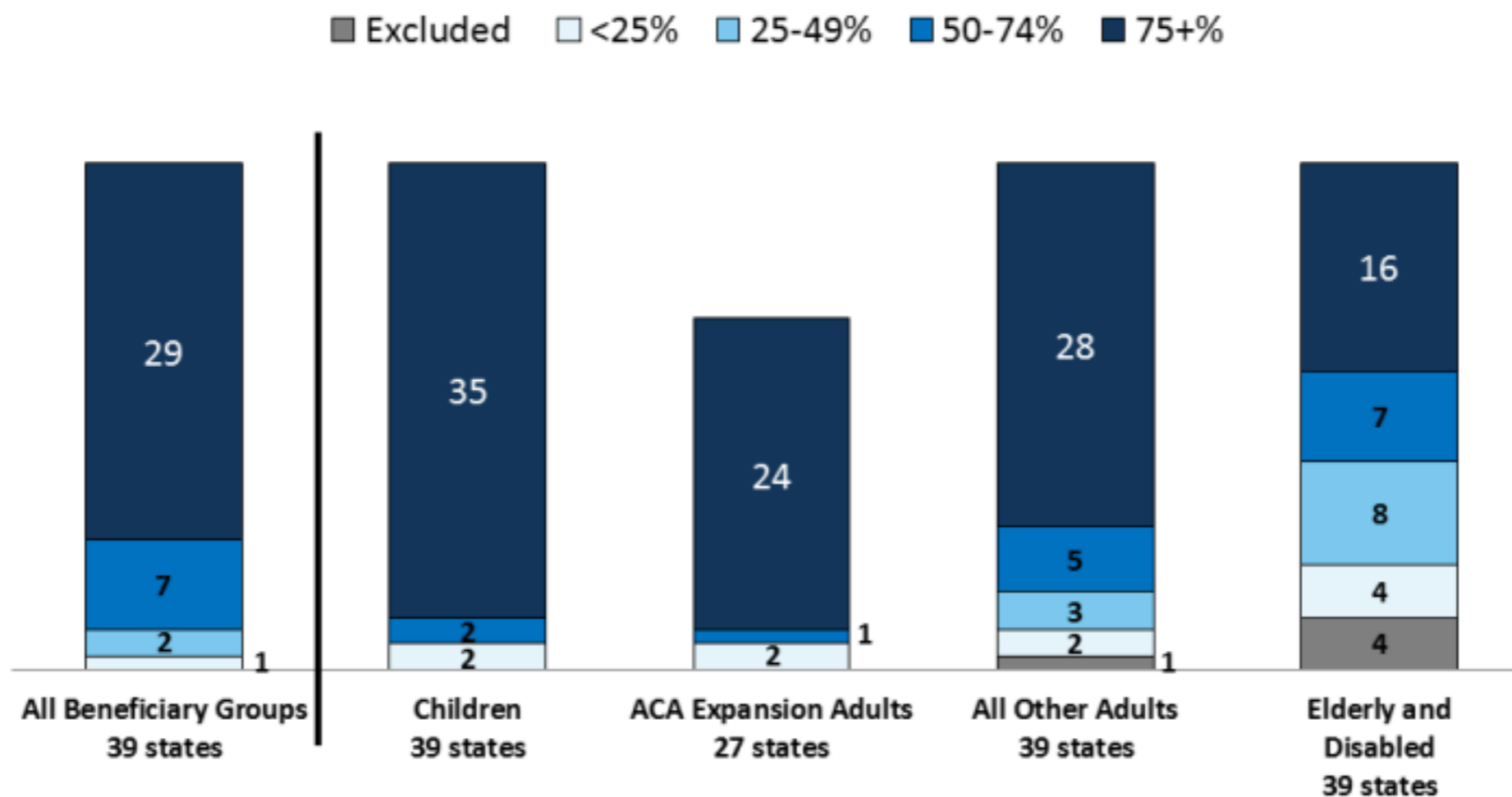
SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2017.



Managed Care Options for LTSS Continue to Increase

Figure 3

MCO Managed Care Penetration Rates for Select Groups of Medicaid Beneficiaries as of July 1, 2017



NOTES: Limited to 39 states with MCOs in place on July 1, 2017. Of the 32 states that had implemented the ACA Medicaid expansion as of July 1, 2017, 27 had MCOs in operation.

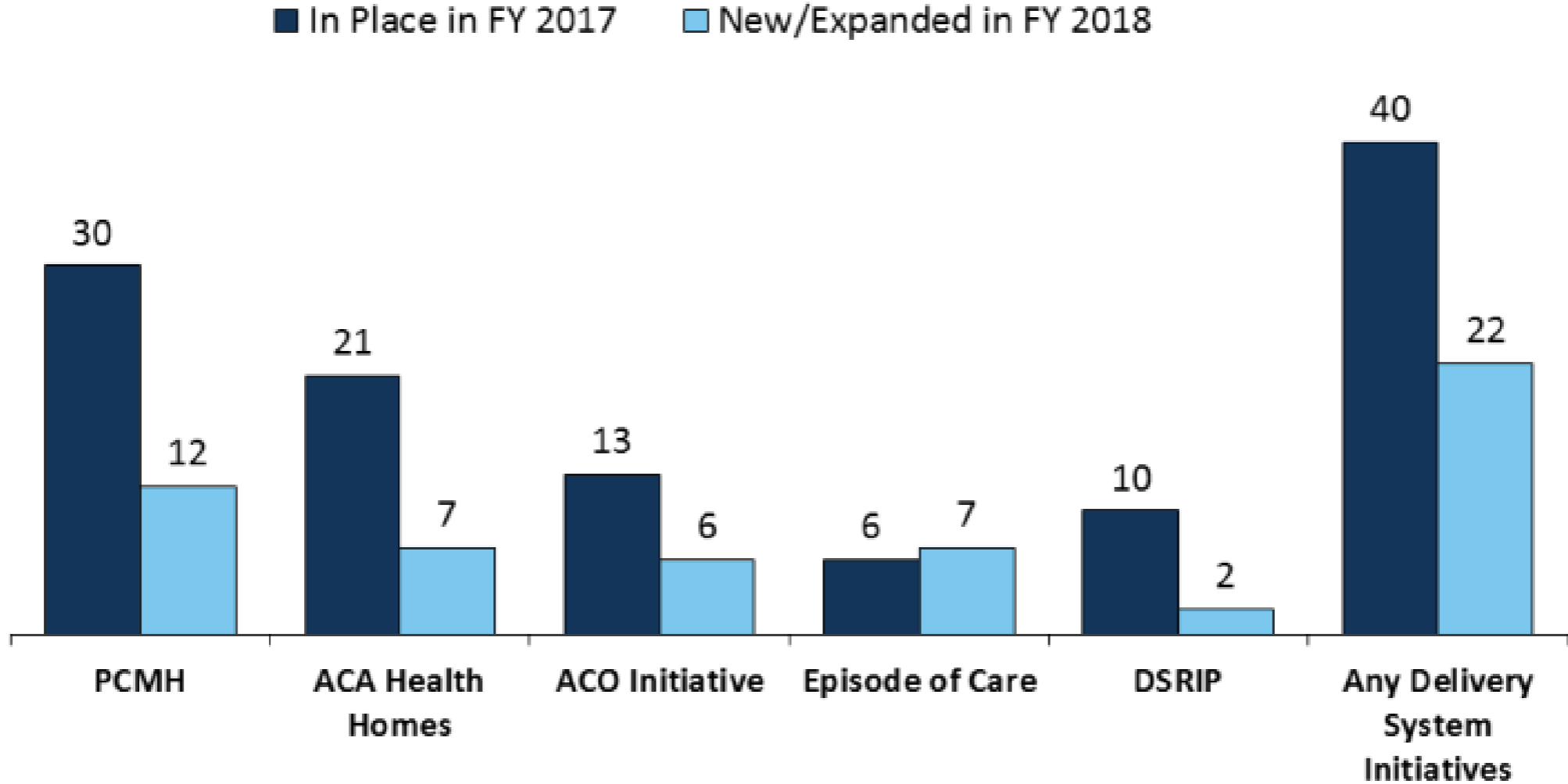
SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2017.



As Pressures Mount on the Cost and Effectiveness of Medicaid, States Look to New Delivery Models

Figure 5

State Delivery System Reform Activity, FYs 2017-2018



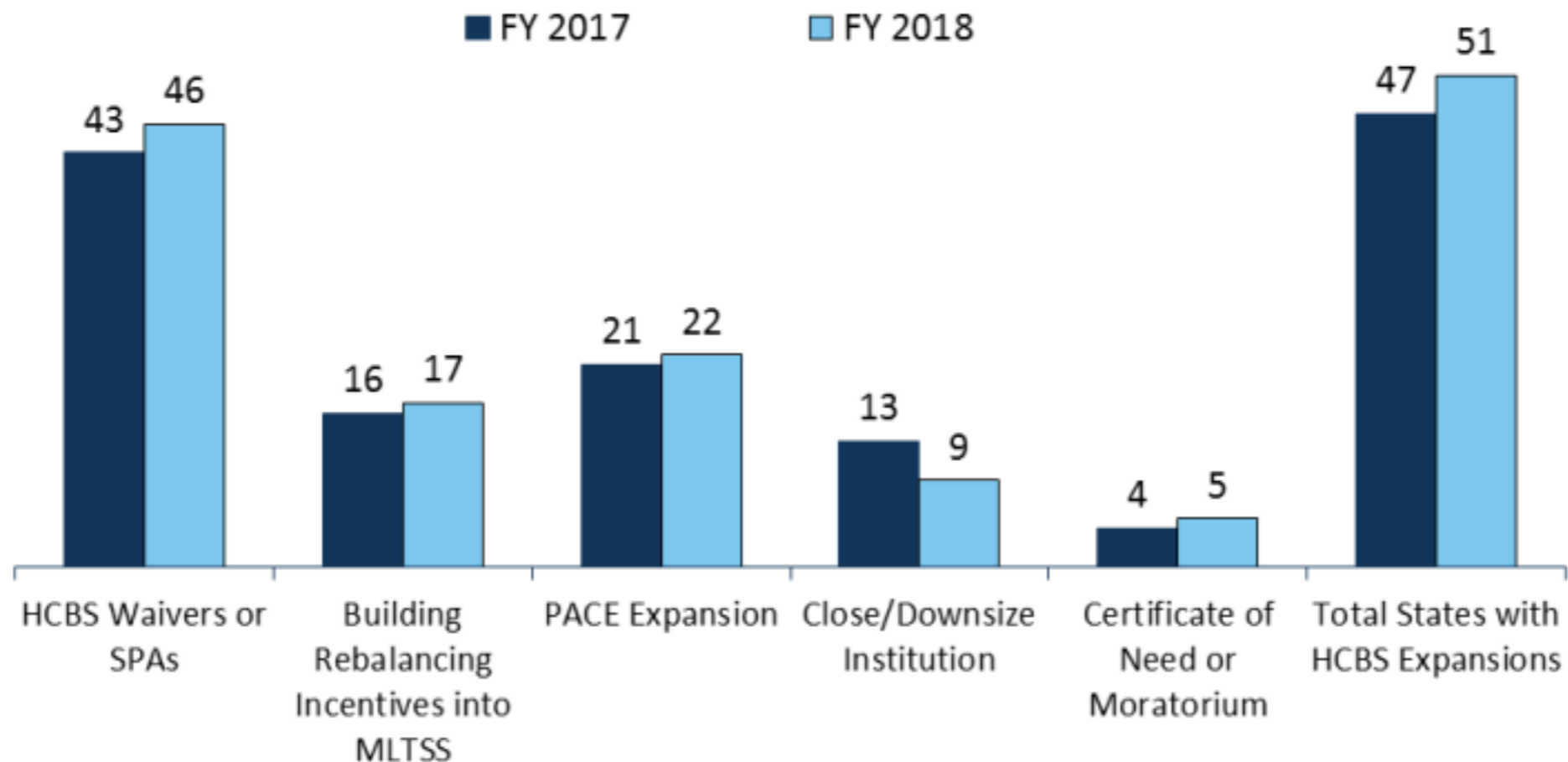
NOTES: Expansions of existing initiatives include rollouts of existing initiatives to new areas or groups, and other increases in enrollment or providers.

SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2017.

For LTSS, Most States Continue to Increase the Number Served in the Community

Figure 6

Long-Term Care Actions to Serve More Individuals in Community Settings, FYs 2017-2018



NOTES: "HCBS Waivers or SPAs" actions include: adopting new waivers; adding *and* filling more waiver slots; filling more waiver slots; adding new 1915(i) or 1915(k) SPAs; or serving more individuals through existing 1915(i) or 1915(k) SPAs. "Certificate of Need or Moratorium" actions include: implementing/tightening a CON program or imposing a new/extended moratorium on construction of new nursing facility or ICF-ID beds.

SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2017.



The Home and Community-Based Services (HCBS) Waivers allow Virginia to spend a majority of its LTC funds in the community

Alzheimer's Assisted Living Waiver

Community Living Waiver

Family and Individual Supports Waiver

Building Independence Waiver

Commonwealth Coordinated Care Plus Waiver

Developmental
Disability Waivers

The following specialized Medicaid benefits and programs allows Virginia to target certain services and interventions to designated populations

Program	Features
Program of All-Inclusive Care for the Elderly (PACE)	The Program of All-Inclusive Care for the Elderly (PACE) is a community-based program that serves individuals receiving Medicare and Medicaid who are age 55 or older and qualify for nursing home level of care. Through an interdisciplinary care model, the PACE program offers a community alternative to nursing home care and provides the full continuum of medical and social supports for older adults.
Governor's Access Plan (GAP)	DMAS successfully launched the GAP program in January 2015. This demonstration provides primary care and behavioral health services for 15,352 uninsured, seriously mental ill Virginians with incomes at or below 80% of the Federal Poverty Level. GAP increases access to care, and improves physical and behavioral health outcomes.
Addiction Recovery Treatment Services (ARTS)	In response to the statewide opioid epidemic, DMAS launched the Addiction and Recovery Treatment Services (ARTS) benefit April 1, 2017. The ARTS benefit provides the full continuum of evidence-based addiction treatment to any of the 1.3 million Medicaid and FAMIS members who need treatment.

What is PACE

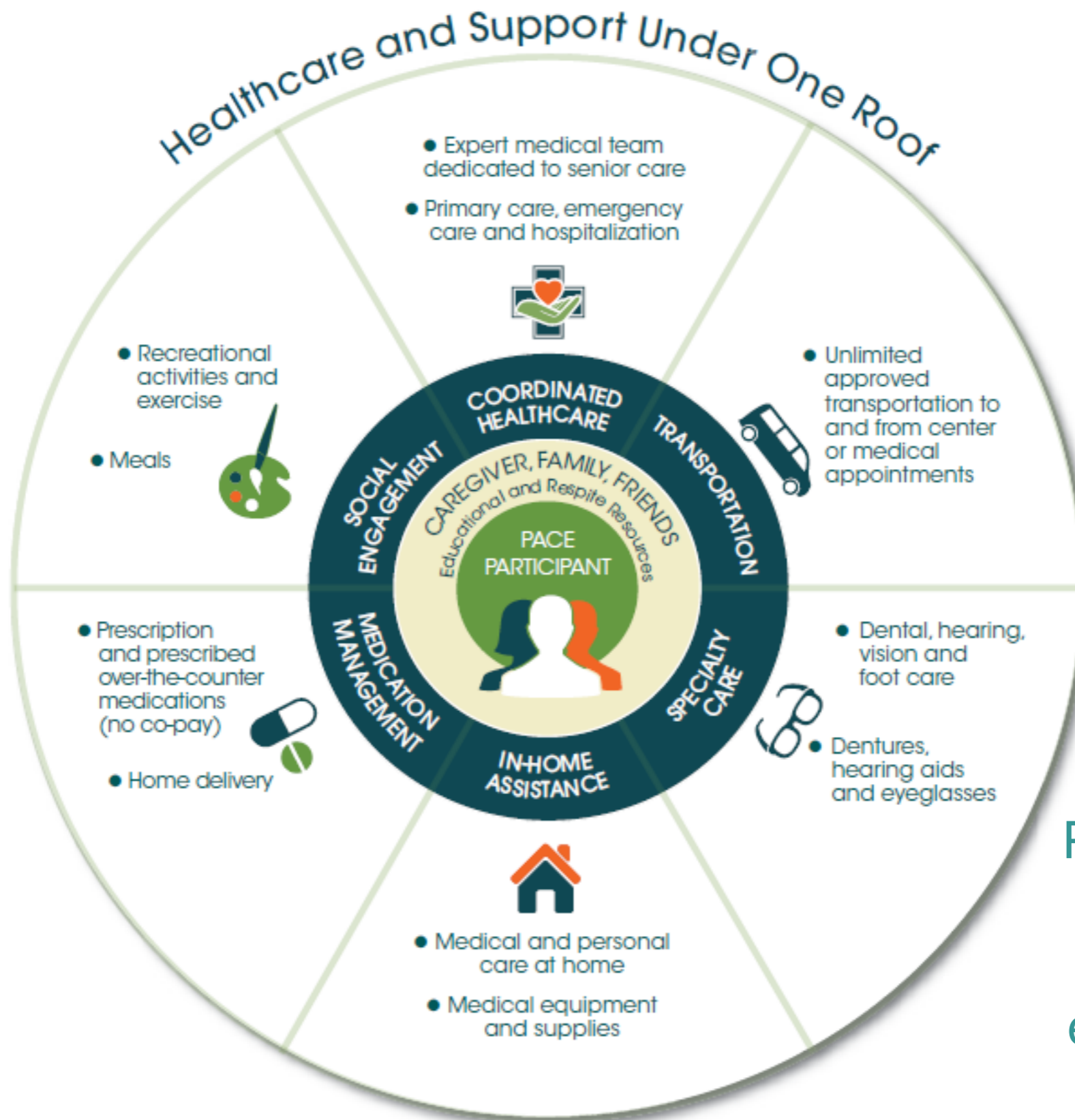
Preferred option to nursing facilities

Integrated primary, acute and long-term care

Covers all Medicaid and Medicare services, plus more

There are **122 PACE providers** with **242 PACE centers** in **31 states**

PACE programs serve **>45,000** nursing-home eligible **seniors** nationwide



PACE Services

Many Services Are Provided at the PACE Center

- Primary care, including physician, nursing services, and mental health and psychiatric as needed
- Social services
- Restorative therapies, including physical therapy and occupational therapy
- Personal care and supportive services
- Nutritional counseling
- Recreational therapy
- Meals
- Speech therapy
- Dental service (most InnovAge facilities have full dental suites)
- Lab / X-Ray
- Medical Equipment
- Activities (yoga, dance, cards, trivia, computers, etc.)

Employed Interdisciplinary Care Team Develops Individualized Care Plans

- The interdisciplinary care team at each PACE center comprehensively assesses and meets the individual needs of each participant. Each participant is assigned to an interdisciplinary care team. These individuals are focused exclusively on PACE and are either employed by InnovAge or in the case of physicians sometimes contracted given regulatory dynamics
- Team members include: primary care physician, registered nurse, Master's-level social worker, physical therapist, occupational therapist, recreational therapist or activity coordinator, dietician, PACE center manager, Home Care coordinator, Personal Care attendant, driver

Flexible Home Support Provided to Keep Participants at Home

- Transportation is provided to and from the center and appointments (InnovAge vans complete >30,000 one way trips per month)
- Home Care (skilled, unskilled, personal care etc.) is provided in the home
- Total flexibility of funds means InnovAge can install an air conditioner or grab bars or a ramp, adjust the height of the microwave, anything to facilitate keeping a participant at home

Services Also Covered Outside PACE Center and Home

- Hospital services (inpatient, ER, etc.) are covered as well as specialist visits
- If a participant is no longer able to live independently in the home safely, InnovAge covers the cost of a nursing home or facilitates assisted living

InnovAge Footprint

13 PACE centers serving 5,000 participants

with pending acquisitions in Virginia, census will reach 5,500

Colorado

Six centers with 3,096 participants

California

One center in San Bernardino with 546 participants; Developing a new center in Sacramento

New Mexico

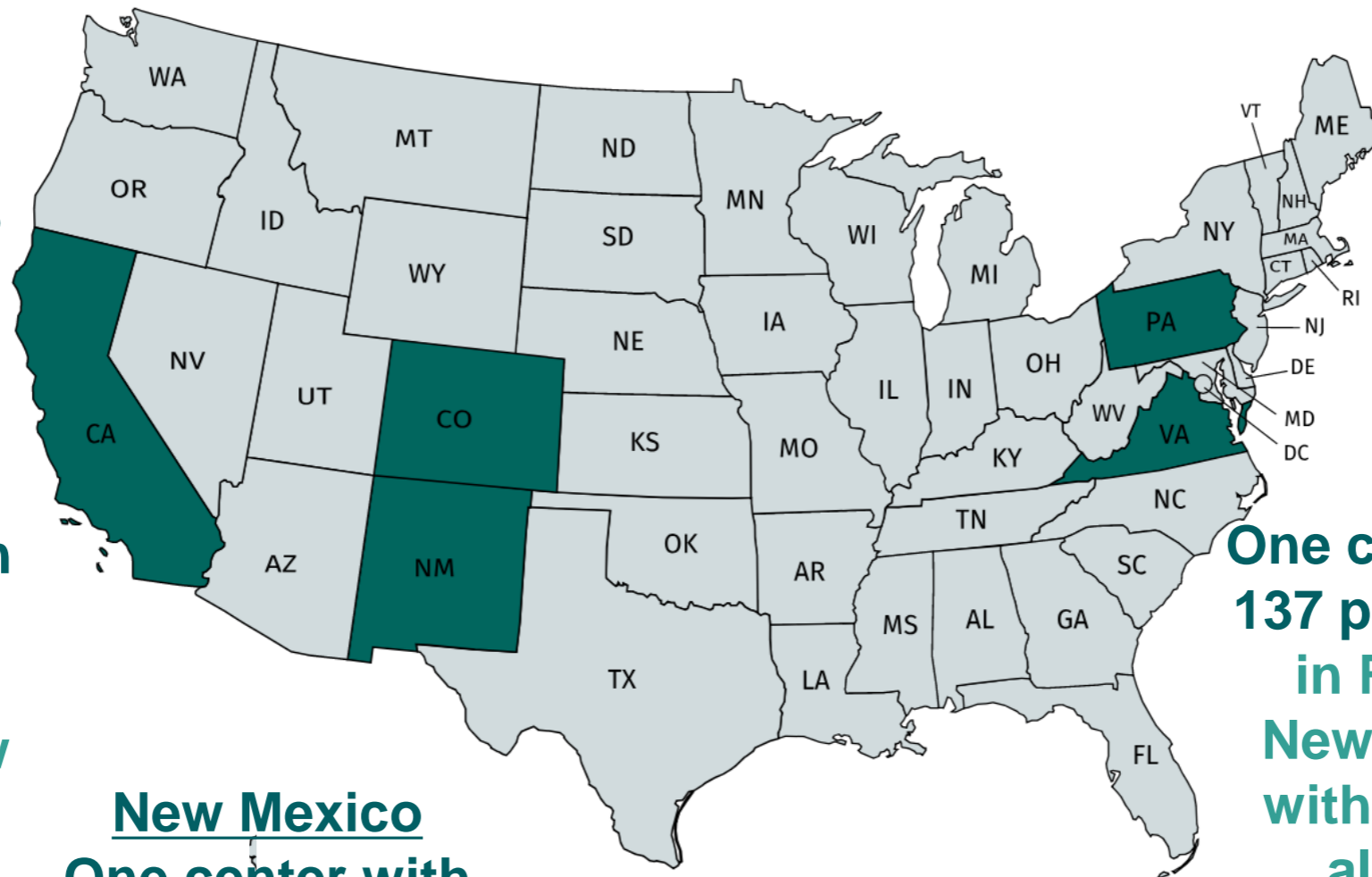
One center with 408 participants (capped by State)

