CURRENT ISSUES IN MEDICAID AND IMPLICATIONS FOR AGING AND DISABILITY PROGRAMS

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NASUAD Overview

- National association that represents state agencies providing LTSS and other services and supports to older adults and people with disabilities
  - 56 members (50 states, DC, 5 territories)
- Led by a board of directors comprised of state agency officials
- Provides direct technical assistance, research, regulatory and policy analysis to states
- Facilitates state-to-state information sharing via teleconferences/webinars, e-mail surveys, policy committees, and national conferences
- Educates and advocates for state agency interests in front of Congress and the Federal government
Contents

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Medicaid Overview
Medicaid Overview

- Created in 1965, along with Medicare (P.L. 89-97), under the Social Security Amendments of 1965;
- State & Federal partnership for funding and policy:
  - Medicaid administration
- Originally intended to be a health plan for low-income individuals on welfare:
  - The role of the program has expanded and changed over its 50+ years
- 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 Enrollment & Expenditures

<table>
<thead>
<tr>
<th>Enrollment</th>
<th>Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled 13%</td>
<td>Disabled 34%</td>
</tr>
<tr>
<td>Adults 36%</td>
<td>Adults 32%</td>
</tr>
<tr>
<td>Children 43%</td>
<td>Children 19%</td>
</tr>
<tr>
<td>Older Adults 8%</td>
<td>Older Adults 14%</td>
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Source: Center for Budget and Policy Priorities
Older adults and persons with disabilities represent a majority of Medicaid expenditures despite being less than half of enrollees.

Chronic care and significant health conditions are a major component of these expenses, as are Long-term Services and Supports (LTSS).

Medicaid is the largest source of LTSS financing in the USA, paying for over $144 billion in 2013 which represented 42% of overall expenditures on LTSS\(^1\)

- Medicare ($74B) and out-of-pocket ($57B) were the next two largest sources of LTSS expenditures

Current Status of State Medicaid Expansion

Status of State Medicaid Expansion Decisions

NOTES: Current status for each state is based on KFF tracking and analysis of state activity. *AR, AZ, IA, IN, KY, MI, MT, and NH have approved Section 1115 expansion waivers. CMS approved the Kentucky HEALTH expansion waiver on January 12, 2018; implementation of some provisions was scheduled to begin in April 2018. VA is considering adopting expansion in their FY 2019 state budget. UT passed a law directing the state to seek CMS approval to partially expand Medicaid to 100% FPL using the ACA enhanced match, and UT also has a measure on the ballot in November to fully expand to 138% FPL. Expansion proponents in ID and NE are collecting signatures to place expansion on their November ballots. ME adopted the Medicaid expansion through a ballot initiative in November 2017, but the Governor failed to meet the SPA submission deadline (April 3). (See the link below for more detailed state-specific notes.)

Role of CMS and the States

- 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, benefits, provider payments, delivery systems and other aspects of their programs.

- Each state must have a “single state agency” that administers Medicaid.
Medicaid Waivers

- Allow the state to “waive” certain Medicaid requirements, including state-wideness, freedom of choice, and comparability;
- Not always an “entitlement” – some can have enrollment limits or waiting lists;
- Cost-neutrality requirements;
- Most common include:
  - 1115: 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.
Current Issues in Medicaid
Current Considerations

- As the push to repeal the ACA has dissipated, focus in health reform has shifted to state-flexibility and state-actions around Medicaid and, to a lesser extent, ACA tax credits.

- 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 (among MANY others):
  - Indiana
  - Wisconsin
  - Kentucky
  - Arizona
  - Arkansas
  - Washington
A variety of programs exist that provide Long-term Services and supports in Medicaid

LTSS in Medicaid includes institutional services in nursing homes (mandatory) as well as HCBS (optional)

Each state sets their own standards for clinical eligibility, known as “level of care”

LTSS can also have different eligibility criteria

- The “special income group” allows individuals who require LTSS to qualify with income at 300% of SSI (approximately 225% FPL) instead of lower levels for non-LTSS groups
- Special income group exists in many states, but not all cover up to 300% SSI
The Medicaid home and community-based services (HCBS) regulation establishes new criteria and requirements for Medicaid-funded HCBS, with an emphasis on ensuring that services are provided in an integrated and community-based setting.