Pennsylvania

Four centers in Philadelphia with 669 participants

Virginia

One center in Roanoke with 137 participants; Programs in Richmond, Newport News and Charlottesville with 550 participants will also become part of InnovAge (expected to Close in September and November)



Medicaid Financing and Program Integrity

- Thanks to Andy Allison
- Financing today is not Financing tomorrow
- You will NEVER be bored....

Medicaid Reimbursement and Matching Rates

- General Administration: 50/50 EXCEPT
 - Salaries for skilled health care professionals – doctors and nurses
 - Computer systems
- Computer Systems
 - 75/25 on going operations
 - 90/10 for updates or new systems
- Programs: The state's Federal Medical Assistance Percentage (FMAP) EXCEPT
 - Family planning
 - Medicaid expansion population

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)*)
- 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, OPSS 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

- 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

*Source: 42 CFR 447.203, as amended November 2, 2015 (see Federal Register 80:211 p. 67611 and following)

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.

Approach the “patient centered approach” that manages care for the entire range of services, including social services needed by a patient

VBP opportunities

Bundled Payments

Managed Care with Carve-Outs

Managed Care without Carve-Outs

Provider Led Entities (PLEs)

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

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AGENDA

- COSTS AND MEDICAID'S ROLE IN LTSS
- INSTITUTIONAL AND HOME AND COMMUNITY-BASED BENEFITS
- *OLMSTEAD V. LC* AND THE EVOLUTION OF HOME AND COMMUNITY-BASED SERVICES
- AUTHORITIES: STATE PLAN AMENDMENTS, WAIVERS AND DEMONSTRATIONS
- ADMINISTRATION AND OVERSIGHT
- CHALLENGES AHEAD

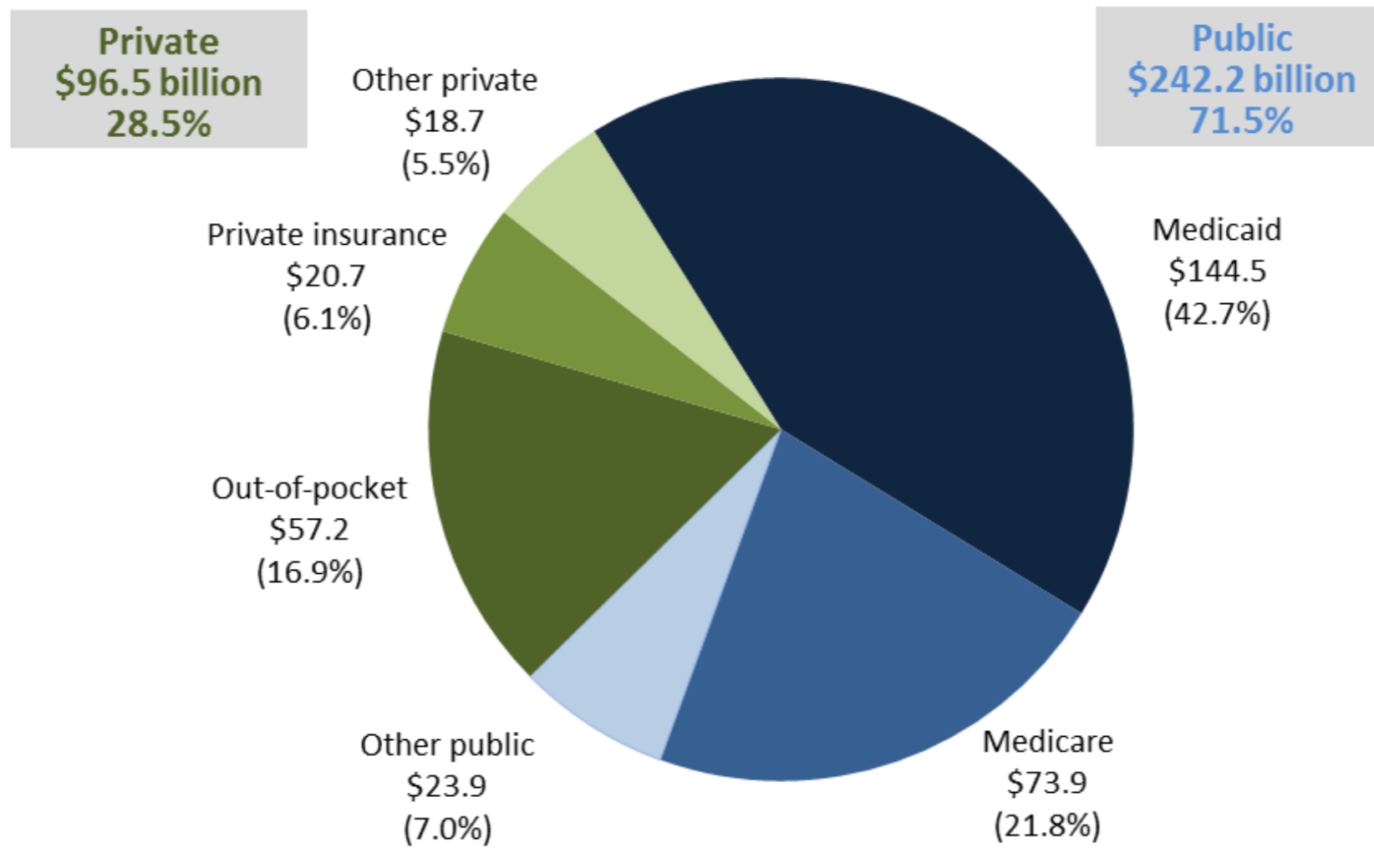
WHAT DO LTSS SERVICES COST?

Service Type	National Monthly Average	Low	High
Nursing Facility (Private)	\$8,121	\$1,945	\$42,948
Nursing Facility (Semi-Private)	\$7,148	\$1,612	\$42,958
Assisted Living	\$3,750	\$ 573	\$21,240
Adult Day Health	\$1,517	\$ 108	\$10,573
Home Maker	\$3,994	\$1,525	\$9,533
Home Health Aide	\$4,099	\$1525	\$10,479

Genworth, 2017 Cost of Care Survey, <https://www.genworth.com/aging-and-you/finances/cost-of-care.html> (accessed July 26, 2018).

WHO PAYS FOR LTSS

LTSS Total Spending: \$338.8 billion



Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December, 2014. Accessed at: <https://fas.org/sgp/crs/misc/R43483.pdf> on July 26, 2018.

MEDICAID LTSS INCLUDES BOTH INSTITUTIONAL AND HOME AND COMMUNITY-BASED SERVICES

- INSTITUTIONAL SERVICES INCLUDE NURSING FACILITY (NF), INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITY (ICF/IDS).
- HOME AND COMMUNITY-BASED SERVICES INCLUDE A WIDE-RANGE OF SUPPORTS AND SERVICES DESIGNED TO HELP INDIVIDUALS LIVE FULL LIVES IN THE COMMUNITY. EXAMPLES INCLUDE:
 - *PERSONAL CARE ASSISTANCE *CASE MANAGEMENT *HOME MODIFICATIONS
 - *PERSONAL EMERGENCY RESPONSE SYSTEMS *FAMILY SUPPORT & TRAINING* RESPITE CARE
 - * ASSISTED LIVING *HOME DELIVERED OR CONGREGATE CARE MEALS *HOME HEALTH SERVICES
 - *HOME SAFETY ASSESSMENTS * SUPPORTED AND SHARED LIVING * SUPPORTED EMPLOYMENT * PRE-VOCATIONAL TRAINING *ASSISTIVE DEVICES AND SUPPLIES *TRANSITION ASSISTANCE
 - *CONSUMER-DIRECTED CARE * HOMEMAKER AND CHORE SERVICE *CRISIS SERVICES *TRANSPORTATION *BEHAVIORAL SUPPORTS. *DIET AND NUTRITION SERVICES
- NF SERVICES AND HOME HEALTH SERVICES ARE MANDATORY; WHILE ICF/ID AND HCBS SERVICES ARE OPTIONAL.

THE IMPACT OF THE ADA AND *OLMSTEAD V. LC*

- 1990 – AMERICANS WITH DISABILITIES ACT (ADA), TITLE II, PROHIBITS PUBLIC ENTITIES FROM DISCRIMINATING AGAINST INDIVIDUALS WITH DISABILITIES IN THE PROVISION OF PUBLIC SERVICES.
- “INTEGRATION REGULATION” – REQUIRES PUBLIC ENTITIES TO ADMINISTER PROGRAMS IN THE MOST INTEGRATED SETTING APPROPRIATE TO THE NEEDS OF QUALIFIED INDIVIDUALS WITH DISABILITIES. (28 CFR 35.130(D))
- PUBLIC ENTITIES FURTHER MUST MAKE “REASONABLE MODIFICATIONS” TO AVOID DISCRIMINATION BASED UPON DISABILITY.

OLMSTEAD V L.C.

527 U.S. 581 (1999)

- THE US. SUPREME COURT RULED (1999)
- UNJUSTIFIED ISOLATION IS PROPERLY REGARDED AS DISCRIMINATION BASED UPON DISABILITY. STATES MUST PLACE PERSONS WITH DISABILITIES IN COMMUNITY SETTINGS RATHER IN INSTITUTIONS:
 - WHEN THE STATES TREATING PROFESSIONALS HAVE DETERMINED THAT COMMUNITY PLACEMENT IS APPROPRIATE,
 - THE TRANSFER IS NOT OPPOSED BY THE AFFECTED INDIVIDUAL, AND
 - THE PLACEMENT CAN BE REASONABLY ACCOMMODATED, TAKING INTO ACCOUNT THE RESOURCES AVAILABLE TO STATE AND THE NEEDS OF OTHER WITH MENTAL DISABILITIES.

THE LIMITS OF THE INTEGRATION MANDATE

- BUT, STATES OBLIGATION TO PROVIDE COMMUNITY-BASED CARE IS NOT UNLIMITED.
- STATES NEED NOT MAKE CHANGES THAT FUNDAMENTALLY ALTER THE STATES SERVICES AND PROGRAMS.
- STATES MUST BE ALLOWED TO SHOW THAT, IN THE ALLOCATION OF AVAILABLE RESOURCES, IMMEDIATE RELIEF FOR THE PLAINTIFFS WOULD BE INEQUITABLE, GIVEN THE RESPONSIBILITY THE STATE HAS UNDERTAKEN FOR THE CARE AND TREATMENT OF A LARGE AND DIVERSE POPULATION OF PERSONS WITH DISABILITIES.

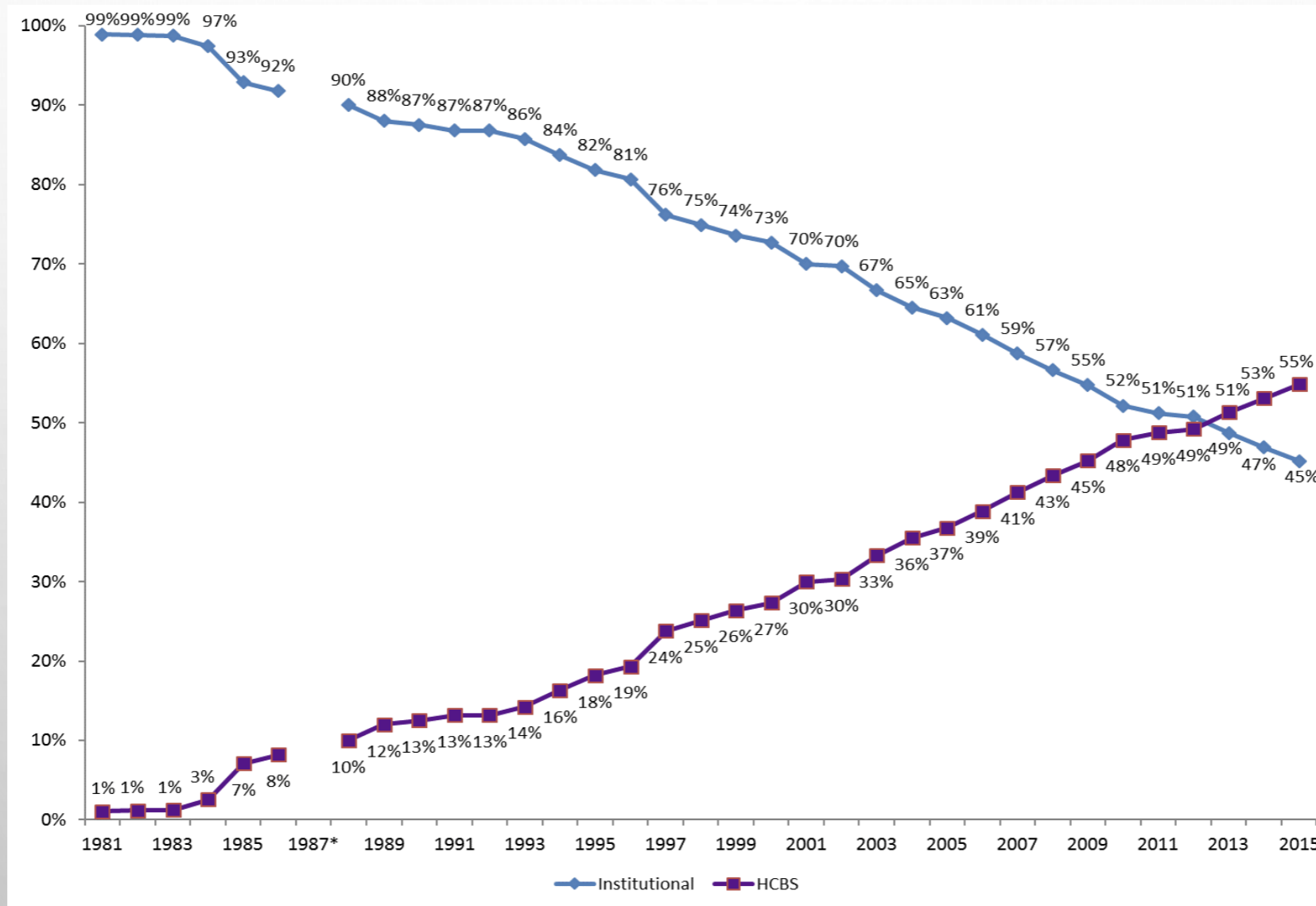
“If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace, not controlled by the State’s endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met.”

TURNING THE OLMSTEAD “DEFENSE” INTO A TOOL TO PROMOTE COMMUNITY INTEGRATION

UNPRECEDENTED FEDERAL EFFORT TO PROACTIVELY PROMOTE STATE OLMSTEAD PLANS AND COMMUNITY INTEGRATION:

- GUIDANCE AND TECHNICAL ASSISTANCE
- GRANTS – SYSTEM CHANGE, BALANCING INCENTIVES, MONEY FOLLOWS THE PERSON
- POLICY INITIATIVES TO ELIMINATE “INSTITUTIONAL BIAS” IN MEDICAID
- PRESIDENT BUSH’S NEW FREEDOM INITIATIVE
- HCBS SETTINGS RULE

MEDICAID HCBS AND INSTITUTIONAL LTSS EXPENDITURES AS A PERCENTAGE OF TOTAL MEDICAID LTSS EXPENDITURES, FY 1981–2015

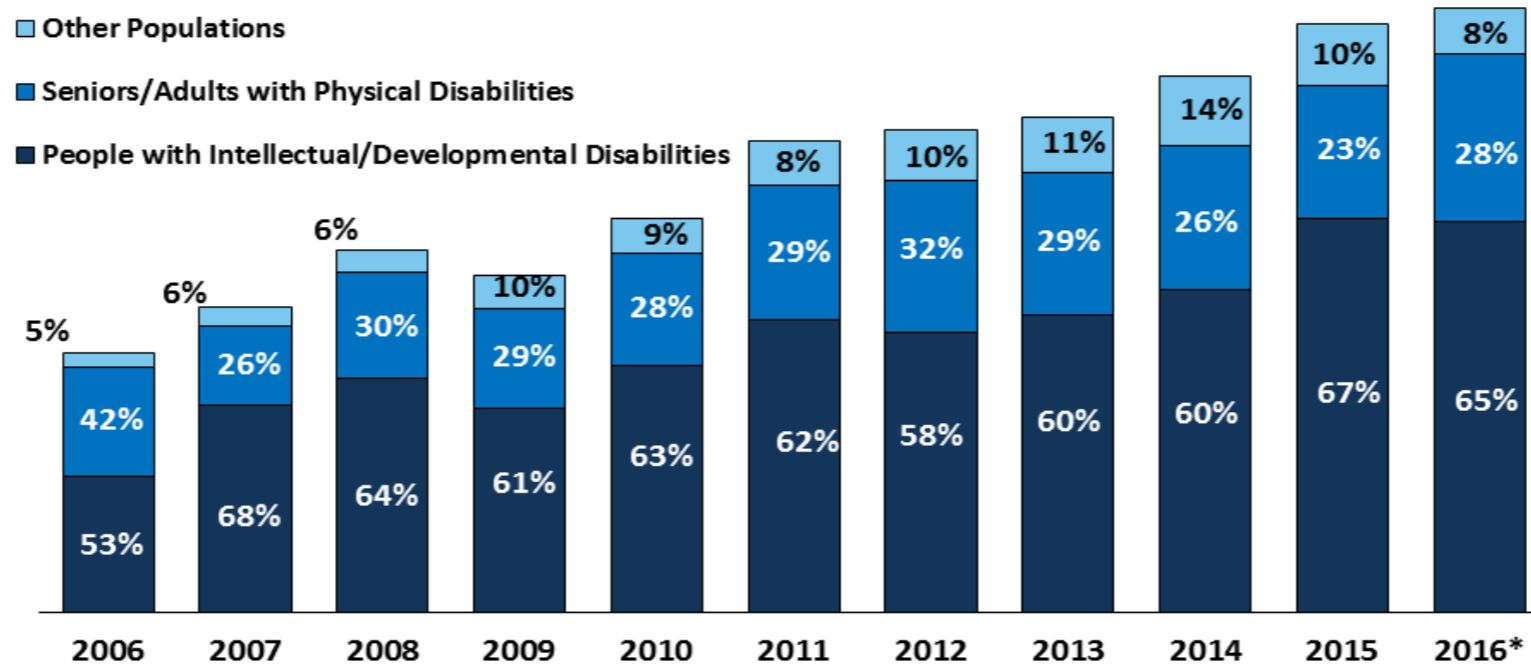


Truven Health Analytics, Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015 , April 14, 2017

DEMAND FOR HCBS EXCEEDS SUPPLY

Figure 9

Medicaid HCBS waiver waiting lists, by target population, 2006-2016.



Total: 280,176 331,689 393,096 365,553 428,571 511,174 523,710 536,464 582,066 640,841 656,195

NOTES: Percentages may not sum to 100 percent due to rounding. "Other Populations" includes children who are medically fragile or technology dependent, people with HIV/AIDS, people with mental health needs, and people with traumatic brain or spinal cord injuries. *The 2016 total includes Section 1115 HCBS waiver waiting lists reported by NM and TX. Prior years include only Section 1915 (c) waiver waiting lists.

SOURCE: Kaiser Family Foundation Medicaid HCBS program survey conducted in 2016.



AUTHORITIES THAT SUPPORT HCBS SERVICES

- **MEDICAID STATE PLAN** – OPERATIONAL AGREEMENT BETWEEN FEDERAL GOVERNMENT AND STATE THAT GIVES STATE AUTHORITY TO DRAW DOWN FEDERAL MATCH FOR APPROVED SERVICES.
- **WAIVERS** – ALLOWS FEDERAL GOVERNMENT TO EXEMPT STATES FROM SPECIFIC MEDICAID STATUTORY REQUIREMENTS:
 - SECTION 1115 – RESEARCH AND DEMONSTRATION WAIVERS
 - SECTION 1915(B) FREEDOM OF CHOICE
 - SECTION 1915(C) HOME AND COMMUNITY BASED SERVICES (1981)
(TITLE 42 OF SOCIAL SECURITY ACT (SSA))
- **NEW(ER) STATE PLAN OPTIONS**
 - 1915(I) HCBS STATE PLAN OPTION (2005)
 - 1915(J) SELF-DIRECTED PCA (2005)
 - 1915(K) COMMUNITY FIRST CHOICE (2010)

SECTION 1115 RESEARCH AND DEMONSTRATION WAIVERS

- GIVE HHS SECRETARY BROAD AUTHORITY TO APPROVE EXPERIMENTAL, PILOT OR DEMONSTRATION PROJECTS TO PROMOTE THE OBJECTIVES OF THE MEDICAID PROGRAM.
- DEMONSTRATIONS MUST BE “COST NEUTRAL” TO THE FEDERAL GOVERNMENT MEANING FEDERAL MEDICAID EXPENDITURES WILL NOT BE MORE THAN FEDERAL SPENDING WITHOUT THE DEMONSTRATION OVER THE LIFE OF THE PROJECT.
- GENERALLY APPROVED FOR AN INITIAL FIVE YEAR PERIOD AND CAN BE EXTENDED AN ADDITIONAL 3-5 YEARS.
- EVALUATION/REPORTING REQUIREMENTS.
- EXAMPLES:
 - (1) “CASH AND COUNSELING” IN 1990(S), LEAD TO INCLUSION OF PARTICIPANT-DIRECTED SERVICES IN 1915(C) WAIVERS WHICH LED TO DRA, SECTION 1915(I), 1915(J) AND LATER 1915(K).
 - (2) MANAGED CARE
 - (3) COMPREHENSIVE SUD SERVICES
 - (4) SERVICES TO INDIVIDUALS NOT YET ELIGIBLE FOR MEDICAID LTSS
 - (5) PRE-ACA – SERVICES TO CHILDLESS ADULTS

1915 (C) HOME AND COMMUNITY-BASED WAIVERS

WHAT CAN BE WAIVED UNDER SECTION 1915(C)?