CMS’ compliance activities are a process-based approach using transition plans to outline objectives and milestones towards meeting the rule requirements by the 2022 deadline.

States have, for the most part, not made any final determinations regarding the settings that are allowable and those which violate the integration mandate.
Current Status and Issues

- **Heightened Scrutiny:**
  - What process will states use to identify settings subject to heightened scrutiny, determine whether they are compliant with the rules, and submit evidence of the determination to CMS?

- **Assessment of settings:**
  - Objective criteria (prongs 1&2): “are they collocated with institutional services?”
  - Subjective criteria (prong 3): “does the setting isolate individuals?”

- **CMS workgroup with states to clarify:**
  - Ways to identify violations of prong 3
  - Process and information submitted for heightened scrutiny reviews
  - Role of CMS and states in the process

- **CMS recently discussed using six states as a pilot (a few settings in each state) to provide feedback on heightened scrutiny packages**
The 21st Century CURES Act mandates that state Medicaid programs have electronic visit verification for:

- Personal care services by 2019;
- Home health services by 2023.

If a state does not have the system in place, they receive a decrease in FMAP:

- Begins at 0.25% and grows to 1% over time;
- Does not apply to all Medicaid services – FMAP only cut for the noncompliant services.
Electronic Visit Verification

■ Challenging timeline:
  - 1/1/2019 is less than 8 months from now but no formal CMS guidance has been issued:
    - States may receive a 1 year reprieve from the FMAP cut if they made a “good faith effort” and experienced “unavoidable delays”;
    - CMS has not yet defined what a good faith effort entails
  - States must submit an Advance Planning Document to secure approval for increased federal funding to implement EVV or else fund at lower match rates;
  - Competitive procurements and potential appeals will be lengthy;
  - Final design, development, and implementation must follow these processes.

■ Key questions remain:
  - What does “in-home visit” mean?
    - Licensed providers (ie: Assisted living/group homes/etc) not included
    - What about shared living arrangements? Family members in the same home?
Several Federal reports have raised concerns about oversight of health and welfare in HCBS, including DD group homes and assisted living.

ACL/OIG/OCR put out a joint report of recommendations, including ensuring that states have:
- Reliable incident management & investigation processes;
- Audit protocols to ensure compliance with reporting;
- Mortality reviews for unexpected deaths; and
- Quality assurance mechanisms in place.

CMS expects to release guidance (CIBs) on H&W in the near future.
Overview – FFS vs. MMC

Fee-for-service (FFS)

• **Relationship:** State contracts directly with health care providers.
• **Payment:** Providers receive payment for each health care service provided to consumers.
• **Accountability:** Providers do not bear financial risk for the provision of services.
• Note: FFS has historically been the predominant delivery system.
Medicaid Managed Care (MMC)

- **Relationship**: State contracts with a Managed Care Organization (MCO), not a direct service provider.
- **Service Delivery**: Consumers receive part or all of Medicaid services from health care providers that are paid by a MCO that is under contract with the state.
- **Payment**: MCOs receive capitated payment from the state for a specified benefit package on a per member per month basis.
- **Accountability**: The MCO is responsible for the provision and coverage of Medicaid services.
Current MLTSS Programs

Source: NASUAD survey; CMS data
**KEY Takeaway: Locus of Control for Medicaid service provision shifts from State to MCO**

- In order to keep serving waiver clients, an LTSS provider will have to execute contracts with one (or more) MCOs

- MCOs have contract mandates that full range of HCBS is available to enrollees
  - MCOs will either ‘build’ it or ‘buy’ it.
  - What is ‘it’? Expertise in delivering high-quality and effective HCBS services
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