- COMPARABILITY (SECTION 1902(A)(10)(B)) – THIS PERMITS A STATE TO LIMIT THE HCBS WAIVER SERVICES TO MEDICAID BENEFICIARIES WHO REQUIRE AN INSTITUTIONAL LEVEL OF CARE AND ARE IN THE SPECIFIED TARGET GROUP(S).
- STATEWIDENESS (SECTION 1902(A)(1)) – THIS PERMITS A STATE TO LIMIT THE OPERATION OF A WAIVER TO SPECIFIED GEOGRAPHIC AREAS OF THE STATE, AND
- INCOME AND RESOURCES FOR MEDICALLY NEEDY (1902(A)(10)(I)(III))– THIS ALLOWS A STATE TO APPLY INSTITUTIONAL INCOME AND RESOURCE “ELIGIBILITY” RULES FOR MEDICALLY NEEDY IN THE COMMUNITY (IF THEY OTHERWISE QUALIFY FOR SERVICES).
- STATES COMBINE A 1915(C) WAIVER WITH A 1915(B) FREEDOM OF CHOICE WAIVER – THIS PERMITS A STATE TO MANDATE ENROLLMENT OR LIMIT THE BENEFICIARY’S ABILITY TO CHOOSE ANY PARTICIPATING PROVIDER. CAN BE USED FOR MANAGED LTSS, CARVE OUTS, ETC.
- INITIAL THREE-YEAR APPROVAL; RENEWED EVERY FIVE YEARS (EXCEPT WAIVERS THAT INCLUDE DUALS MAY RECEIVE INITIAL FIVE YEAR APPROVAL)

WHO CAN BE SERVED IN A 1915(C) WAIVER?

- INDIVIDUALS WHO REQUIRE AN INSTITUTIONAL LEVEL OF CARE (HOSPITAL, NURSING FACILITY OR ICF/ID).
- ARE A MEMBER OF A TARGET GROUP THAT IS INCLUDED IN THE WAIVER. (STATES MAY INCLUDE MULTIPLE TARGET GROUPS IN A SINGLE WAIVER).
- MEET APPLICABLE FINANCIAL ELIGIBILITY CRITERIA.
- REQUIRE ONE OR MORE WAIVER SERVICES IN ORDER FUNCTION IN THE COMMUNITY, AND
- EXERCISE FREEDOM OF CHOICE BY CHOOSING TO ENTER THE WAIVER IN LIEU OF RECEIVING INSTITUTIONAL CARE
- STATE MUST SPECIFY THE UNDUPLICATED NUMBER OF INDIVIDUALS TO BE SERVED.

WHAT SERVICES CAN BE OFFERED UNDER SECTION 1915(C)

- STATE MAY OFFER SERVICES ENUMERATED IN THE STATUTE OR PROPOSE OTHER SERVICES THAT ASSIST INDIVIDUALS TO REMAIN IN THE COMMUNITY – THERE ARE NO REQUIRED SERVICES.
- WAIVER SERVICES COMPLIMENT STATE PLAN SERVICES; A WAIVER PARTICIPANT MUST HAVE FULL ACCESS TO STATE PLAN SERVICES.
- STATES CAN OFFER EXTENDED STATE PLAN SERVICES THAT EXCEED THE LIMITS THAT APPLY UNDER A STATE PLAN.
- THERE IS NO LIMIT TO THE NUMBER OF SERVICES THAT A STATE MAY OFFER IN A WAIVER.
- STATES MAY NOT CLAIM FEDERAL MATCH (FFP) FOR ROOM AND BOARD

1915(C) HCBS WAIVERS ASSURANCES

- STATES MUST ASSURE CMS THAT HCBS WAIVER PROGRAMS WILL:
 - BE COST NEUTRAL (CANNOT COST THE FEDERAL GOVERNMENT MORE THAN PROVIDING SERVICES IN AN INSTITUTION).
 - PROTECT THE HEALTH AND SAFETY OF INDIVIDUALS IN THE PROGRAM.
 - PROVIDE ADEQUATE AND REASONABLE PROVIDER STANDARDS TO MEET THE NEEDS OF INDIVIDUALS SERVED IN THE WAIVER.
 - ENSURE THAT SERVICES FOLLOW AN INDIVIDUALIZED AND PERSON-CENTER PLAN OF CARE.
 - DEVELOP AND IMPLEMENT A QUALITY IMPROVEMENT STRATEGY.
 - COMPLY WITH HCBS SETTINGS RULE REQUIREMENTS.

A NOTE ON COST NEUTRALITY

- STATES MUST ENSURE THAT THE AVERAGE PER CAPITA EXPENDITURE UNDER THE WAIVER DOES NOT EXCEED 100 PERCENT OF THE AVERAGE PER CAPITAL EXPENDITURES THAT WOULD HAVE BEEN MADE HAD THE WAIVER NOT BEEN GRANTED.
- COST NEUTRALITY FORMULA LOOKS AT TOTAL MEDICAID COSTS, NOT JUST WAIVER COSTS.

FACTOR D – PER CAPITA MEDICAID COST FOR HCBS SERVICES

FACTOR D' – PER CAPITA MEDICAID COST FOR ALL OTHER SERVICES PROVIDED TO WAIVER PARTICIPANTS

FACTOR G – PER CAPITAL MEDICAID COST FOR NF OR ICF/ID CARE

FACTOR G'- PER CAPITA MEDICAID COSTS FOR ALL SERVICES OTHER THAN THOSE IN G

FORMULA: $D+D'$ COMPARED TO $G+G'$

1915(C) QUALITY IMPROVEMENT STRATEGY (QIS)

THERE ARE SIX WAIVER ASSURANCES THAT MUST BE INCLUDED IN THE QIS

- ADMINISTRATIVE AUTHORITY – STATE RETAINS ULTIMATE AUTHORITY
- LEVEL OF CARE (LOC) – STATE EVALUATES AND RE-EVALUATES LOC
- QUALIFIED PROVIDERS – STATE ENSURES THAT PROVIDERS MEET QUALIFICATIONS.
- SERVICE PLAN – STATE MUST MONITOR ADEQUACY OF OF SERVICE PLANS, ENSURES THEY ARE UPDATED AND THAT SERVICES ARE DELIVERED IN ACCORDANCE WITH THE PLAN.
- HEALTH AND WELFARE – STATE MUST HAVE SYSTEM FOR PREVENTING ABUSE, NEGLECT, EXPLOITATION AND UNEXPLAINED DEATHS, MANAGING INCIDENTS, OVERSEEING USE AND PROHIBITION OF RESTRICTIVE INTERVENTIONS AND FOR MONITORING OVERALL HEALTHCARE STANDARDS
- FINANCIAL ACCOUNTABILITY – CLAIMS MUST BE CODED CORRECTLY AND RATES ARE PAID CONSISTENT WITH THE APPROVED RATE METHODOLOGY.

1915(I) HCBS STATE PLAN OPTION

- DOES NOT REQUIRE COST NEUTRALITY OR AN INSTITUTIONAL LEVEL OF CARE (LOC) – ELIGIBILITY BASED UPON NEEDS-BASED CRITERIA ASCERTAINED THROUGH INDEPENDENT, INDIVIDUALIZED ASSESSMENT.
- TARGETS ONE OR MORE SPECIFIC POPULATIONS DEFINED BY AGE, DIAGNOSIS OR MEDICAID ELIGIBILITY GROUP.
- ELIGIBILITY: INDIVIDUALS WITH INCOME UP TO 150% FPL (NO RESOURCE TEST) OR MAY INCLUDE INDIVIDUALS WITH INCOME UP TO 300% SSI BUT MUST BE ELIGIBLE FOR EXISTING 1915(C) OR DEMONSTRATION.
- CAN WAIVE COMPARABILITY, BUT NOT STATEWIDENESS.
- ENROLLMENT CAPS AND WAITING LISTS ARE PROHIBITED.
- ALLOWS USE OF SELF-DIRECTION AND PRESUMPTIVE PAYMENT.
- STATE MUST HAVE IMPLEMENT AN HCBS QUALITY IMPROVEMENT STRATEGY.
- EXAMPLES OF SERVICES OFFERED: TRANSITIONAL CASE MANAGEMENT SERVICES, ASSISTED LIVING, ADULT DAY HEALTH, BEHAVIORAL SUPPORTS, ETC.

BENEFITS AND CHALLENGES TO 1915(I)

BENEFITS

- CAN FILL GAPS IN MEDICAID COVERAGE FOR TARGETED POPULATIONS INCLUDING PEOPLE WITH SERIOUS MENTAL ILLNESS AND/OR SUD, PEOPLE IN TRANSITION FROM CRIMINAL JUSTICE SYSTEM, CHILDREN WITH SPECIAL CONDITIONS SUCH AS AUTISM
- CAN PROVIDE COVERAGE FOR SPECIFIC SERVICES: ADULT DAY HEALTH, SELF-DIRECTION, HOUSING SUPPORTS
- ALLOWS STATE TO TIGHTEN CRITERIA FOR INSTITUTIONAL CARE WITHOUT TIGHTENING ACCESS TO HCBS

CHALLENGES

- FINANCIAL RISK - DIFFICULT TO CONTAIN COSTS DUE TO PROHIBITION ON ENROLLMENT CAPS
- CANNOT PHASE-IN OR LIMIT GEOGRAPHIC REACH DUE TO REQUIREMENT TO IMPLEMENT STATEWIDE
- FOR NON-INSTITUTIONAL LOC, INCOME LIMIT OF 150% FPL ADDS ADMINISTRATIVE COMPLEXITY AND LIMITS COVERAGE (ESPECIALLY FOR CHILDREN OR WORKING ADULTS)
- VIEWED AS ADMINISTRATIVELY BURDENSOME

1915(J) SELF DIRECTED PERSONAL CARE ATTENDANT SERVICES STATE PLAN OPTION

- PERMITS SELF-DIRECTION FOR PCA SERVICES. AT STATE OPTION,
 - LEGALLY RESPONSIBLE RELATIVES (SPOUSES/PARENTS) MAY PROVIDE CARE AND BE PAID.
 - ALLOWS PARTICIPANTS TO MANAGE A CASH DISBURSEMENT AND/OR PURCHASE GOODS, SERVICES AND SUPPLIES TO SUPPORT COMMUNITY LIVING.
 - USE A DISCRETIONARY AMOUNT OF THE BUDGET TO PURCHASE ITEMS NOT OTHERWISE LISTED IN THE BUDGET.
- STATE MAY LIMIT GEOGRAPHIC AREA AND CAP THE NUMBER OF PEOPLE WHO CAN ENROLL.
- CAN INCLUDE PEOPLE ALREADY ENROLLED IN 1915(C).

1915(K) COMMUNITY FIRST CHOICE STATE PLAN OPTION

- ALLOWS STATE TO ESTABLISH PERSONAL CARE ATTENDANT OR PARTICIPANT DIRECTED CARE PROGRAM THROUGH STATE PLAN AMENDMENT FOR INDIVIDUALS WITH INSTITUTIONAL LOC
- STATE MUST PROVIDE SUPPORT AND BACKUP SYSTEMS INCLUDING VOLUNTARY TRAINING
- STATE MAY PROVIDE TRANSITIONAL SERVICES TO HELP INDIVIDUALS MOVE FROM INSTITUTIONS TO THE COMMUNITY AND SERVICES THAT INCREASE INDEPENDENCE INCLUDING ASSISTIVE TECHNOLOGIES, MEDICAL SUPPLIES/EQUIPMENT AND HOME MODIFICATIONS.
- PROVIDE 6% INCREASE IN FMAP FOR SERVICES PROVIDED
- ENROLLMENT CAPS/WAITING LISTS PROHIBITED
- MUST BE OFFERED STATEWIDE, BENEFITS MUST BE COMPARABLE FOR ALL AND PARTICIPANTS MUST HAVE FREEDOM OF CHOICE (CANNOT TARGET SPECIFIC POPULATIONS)
- CAN LIMIT AMOUNT DURATION AND SCOPE AS LONG AS LIMITS ARE SUFFICIENT TO ACHIEVE PROGRAM PURPOSE.
- ELIGIBLE INDIVIDUALS INCLUDE INDIVIDUALS ELIGIBLE FOR NF SERVICES UNDER THE STATE PLAN OR, IF NOT IN SUCH AN ELIGIBILITY GROUP, HAVE INCOME AT OR BELOW 150% OF FPL.
- MAINTENANCE OF EFFORT REQUIREMENT FOR FIRST 12 MONTHS.
- MANDATORY DATA COLLECTION AND REPORTING, QUALITY ASSURANCE SYSTEM AND DEVELOPMENT AND IMPLEMENTATION COUNCIL

BENEFITS AND CHALLENGES TO 1915(K)

BENEFITS

- ALLOWS STATES TO CONSOLIDATE PROGRAMS AND STANDARDIZE ELIGIBILITY AND NEEDS ASSESSMENTS
- INCREASED FMAP

CHALLENGES

- DOES NOT ELIMINATE NEED TO MAINTAIN MULTIPLE HCBS PROGRAMS
- COMPLEX ELIGIBILITY REQUIREMENTS
- INCREASED FMAP NOT SUFFICIENT TO COVER NEW COSTS ASSOCIATION WITH IMPLEMENTATION, PROGRAM EXPENDITURES AND EVALUATION.
- FINANCIAL RISK - DIFFICULT TO CONTAIN COSTS DUE TO PROHIBITION ON ENROLLMENT CAPS
- BURDENSOME ADMINISTRATIVE REQUIREMENTS

HCBS PROGRAM DESIGN CONSIDERATIONS

- FIRST, IDENTIFY YOUR GOALS AND OBJECTIVES.
- SECOND, IDENTIFY THE NEEDS OF THE TARGET POPULATION – CLAIMS ANALYSIS, HISTORICAL SPENDING, KEY INFORMANT INTERVIEWS, STAKEHOLDER INPUT, RESEARCH INTO OTHER STATE AND PAYOR PRACTICES
- THIRD, IDENTIFY THE KEY DESIGN FEATURES THAT WILL HELP ATTAIN THE GOALS AND OBJECTIVES.
- DESIGN PROGRAMS AROUND THOSE IDENTIFIED GOALS AND OBJECTIVES.
- THEN, LOOK TO THE AUTHORITY THAT BEST SUPPORTS WHAT YOU HOPE TO ACHIEVE.
- THERE IS NO RIGHT ANSWER AND THERE ALWAYS WILL BE TRADE-OFFS.

HCBS FINAL RULE

JANUARY 16, 2014

- APPLIES TO 1915(C) WAIVERS AND 1915(I) AND 1915(K) STATE PLAN OPTIONS
- DESIGNED TO PROMOTE FULL ACCESS TO BENEFITS OF COMMUNITY LIVING IN THE MOST INTEGRATED SETTING APPROPRIATE
- MANDATES CONFLICT-FREE ASSESSMENTS AND CASE MANAGEMENT SERVICES
- MANDATES A PERSON-CENTERED PLANNING PROCESS AND PLAN FOR SERVICES
- ESTABLISHES MANDATORY REQUIREMENTS THAT DEFINE AN HCBS SETTING.

HCBS SETTINGS RULE

- GENERAL REQUIREMENTS FOCUS ON INDIVIDUAL CHOICE, AUTONOMY AND INTEGRATION INTO THE BROADER COMMUNITY.
- ADDITIONAL REQUIREMENTS FOR PROVIDER CONTROLLED SETTINGS
- SETTINGS THAT ARE NOT HCBS INCLUDE: NURSING HOMES, IMDS, ICF/IDS AND HOSPITALS
- SETTINGS THAT ARE PRESUMED NOT TO BE HCBS AND SUBJECT TO CMS HEIGHTENED SCRUTINY REVIEW INCLUDE:
 - SETTINGS IN A PUBLICLY OR PRIVATELY-OWNED FACILITY PROVIDING INPATIENT TREATMENT
 - SETTINGS ON GROUNDS OF, OR ADJACENT TO, A PUBLIC INSTITUTION
 - SETTINGS WITH THE EFFECT OF ISOLATING INDIVIDUALS FROM THE BROADER COMMUNITY OF NON-MEDICAID INDIVIDUALS
- STATE COMPLIANCE DEADLINE - FOR PROGRAMS IN EXISTENCE ON MARCH 17, 2014 STATES HAVE UNTIL MARCH 17, 2019 TO SUBMIT AND RECEIVE APPROVAL OF STATEWIDE TRANSITION PLANS. STATES MUST THEN SUBMIT SETTINGS SUBJECT TO HEIGHTENED SCRUTINY WITH FINAL COMPLIANCE DUE MARCH 17, 2022.

PROGRAM INTEGRITY

THE OFFICE OF INSPECTOR GENERAL (OIG) HAS FOUND SIGNIFICANT AND PERSISTENT COMPLIANCE, PAYMENT AND FRAUD VULNERABILITIES IN MEDICAID PCA SERVICES.

FROM FY 2013 TO FY 2015, MEDICAID IMPROPER PAYMENTS FOR PCS GREW FROM \$14.4 BILLION TO \$29.1 BILLION

OIG HAS MADE RECOMMENDATIONS TO IMPROVE PROGRAM VULNERABILITIES DETECTED IN MORE THAN TWO DOZEN PUBLISHED AUDITS AND EVALUATIONS AND HUNDREDS OF INVESTIGATIONS.

- ESTABLISH MINIMUM FEDERAL QUALIFICATIONS AND SCREENING STANDARDS FOR PCS WORKERS, INCLUDING
- REQUIRE STATES TO ENROLL OR REGISTER ALL PCA ATTENDANTS AND ASSIGN THEM UNIQUE NUMBERS.
- REQUIRE THAT PCS CLAIMS TO IDENTIFY THE DATES OF SERVICE AND THE PCS ATTENDANT WHO PROVIDED THE SERVICE*

SOURCE: HHS OIG, INVESTIGATIVE ADVISORY ON MEDICAID FRAUD AND PATIENT HARM INVOLVING PERSONAL CARE SERVICES, OCTOBER 3, 2016, ACCESSED AT [HTTPS://OIG.HHS.GOV/REPORTS-AND-PUBLICATIONS/PORTFOLIO/IS-MPCS2016.PDF](https://oig.hhs.gov/reports-and-publications/portfolio/is-mpcs2016.pdf).

CHALLENGES AHEAD – ELECTRONIC VISIT VERIFICATION (EVV)

- 21ST CENTURY CURES ACT MANDATES STATES TO USE EVV FOR PCA AND HOME HEALTH SERVICES. ANTICIPATED TO SAVE \$290 MILLION OVER 10 YEARS.
- ORIGINAL DEADLINE FOR IMPLEMENTATION EXTENDED TO JANUARY 1, 2020 FOR PCA SERVICES.
- EVV SYSTEM MUST ELECTRONICALLY VERIFY: TYPE OF SERVICE PERFORMED, WHO RECEIVED SERVICE, DATE OF SERVICE, LOCATION, INDIVIDUAL PROVIDING SERVICE AND THE TIME SERVICE BEGAN AND ENDED.
- STATES SUBJECT TO PENALTY FOR NON-COMPLIANCE – PENALTY IS INCREMENTAL REDUCTIONS IN FEDERAL MATCH FOR SERVICES – WILL EQUAL 1% AFTER FIVE YEARS.
- LIMITED EXCEPTION– STATES THAT HAVE MADE GOOD FAITH EFFORT TO COMPLY AND HAVE ENCOUNTERED UNAVOIDABLE DELAYS IN IMPLEMENTATION CAN AVOID PENALTY IN FIRST YEAR.
- ENHANCED (90:10) FUNDING IS AVAILABLE TO STATES TO DESIGN, DEVELOP AND IMPLEMENT EVV IF EVV SYSTEM IS OPERATED BY THE STATE OR BY A CONTRACTOR ON BEHALF OF THE STATE. [STATES MUST FOLLOW ADVANCED PLANNING DOCUMENT REQUIREMENTS TO SECURE APPROVAL FOR ENHANCED MATCH.

CHALLENGES AHEAD – INCREASED OVERSIGHT

- CMS IS FOCUSING ON POLICIES AND PROJECTS TO INCREASE FEDERAL FLEXIBILITY, STATE ACCOUNTABILITY AND PROGRAM INTEGRITY.
- IN MANAGED CARE: STATES MUST HAVE A COMPREHENSIVE MANAGED CARE QUALITY STRATEGY
- RECENTLY RELEASED: MEDICAID & CHIP SCORECARD 1.0 – INCLUDES MEASURES VOLUNTARILY REPORTED BY STATES, AS WELL AS FEDERALLY REPORTED MEASURES IN THREE DOMAINS
 - STATE HEALTH SYSTEM PERFORMANCE
 - STATE ADMINISTRATIVE ACCOUNTABILITY
 - FEDERAL ADMINISTRATIVE ACCOUNTABILITY
- FUTURE ITERATIONS WILL INCLUDE MEASURES THAT FOCUS ON LTSS AND PROGRAM INTEGRITY
- INTENT IT TO USE THE SCORECARD AS AN ACCOUNTABILITY TOOL FOR STATE PERFORMANCE AND OUTCOMES

SCORECARD LINK: [HTTPS://WWW.MEDICAID.GOV/STATE-OVERVIEWS/SCORECARD/INDEX.HTML](https://www.medicaid.gov/state-overviews/scorecard/index.html)

CHALLENGES AHEAD - WORKFORCE ISSUES

- AS THE BABY BOOM AGES AND THE ELDERLY POPULATION GROWS, MORE INDIVIDUALS WILL BE CALLED UPON TO PROVIDE UNPAID/INFORMAL CARE. TODAY, INFORMAL CAREGIVERS PROVIDE AN ESTIMATED 75% OF ALL LONG-TERM CARE TO ELDERLY FRIENDS AND FAMILY.
- DEMAND FOR INFORMAL CARE GIVERS AND PAID HOME HEALTH AIDES AND PERSONAL CARE AIDES WILL CONTINUE TO INCREASE.
- ACCORDING TO DOL/BLS, DEMAND FOR HOME HEALTH AND PERSONAL CARE AIDES IS PROJECTED TO GROW 41% FROM 2016 TO 2026.*
- YET, NUMBER OF DIRECT CARE WORKERS IS PROJECTED TO INCREASE BY ONLY 20%.

*Bureau of Labor Statistics, US Department of Labor, Occupational Outlook Handbook, Home Health Aides and Personal Care Aides, accessed at <https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm>, visited on July 30, 2018.

LTSS – TOWARD A FUTURE STATE

- IN PROCESS - EXPANSION OF INTEGRATED CARE MODELS INCLUDING:
 - INCREASED RELIANCE ON MEDICAID MANAGED LONG-TERM CARE
 - CHRONIC CARE ACT
 - ALLOWS MEDICARE ADVANTAGE PLANS (IN 2020) TO TEST VARIOUS VALUE-BASED MODELS THAT ALLOW FOR A MORE FLEXIBLE BENEFIT PACKAGE.
 - ALLOWS MA PLANS TO OFFER SUPPLEMENTAL BENEFITS TO INDIVIDUALS WITH CHRONIC ILLNESS IF THEY HAVE “REASONABLE EXPECTATION OF IMPROVING OR MAINTAINING THE HEALTH OR OVERALL FUNCTION OF THE ENROLLEE.”
 - INCREASED OPPORTUNITIES TO COORDINATE MEDICARE AND MEDICAID LTSS
 - INCREASES USE OF TELEHEALTH IN MA PLANS AND FOR HOME HEALTH SERVICES
 - REQUIRES THE ESTABLISHMENT OF A PAYMENT CODE UNDER MEDICARE FOR LONGITUDINAL COMPREHENSIVE-CARE PLANNING SERVICES
- IN PROCESS- GREATER FLEXIBILITY WITH GREATER ACCOUNTABILITY
- FOCUS NEEDED ON INCREASED SUPPORT FOR FORMAL AND PAID CAREGIVERS.

ADDITIONAL RESOURCES

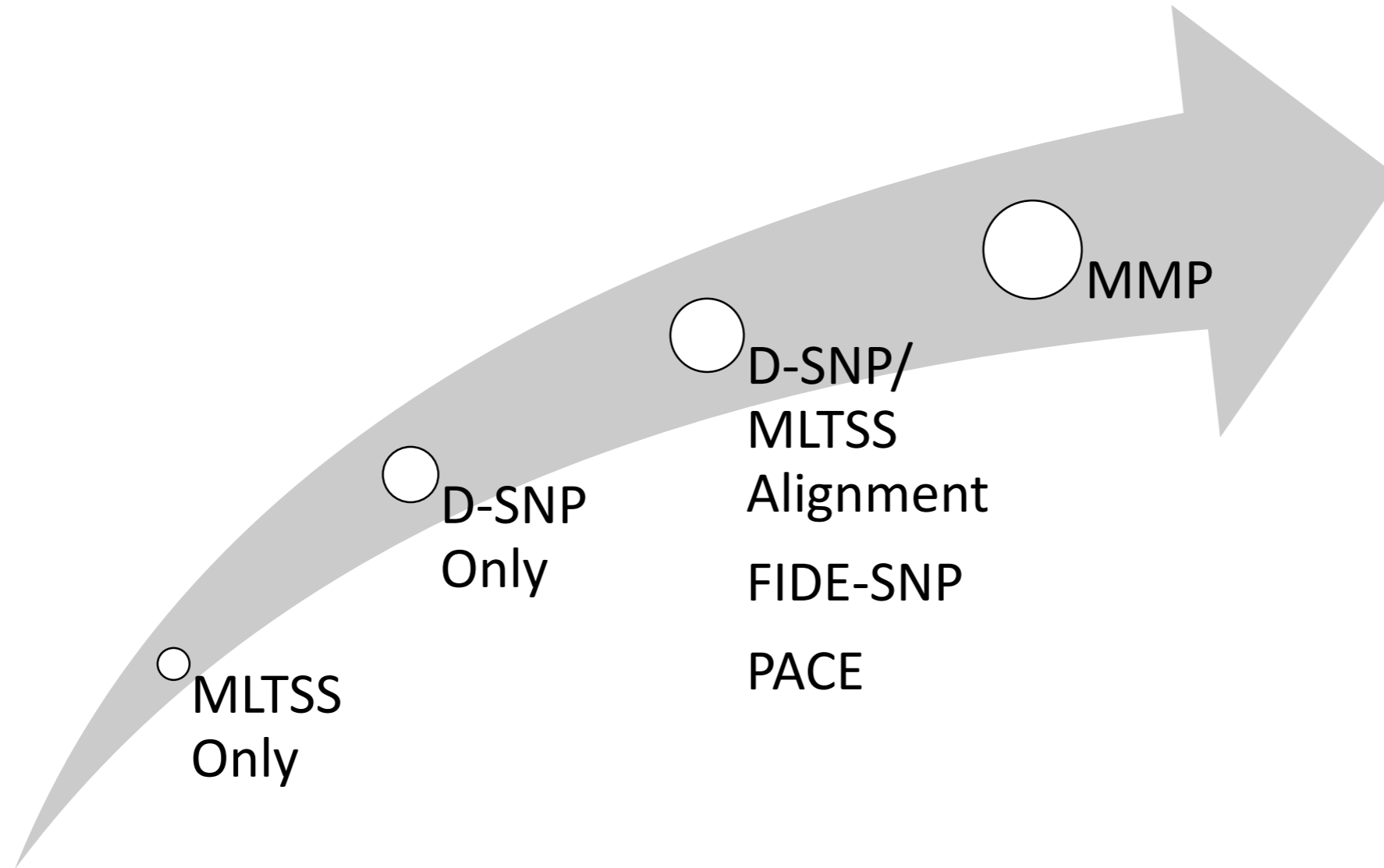
- CMS WAIVER LIST – [HTTPS://WWW.MEDICAID.GOV/MEDICAID/SECTION-1115-DEMO/DEMONSTRATION-AND-WAIVER-LIST/INDEX.HTML](https://www.MEDICAID.GOV/MEDICAID/SECTION-1115-DEMO/DEMONSTRATION-AND-WAIVER-LIST/INDEX.HTML)
- CMS 1915(C) WAIVER TECHNICAL GUIDANCE – [HTTPS://WWW.MEDICAID.GOV/MEDICAID-CHIP-PROGRAM-
INFORMATION/BY-TOPICS/WAIVERS/DOWNLOADS/TECHNICAL-GUIDANCE.PDF](https://www.MEDICAID.GOV/MEDICAID-CHIP-PROGRAM-INFORMATION/BY-TOPICS/WAIVERS/DOWNLOADS/TECHNICAL-GUIDANCE.PDF)
- CMS TECHNICAL ASSISTANCE WEBPAGE FOR HCBS –
[HTTPS://WWW.MEDICAID.GOV/MEDICAID/HCBS/TECHNICAL-ASSISTANCE/INDEX.HTML](https://www.MEDICAID.GOV/MEDICAID/HCBS/TECHNICAL-ASSISTANCE/INDEX.HTML)
- CMS SPA AND WAIVER PROCESSING PAGE – [HTTPS://WWW.MEDICAID.GOV/STATE-RESOURCE-CENTER/SPA-
AND-1915-WAIVER-PROCESSING/INDEX.HTML](https://www.MEDICAID.GOV/STATE-RESOURCE-CENTER/SPA-AND-1915-WAIVER-PROCESSING/INDEX.HTML)
- NASUAD, ELECTRONIC VISIT VERIFICATION: IMPLICATIONS FOR STATES, PROVIDERS, AND MEDICAID PARTICIPANTS, MAY 2018 -
[HTTP://NASUAD.ORG/SITES/NASUAD/FILES/2018%20ELECTRONIC%20VISIT%20VERIFICATION%20REPORT-
%20IMPLICATIONS%20FOR%20STATES%2C%20PROVIDERS%2C%20AND%20MEDICAID%20PARTICIPANTS_0.PD
F](http://NASUAD.ORG/SITES/NASUAD/FILES/2018%20ELECTRONIC%20VISIT%20VERIFICATION%20REPORT-%20IMPLICATIONS%20FOR%20STATES%2C%20PROVIDERS%2C%20AND%20MEDICAID%20PARTICIPANTS_0.PDF)

QUESTIONS?

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

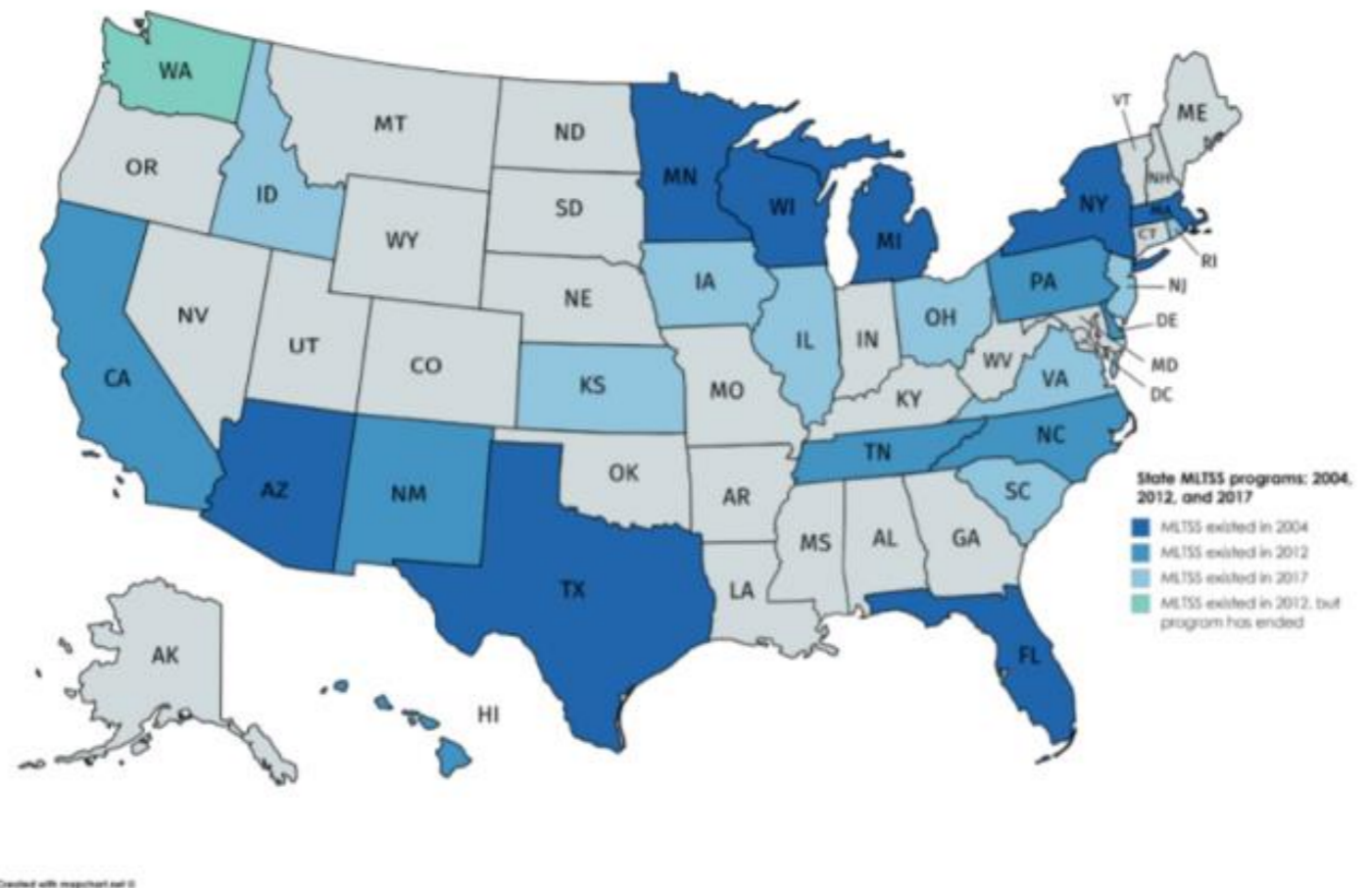
Spectrum of Integration



MLTSS

- 24 states operated MLTSS programs in 2017 (up 50% from 2012)
- Total enrollment more than doubled from 800,000 in 2012 to 1.8M in 2017

Figure 2.1: Prevalence of MLTSS in 2004, 2012, and 2017



Source: <https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf>

Movement to Managed Long Term Services and Supports

- MLTSS includes institutional and community based services and supports
- States pursue MLTSS because of:
 - Budget predictability
 - Cost savings from rebalancing
 - Improved care management and care coordination
 - Greater accountability for more systematic measurement and monitoring
- Assessment of all members to determine unmet needs
- Flexibility in services

MLTSS Can Include all Populations and Waiver Services

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

~~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
- Ensure long-term sustainability of the system as demand for LTSS grows

State MLTSS-Related Initiatives

- 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 increased NF utilization
- Money Follows the Person and Balancing Incentive Program

What do MCOs Know About LTSS?

- Look for an MCO that knows LTSS services
 - Can be a steep learning curve – particularly for concepts like self-direction
- Need to have good training on the provider community and how they have been doing business with the state
- Look for a strong approach to assuring cash flow to providers
- Must have specialized care management systems
- National MCOs can bring program experience from one state to start programs in other states
- Ensure that measures are in place to prevent inappropriate cutting of LTSS services

MCO MLTSS Initiatives

- Reaching hard to locate persons
 - Building relationships with members
 - Meeting members “where they are”
- Electronic care management systems
- Value based purchasing
- Diversion, transition and relocations
- Housing supports
- Whole person centered service plans that offer increased options

Examples of MCO MLTSS Innovations

- Finding housing solutions and leveraging housing relationships
 - Molina example: Change in Care program
- Bringing the services to persons where they live
- Person-centered service substitutions
- Shared savings with providers and value-based contracts
- Telemedicine and telehealth
 - Molina example: SNF Tele-psych program
- Value added services
- Caregiver supports
 - Molina example: Caregiver Support program

Focus on Quality Improvement and Performance

- Begins with the contract - Value based purchasing concepts
 - Molina example: Quality of Living program
- 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?

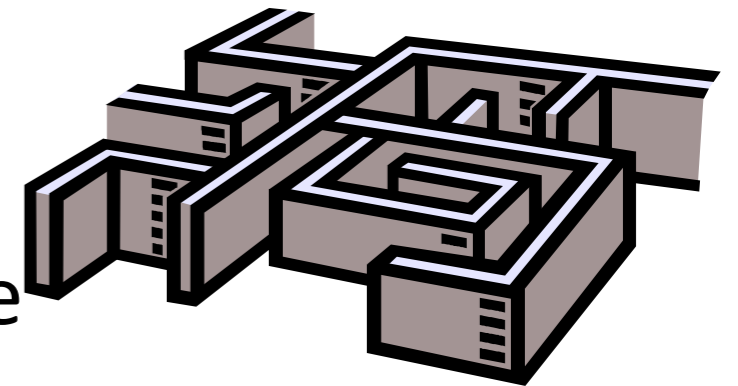
- Consolidation and acquisition
- Survival of the fittest
- Competition for members
- Any willing provider changes
- Changing roles for ADRC and AAAs
- New relationships with different MCOs
 - Need for innovation and creativity

Navigating Fragmented Systems

- Unless in integrated programs, dually eligible individuals must navigate:

- Three ID cards
- Three different sets of benefits
- Multiple providers who rarely communicate
- Uncoordinated health care decisions, not person-centered

- No integrated funding stream for states
- States fund the LTSS costs while savings go to Medicare
- Institutional bias



Options for States to Integrate Care for Duals

- **Financial Alignment Demos**
 - Allows for shared savings of Medicare dollars
 - Capitated
 - Utilizes three-way contracts between CMS, state, and plans
 - 9 states participating: CA, IL, OH, MA, MI, NY (2 demos), RI, SC, TX
 - 379,047 enrollees as of July 2018
 - Managed Fee For Service
 - WA state already demonstrated significant savings through their Health Homes-based model
- **Program for All-Inclusive Care (PACE)**
 - Integrated programs for adults 55+ who need NF level of care
 - As of July 2018 – sites in 31 states served 42,326 enrollees

Options for States to Integrate Care for Duals

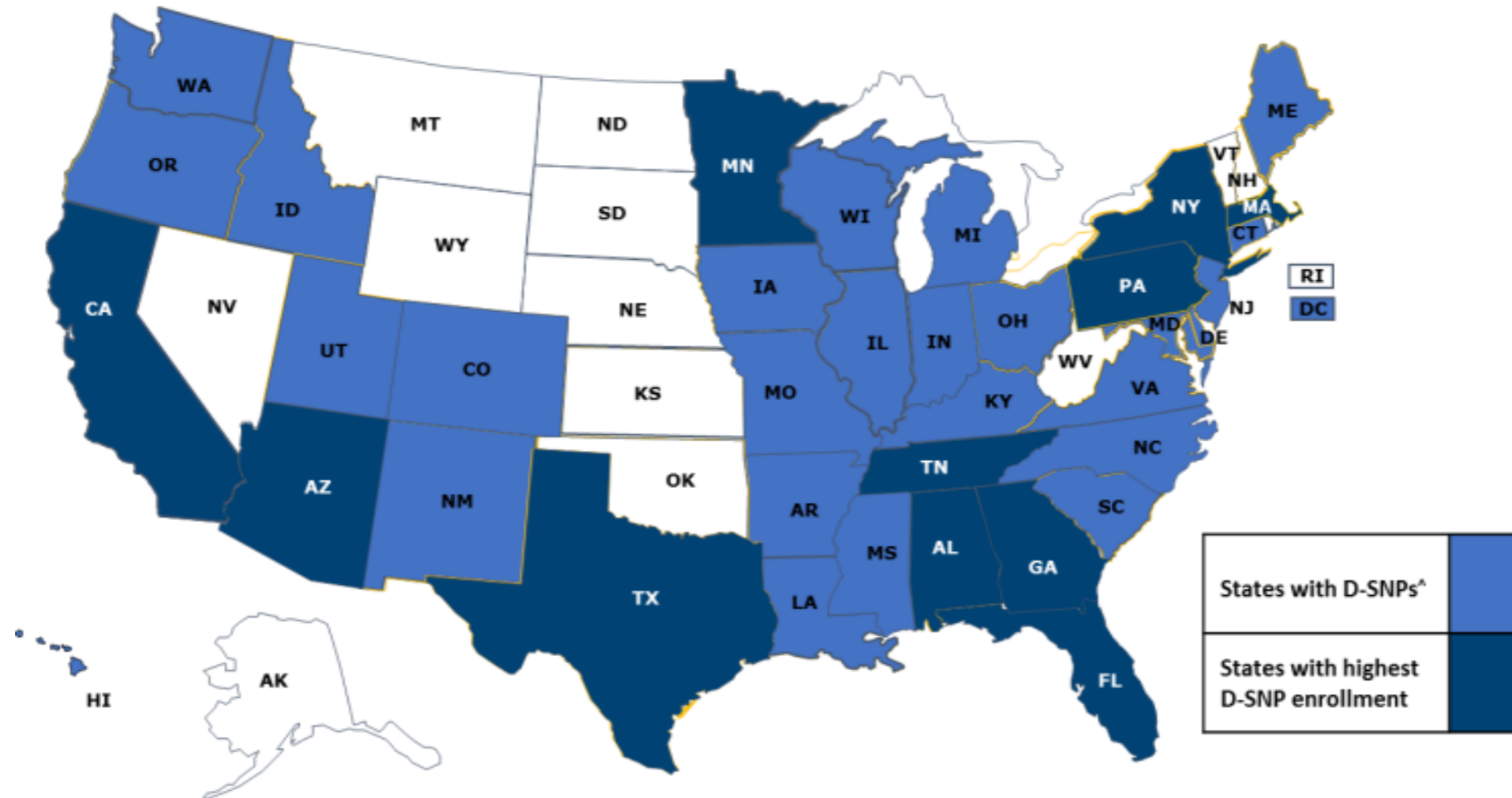
Dual Eligible Special Needs Plans (D-SNPs)

- 1.9M enrollees (including FIDE enrollees) nationally
- D-SNPs (Medicare Advantage plans) required to sign MIPPA contracts with state Medicaid agencies to operate
- Varying levels of integration with Medicaid
- Separate Medicaid and Medicare funding streams
- 41 states have D-SNPs

Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)

- 146k enrollees nationally
- Highest level of integration on the D-SNP platform that incorporates LTSS, primary, acute, and behavioral healthcare into a single plan
- FIDE-SNPs must be at risk for coverage of Medicaid LTSS and have procedures for administrative alignment of Medicare and Medicaid
- May be eligible to receive additional MA payments that reflect frailty of enrollees
- Examples: ID, MA, NJ, WI

National D-SNP Enrollment



[^] D-SNP contracts for Puerto Rico as well as those with no enrollment as of February 2014 are not included.
Source: CMS SNP Comprehensive Report for February 2014 – Found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/Special-Needs-Plan-SNP-Data.html>

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
- 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

Changing Winds: Current Policy Issues in Medicaid



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- As the push to repeal the ACA has dissipated, focus has shifted to state-level actions and reforms in Medicaid and, to a lesser extent, the Exchanges
- Questions center around:
 - ▣ 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
 - ▣ Retroactive eligibility waivers
 - ▣ Non-emergency Medical Transportation
 - ▣ Exchange-based Medicaid delivery
 - ▣ Expansion to “Pre-LTSS” populations
 - ▣ Caregiver Support
- Important states to watch:

Indiana	Wisconsin	Kentucky	Many Others!
Arizona	Arkansas	Washington	

Open discussion with panelists



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- Carol Steckel, Former Medicaid director in Alabama and North Carolina; Former Senior Advisor in Louisiana Department of Health and Hospitals; carolsteckel@gmail.com
- Jerry Dubberly, Principal, Myers and Stauffer LC; Former Medicaid director in Georgia; jdubberly@mslc.com
- Ruth Kennedy, Health Policy Director Southern Strategy Group-LA; Former Medicaid director in Louisiana; kennedy@ssgla.com
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